

**Pay-for-Performance and Medicare:
Moving from the Drawing Board to the Doctor's Office:
The Alliance for Health Reform and the Commonwealth Fund
December 15, 2006**

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ED HOWARD: – indicated, I'm Ed Howard with the Alliance for Health Reform. There are still a few seats up front, as always, in case you're in the back looking for one. I want to welcome you on behalf of Jay Rockefeller, our chairman; Bill Frist, our vice-chairman; our soon to be co-chair, Susan Collins; to a briefing on a topic that's really right at the forefront of every discussion about how to improve U.S. health care system and that is paying for better performance, P4P.

Since we last looked at this topic broadly, why almost 18 months ago, a lot of new P4P arrangements have been put in place, most recently assuming a presidential signature, a plan to begin a P4P arrangement for physicians in Medicare that was put in place as part of the fix for what would otherwise have been a 5-percent cut in Medicare reimbursement for physicians starting in January. It's a new Institute of Medicine report on the topic that has stimulated a lot of interest in this area and we're going to hear a lot more about that today. We have three of the members of the panel with us on our panel today.

Our partner in today's endeavor is the Commonwealth Fund, a private philanthropy whose work stresses the need for a health system that performs at a high-level and therefore is looking for the right incentives. Happy to have both Stu Guterman, who will be co-moderating with us today from

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Commonwealth and, I believe, Karen Davis, who's the president of the Commonwealth Fund, is in the audience. Thank you, Karen. And we have a number of other staffers. I want to thank all of them for their effort in putting together this event.

Let me just handle a couple of logistical items before we get started. You'll find a lot of information in your packets. That information will be, in fact, in most cases already is on our Web site in case you want to access it electronically, that's allhealth.org. Tomorrow morning, or maybe Monday morning, I guess we ought to give them the weekend to work on it. You can view a webcast of this briefing on kaisernetwork.org and see the materials from the packets there as well. You'll find in your packets biographical information about the speakers, more extensive than we have time to give them credit for from the podium here. And of course, at the appropriate time, we'd love for you to fill out that blue evaluation form and feedback some information on how we can make these briefings better for you. There are floor mics when we get to the Q&A. There are also green cards that you can write a question on when we get to that point.

As I noted, Stu Guterman is with us here from Commonwealth. He's the senior program director of their program on Medicare's future and he was a senior Medicare

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analyst within CMS before that. So we're very pleased to have him here. Stu?

STUART GUTERMAN: Thanks, Ed, and I want to welcome everybody here and thank Ed and Lisa and the rest of the rest of the Alliance staff for helping us put this meeting together. I think it's going to be a very interesting discussion, particularly in light of the comments that have been aired this week and the legislation that was done last week.

I just want to sort of set the stage for what I think is a terrific panel here by reminding people of an old maxim that I think really drives my thinking in this area and that is, "You get what you pay for." There's been a lot of discussion about pay-for-performance and whether it's good or bad. And I think that sort of misses the point. There are two things I need to say about that. One is that our health care system pays for performance now. Particularly, Medicare pays for performance. It pays for more complicated. It doesn't ask whether those services are better or more valuable. And when you think about pay-for-performance, you can argue about how to do it and what are the right measures and there will be some discussions about the detail in which the devil resides. But you have to remember that you do get what you pay for and the objective of pay-for-performance is to start paying for what you want rather than pay for more of whatever happens to be provided.

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So I won't take up too much time before the people who really are into this stuff can say what they have to say. So I'll start by handing the microphone over to Gail Wilensky, who will be the first speaker. She'll be followed by Bob Galvin, then Bob Barrinson [misspelled?], and then Alan Nelson will bat cleanup.

GAIL WILENSKY: Thank you. Good afternoon. It's a pleasure to be here to share with you the results an ILM study that was released in September. As was already mentioned, several of us on the podium here were on that study, as well as Karen Davis, who was also mentioned as being here.

I'm going to take the liberty to summarize as I see it the most important parts of that report. But I want to start by briefly reviewing some of the points from the first report in this series. This is part of the Clinical Pathways to Quality series and represented a two-year effort by the Institute of Medicine. The first report in this series was on measurement performance, since if you want to think about realigning incentives, including but not necessarily limited to pay-for-performance, having a performance measurement system is a first order to accomplish. And so that was really the first order of business for this commission. As part that report, and I encourage you to go online to look at it if you haven't had an opportunity to do so, there were several important points that are relevant I think to today's discussion.

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After a number of years the quality chasm that the Institute of Medicine had reported and its now very famous report, *To Err is Human* in 1999, remains wide and spending is high and continues to grow rapidly. While there are a variety of orders or obstacles in terms of trying to learn how to spend smarter, the first order requirement is making sure that we have a way to assess and report performance. And that's basically the purpose of this first volume. There are a lot of initiatives that need to occur.

But there needs to be a national system of performance measurement if we're going to achieve national goals. There's a lot of concern that's been raised about inconsistencies and duplications, what that will do in terms of being able to measure accurately performance in health care and also concern about the burdens that that would otherwise place on hospitals and physicians, nursing homes, home cares, all of those institutions and clinicians that are involved in providing health care through Medicare or through other parts of the health care sector. In order to have the information be credible and believable and acceptable, it has to be transparent. It has to be understood. And it has to be publicly available to any and all who want to be able to see it.

And finally, as frustrating as it might be, we are where we are. We need to start with a starter set that

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recognizes a health care system where the measurements such as they are, will be for individual events like physician office visits or hospital stays reported on a provider by provider basis, even though most health care is really about the health care provided to an individual during an episode of care and is likely to involve a number of different clinicians and may well cross institutional settings and may well involve care over time. Ultimately that is the kind of information that we want to see available so that shared accountability and performance can be measured sensibly. But it's not where the world is now and that's where we need to start. And so that was the recommendation, is start where we are. And it lays out a blueprint for where we need to go over the course of the next three to five years.

Let me jump forward now to the third report. The second report, by the way, for those of you who are interested, was about QIOs and that was released in March. In this third report, which I also suggest that you look at, there are several key messages and then I'm going to summarize the recommendations themselves.

The first is that Medicare is a broken payment system. As someone who has spent many a year worrying about Medicare as administrator and through MedPAC and PPRC, it is a sad statement to have to make but it is one that I concur with fully. We regard pay-for-performance as an important but

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definitely not the only change that needs to occur. There are unfortunately no magic bullets, no silver panaceas that are out there. Many steps will be needed to be taken in order to remedy the problems in Medicare. But trying to change the reimbursement system using this among other mechanisms is one strategy. We acknowledge that evidence base for pay-for-performance is not robust but the evidence base about the current reimbursement system is quite robust in terms of what it is doing. As Stuart indicated, we are paying for performance; it's just not very desirable performance right now.

We need to encourage the things that we think are important and basically the group summarized them as three different areas: high quality, efficiency, and patient centeredness. That is a way to try to group the six goals that the IOM speaks about. And because there is much that we don't know yet, the report recommends something that has been labeled "active learning." That is we need to make changes, see the results, modify the system in response to the results and continue on that process.

Let me move now to the specific recommendations that were included. The first is that we need to see a phased approach. That's consistent with what I've just said. There are a lot of changes that need to be made. Some of them are easier because there's been more preparatory work than other.

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We don't recommend jumping full-blown into a pay-for-performance system that would have a major shift in reimbursement.

Initially we think that with the growth in Medicare that will be occurring under current law, there is enough money in the system. It's a question about how to redistribute some of the funds, except for the physicians. We recognize that with current law with the SGR there has been and continues to be, other than if the bill is signed for this coming year, expectations of a 4- or 5-percent reduction for the next several years. That would not be tolerable or consistent with the pay-for-performance using existing funds.

While as I've mentioned, we think that ultimately the performance system and therefore the shared accountability and rewards that ought to occur ought to bring together the clinicians and institutions that impact the care an individual receives. Initially the funds ought to be provider specific. So any redistribution among hospitals ought to come from hospital funds and any redistribution under pay-for-performance for homecare ought to come from money that is part of homecare. Ultimately if you want to try to have a shared accountability, you will need to have consolidated pools of funding in order to reward the groups, individuals and institutions that are providing the care.

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And finally as I mentioned early on, if you think different aspects of health care are important, like quality and efficiency and patient-centeredness, you need to make sure all three are included when you design your awards. As a sidebar, I will say that the economists like myself on the group were worried that only quality might be rewarded and therefore you could end up spending more. The physicians and clinicians in the group were worried that only efficiency might be rewarded and that we would spend less but get less care. I think we all agree that you need to include those aspects that you think are important.

Second set of recommendations, and then I'm going to summarize a couple of takeaway messages, is that initially we need to reward both achievement and improvement. Ultimately we would like to weight achievement more but we recognize that there's a lot of variation and quality out there. We want to encourage all or almost all anyone who is interested as a clinician or institution to provide. We need to be able to reward those that show some improvement. Although initially I was personally against pay-for-reporting, it seemed to me that ought to be part of participating in Medicare and getting paid at all, I can see that the pay-for-reporting has worked very well for hospitals. And I think we ought to start with that as the first step for not only physicians but for other groups. We will start with a narrow set of measurements, as I've

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described, and work over time to comprehensive measures. Physicians need to be brought in slowly because their measurement sets are frankly far less developed. We have recommended a voluntary basis for the first three years and then an assessment about how far along it's gone. Some of the groups, like The Society of Thoracic Surgeons, are very advanced in terms of their measures. Others are not nearly so advanced. And finally, but very importantly, in the short-term particularly, we need to make sure there is rewards for the person, probably a physician, who coordinates the care in a world in which most care is done in a fragmented way. This is a very important part about moving ahead into the future.

So the takeaway messages here are some providers are already reporting quality measures like hospitals. Home care starts next year. We're pretty much ready to start for pay-for-performance here. Start it soon but go slow. Second is with docs, it's much more varied. Problems particularly for small groups of physicians so therefore start voluntary and start on pay-for-reporting. And do what we can to encourage the physician participation. And finally recognize explicitly that while moving to this direction and it is an important first step, it is not the only thing that needs to happen. We need to find other ways of realigning financial incentives.

A current one that I have been promoting is a notion of a broad scale or wide concept of gain sharing to encourage

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physician and hospital participating in joint activities. They encourage real or virtual groups through such things as gain sharing and of course encourage health IT that would make life easier all around. Thank you.

ED HOWARD: Terrific. Thanks, Gail. Bob Galvin, would you pick up the [inaudible]?

ROBERT GALVIN, M.D.: Thank you, Ed, and hi, everybody. I think you read from my bio that I work for GE and I'm on the side that's responsible for purchasing health care. And one of the most exciting developments over really the last probably eight or 10 years in health care has been how closely coordinated the public sector and private sector has been around approaching how to buy health care. It's really been bipartisan. It's been across two administrations. And it's because, in a sense, we have more in common than we thought we have, which is we're both facing increasing costs and we're trying to figure out what the value is and kind of where to go next. I mean, one way of thinking about it is employers like GE on the private side can move faster than public sector and we can be a catalyst. But really public sector, particularly CMS when they execute it has a much bigger impact. So what you decide and what Medicare and what the Congress decides to do going forward around pay-for-performance is very important to us.

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So my talk today is going to have two topics equally divided. And the first I'm going to give you a status report on pay-for-performance in the private sector. And then I'm going to give you some thoughts on how to think about P4P because the debate is flying.

So let me get to the private sector. And kind of the word is that the private sector, and these are now employers and the health plans with whom they contract, have committed to pay-for-performance and they're moving very quickly. So there's now well over 150 programs out there. I saw a study recently that suggested that more than 80-percent of doctors and hospitals are feeling in some way a pay-for-performance kind of program. And it's growing very fast. So really a commitment is out there and it's moving. It comes out and it's worth talking a little bit about how we got there on the private sector because we are faced with the same cost pressures that Medicare is. At GE it's the senior management, it's the board, for CMS it's Congress. But it's really the same issue about what do we do about rising costs.

And Gail mentioned and we all had a wake-up call probably right around 2000 when the series of IOM reports came out that told us it wasn't just costs it was quality too. And that led us to kind of move from cost containment to value. And some of us use this with our senior management who are not health care people, we just use this simple phrase of saying,

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"Just remember the numbers 100, 50 and 25." One hundred are the 100,000 avoidable deaths that occur in U.S. hospitals every year. Fifty-percent is the chance you have of getting the right care when you go to your doctor's office. And 25-percent is a low minimum for how much waste there is in the system in terms of variation and duplication.

So as we move from the '90s, the micromanagement, kind of the whole HMO movement, the way that it evolved in the '90s, we really did start to move into much more of what call an accountability agenda. And it was really all about information and incentives. And information is what drove the Leapfrog Group, which I suspect many of you have heard of, to be founded. It was this idea that our employees and their family members and anyone covered under employer sponsored insurance had the right to know the performance of their doctors and hospitals about anywhere we could find out good data about it. And we thought incentives flowed from that as well. And I think Gail said well, it's not that we're driving incentives into the system, it's that the incentives that already exist have resulted in 100, 50 and 25. So doing nothing means we're going to get what we've had.

The whole idea of pay-for-performance, and I'm going to talk to you a little bit about Bridges to Excellence, which is one example of it, really came about from a conversation I had with a practicing physician who saw a lot of patients with

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diabetes. And I was asking her what her thoughts were about beginning to pay differently. And she told me an interesting story. And she said, "You know, I see mostly diabetics in my practice." And she was well known for this in the Boston area. And she said, "I talk to them by phone all the time. You know, I minimize their office visits. I do all the right things." And she said, "Because I get paid for every office visit and test I do, I'm making less money the better that I treat the diabetics." And she finally said something to me that stuck with me. She says, "If I keep getting better, I'm going to go out of business." And so that was a pretty profound statement from someone who was very dedicated to treating a pretty terrible disease.

So we ended up starting this program called Bridges to Excellence. It was crossing the quality chasm. It was, how do we find a bridge over to excellence? And we asked the doctors to create it. And one of the debates going on about P4P is, "Is the government making the rules?" I think a very important tenant we had in the Iwenda [misspelled?] private sector was that the doctor's better be the creators of this because they were the ones who had to live with it. And they knew a lot more about treating patients than we did. So the physicians created it.

And we came up with a recognition program. I'll walk you in the next minute briefly through how it works. So if you

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see at least 35 diabetics a year, we ask these doctors to do chart reviews. And if you meet certain measurements over about 15 measures, you either get recognized or not recognized. Now the recognition program was made by the American Diabetic Association and NCQA. So this was not a bunch of employers deciding, this was the consensus process the NCQA is so well know for. And it's very hard to do. Less than 50-percent of doctors who apply for it get it because these are not simple process measures. You have to have the blood sugar below a certain level. You have to have the cholesterol below a certain level. There are very stringent requirements.

We got an actuarial analysis because, again, it's costs that drives it. We wanted to drive quality, but we really believed that in many cases better quality lowered cost. And it turns out that in this disease if you actually follow those expert guidelines all derived by physicians and the right societies, you actually save what turned out to be in our world, \$250 dollars a year on each diabetic. So we decided this was the physicians and the employers working together that we would spend 50 of those dollars on the patients to incentivize [misspelled?] them to help them to go to stop smoking programs, kind of to do what they needed to do to be better patients. And that we would simply divide the other 200, the payer, in this case GE because we're self-insured gets 100 and the physician would get \$100 dollars per patient per

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year. If you have a few hundred diabetic patients and all the payers in your area are participating, we have several physicians who are making an extra \$15- or 20,000 dollars a year. The program is one example. It's working pretty well, part of this partnership it ended up being a demonstration product in the MMA Project. It's Section 649 as a matter of fact. And it's off and running and Stuart knows all about that.

So I just wanted to give you a granular example of how one of these programs work. It's not always that easy. And you're going to hear that appropriately from the next two speakers that it is not as easy as that one sounded. But as you hear from the two of them and as you kind of probably read the *New York Times* article over this week and that packet you got was quite good, there's incredible debate going on.

So the second part of my talk and it's really just a couple minutes is to kind of just give my thoughts about how you ought to think about this debate going on. So maybe these are guideposts. There's four of them.

The first one is, don't believe the believers because if you do they'll lie to you again. And the reason is, as Gail said, we don't know a lot about this. And I think that if you come in saying this is the solution. We do this and we're going to solve our Medicare cost problem. I would not believe that. On the other hand, if you say all doctors are going to

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reject this, this is offensive, this is not the way that we ought to go, I would not believe that either. So I think you really need to keep an open mind and don't believe the believers.

I think secondly, I think you have to ask the right question. And I don't think the right question is, "Is pay-for-performance the solution to the cost problem in Medicare?" I think the right question is, "What do we do differently than we have today?" because today gives us, as Gail said, 100, 50, 25: 100,000 avoidable deaths, 50-percent quality effectiveness, and at least 25-percent waste. So I think if we get too micro about the decision about pay-for-performance we get into the minutia of it, I think we can't lose the big picture that we have a system today. Remember that diabetologist who I talked to. You have a system today that has all the wrong incentives.

I think the third thing I'd say is something I call, "Hurry up but take your time." And another way of saying this is it is awfully easy to get into analysis paralysis. And I think we find that a lot of very, very smart people on the policy side are appropriate thinking rigorously about this but it's very easy to dive down into analysis paralysis. And I use the word, "Hurry up, but take your time" because I can't help remember when I was a medical student and I was doing a surgery rotation with a very feared surgeon. And we were all scrubbed up in the O.R. and it was my job to suture the wound. And I

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started suturing the wound and as I was suturing it the sutures were absolutely beautiful. And the surgeon toward down and looked over me. And he said, "Son, hurry up." So I then started going as fast as I could. About 30 seconds later he looked down and the sutures did not look good at this point. And he said, "Son, take your time." And so I said, "Which one do you want me to do?" And he kind of looked disgusted and he said, "This is medicine son, hurry up and take your time." And I think that isn't a bad kind of metaphor for what I think we have to do in these kind of decisions.

And the last thing I'd say is we have to use common sense. We're not always going to be right. Common sense doesn't always work, particularly in the health care sector. But common sense is a good guidepost however we make decisions. And in the end I think you have a couple choices. You're either going to pay for what you get, which is what we do now. Or you're going to get what you pay for, which is the way I think we need to move. And with that, I'm done. And I will hand it back to you.

ED HOWARD: Thank you, Bob. Reequip our panel and go to our other Dr. Bob.

BOB BARRINSON: Well, it reminds me of my third-year medical student story of the medical student with the surgeon who basically asked the surgeon, "Do you want me to cut the

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mats too short or too long?" because she never could get it quite right.

Let me go back to the beginning. First I just want to put a little broader context for the discussion of pay-for-performance, which I hope will be helpful. First, that pay-for-performance is not new in health care. I practiced 20 years ago under pay-for-performance. It was the predominant model for paying doctors. The U.S. Health care model had a substantial amount of margin payment based on how we did on our resource use, and then they added things like whether our office hours were open in evenings. It was pay-for-performance. I don't think we've looked at the results of that. There's also lots of pay-for-performance going on in other sectors. So I actually think we could learn a lot more about what has or hasn't worked. Most people talk about the peer-reviewed literature being skimpy, but I think there's some other sources.

But the more important point I want to make is this one. I think there's a tendency to equate pay-for-performance with getting the incentives right. Specifically, pay-for-performance uses marginal incentives and provides provider specific rewards or penalties based on measurable performance. And yet the incentives embedded in the basic payments applying to all providers of that kind are much more powerful than marginal incentives. So when Hospital PPS came in and changed

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cost-based reimbursement to perspective payment for a hospital episode dramatically changed the incentives on hospitals even though we were not measuring individual hospital performance on how they did. And I actually think we used the physician fee schedule as representative, or some people do of all the problems with payment systems. And it's really the glaring exception in my opinion of a fee-for-service system that sends all the wrong signals. Most of the perspective payment systems at Medicare have been quite successful at changing basic incentives. I think a lot of them need fine-tuning and in some cases that's where I would give my attention rather than pay-for-performance. But the final point on this slide is that measuring performance is difficult. Changing incentives is a different story. And I think we should be changing incentives.

So you've all heard this one, "If it ain't broke, don't fix it." The corollary is, "If it's broke, fix it." And one of my concerns is that the tail of pay-for-performance should not lag the dog of basic payment policy. So if the fee-for-service payment for primary care physicians doesn't support what clinicians should be doing for chronic care patients in Medicare, change the system. Don't expect pay-for-performance to solve the problem. Although I do think that in a reformed system, pay-for-performance can play a significant role.

Two points: One is that MedPAC has identified a lot of operational issues with how the RBRBS system is working.

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Nobody's paying any attention to that. It requires resources. It requires attention to do what it is that MedPAC has recommended and yet we're all talking about pay-for-performance. And so that's a sort of concrete thing. More fundamentally, we need to be changing how we pay, at least primary care physicians and maybe all docs, taking lessons from Europe, which combine fee-for-service, capitation, and pay-for-performance in at least a few payment systems. I know Karen Davis has spoken very highly of the Denmark system. We should be focusing there, as how do we change this basic payment system. I think that's what's broke. So to simply say, the basic payment system is broke. We're going to leave that alone, but we're going to provide 2-percent at the margin. It's not going to accomplish everything we want it to accomplish.

So the next point is that even compelling logic does not guarantee success. I spent at least five years of my life being one of those primary prior authorization doctors who had to tell other doctors whether they could do a procedure or not. If you can step back, it actually has some compelling logic to it. You use evidenced based guidelines and if you pick procedures, which are high-priced, where there's good evidence of what appropriateness is, where there are know variations and a lot of inappropriate services, where you have objective data to do that review, and which is elective, not an emergency

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situation, prior authorization makes perfect sense. So what managed care did was take something that makes perfect sense if used selectively and in a focused way and they started applying it everywhere, to the point that even doctors doing routine dermatology referrals were having to go through prior authorization. It was a completely misapplied application of what was in fact a good idea. I think we should approach pay-for-performance in the same way. It will be very effective in some places. We shouldn't apply it where it's not going to be effective.

There are problems with available measures. And here I would distinguish measures that you want for consumers to make choices from what you want for pay-for-performance. Consumers want outcome measures. They want to know about mortality rates, quality of life, costs. Pay-for-performance there's some problems with that. You've got to do case mix adjustment. You create perverse incentives. Some of these apply for the first use I talked about as well, but perverse incentives to not treat sicker, more difficult patients. And importantly you have outcome measures you still don't know what to do to improve. It doesn't necessarily give you actionable information. So then some people recommend process measures and that solves some but not all of those problems. But the problem is that the process measures may not really be

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associated with differential outcomes. So you have two studies that I'm going to cite, both from this year.

The conclusion, "The publicly reported acute myocardial infarction process measures," these are the ones that are in the premier demo that Medicare uses, "capture a small proportion of the variation in hospital's risks, standardized short-term mortality rates." They've in fact explained 6-percent of the variations. So we're ignoring the 94-percent and having a whole program on the 6-percent. The next one was just three days ago. Looking at AMI, CHF, Pneumonia, "Hospital performance measures predict small differences in hospital mortality rates. Efforts should be made to develop performance measures that are linked to patient outcomes." This is a beginning activity. In many areas this is not robust measures that we really know what we're going to get when we put all this effort in. The ideal measure is a process measure that is valid and a reliable surrogate for outcomes like Hemoglobin A1c, which I just went to a course on internal medicine. Every study done on an intervention in diabetes, what they're measuring is Hemoglobin A1c, which is a great surrogate for many real outcomes in diabetes. So I would be more than happy to do a lot of stuff on pay-for-performance related to Hemoglobin A1c. But the fact that that works doesn't mean that you can simply come up with lots of other measures that will work equally. And this fact that you can pass legislation

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saying that somebody's got to come up with measures doesn't mean that those measures are good measures.

In short, in my view, we need to carefully develop criteria for opportunistically and strategically using pay-for-performance, not overload it with expectations of transforming the health care system. Now a few years ago, in 2003, MedPAC actually had a very good chapter on pay-for-performance in which they started laying out criteria for when it should be applied or how to assess the rightness of applying pay-for-performance. They had some criteria for what were good measures. They also had criteria for when to apply it. And they went sector by sector, provider by provider with an analysis, I think in some cases a little too optimistic, but it was exactly the right kind of analysis in my opinion of strategically applying pay-for-performance. These are my notions of what the attributes of good measures are, and I would emphasize the last one. Measures that rely on self-reported data from physicians, I would be very skeptical of as where we should rely a lot of pay-for-performance.

And then the next part to say is that there are a number of strategic issues in selecting pay-for-performance opportunities. Let me just talk about a couple of these. Are the marginal rewards or penalties enough? One point five percent is a big deal for hospitals or health plans. Their margins are in the one to 3-percent range. So you give them

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1.5- or 2-percent, that is a big deal. Physician economics are completely different. Margins are about 40-percent. They have a lot of fixed costs, not a lot of variable costs; it's just all different. And I would refer you to Jim Han's [misspelled?] discussion in the CRS paper in your packet for an example of why 1.5-percent for a physician may be trivial and you're not going to get the same behavior change you're likely to get from a hospital. Just a couple of others about this, do the margin rewards conflict with the incentives in the underlying payment stream? If your concern is overuse of services, most providers are not going to forego a 100-percent payment to get 2-percent at the margin because they've done well. You have to apply the logic. Right now most of the measures are about under use. Prevention, primary and secondary prevention, you can get some improved quality. You can't necessarily get some of your other goals in it.

So let me finish. And I don't have time to go through this now. This is just my semi-informed view. I think we are perfectly ready to do pay-for-performance in dialysis. We've got robust measures to measure exactly what dialysis centers should be doing and we should do it. For Medicare Advantage plans they've been doing it for 20 years. With NCQA, there are established measures. We need to reduce overpayments to MA plans anyway, so combining that with some softening through pay-for-performance makes sense. I don't think we're ready for

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specialists at all. And I do agree we should be collecting data. We should be looking at the opportunities. My view is we have more important things to be doing with the Visin Payment [misspelled?] and that using up all of our energy to do pay-for-performance is obscuring those more important.

ED HOWARD: Terrific, Bob. Alan, you have the chance to correct all the misimpressions that have been given by every one of the speakers.

ALAN NELSON, M.D.: How do physicians view pay-for-performance? Here's a newsflash, there is not a single view. So in order to address the question coherently, you have to ask what physicians are we talking about? And what P4P program? And then we can examine the concerns that physicians appear to share and explore whether they appear to be valid or not.

For the purpose of today's discussion, I'm going to focus on quality measurement and reporting and the payment policies that support it for the Medicare program. Private sector programs are all over the map in their character and structure and it's impossible to characterize how physicians are responding to them for that reason. For some, support and participation appears to be very high. Bridges to Excellence is an example. But for others we're talking about programs that tier physicians based on the resource use. That is the cost of care. And then excludes some physicians from patient panels based on those findings. That's more problematic. You

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might say they are about as popular as the Ebola virus. If time permits, also I'd like to examine briefly their experience in the United Kingdom because there may be some lessons there that we can harvest that might be useful on this side of the Atlantic. And which physicians are we talking about.

The American Medical Association at the meeting of the House of Delegates, which is its policy making body, last month appeared to me also to be divided on the issue. The president of the AMA, in his address to the House of Delegates, referred to "that lunacy of pay-for-performance." But the House of Delegates rejected the calls from militant voices who were calling for just saying no and referred resolutions to the board that effectively keeps the AMA at the table in pay-for-performance. It has been the primary convener of the Physicians Consortium for Quality Improvement, which is the body that has been most active in reaching professional consensus around measures. They've developed 140 measures and they hope to 170 by year's end. The American College of Physicians, the American Academy of Family Physicians have been leaders in the AQA, which was formerly known as the Ambulatory Quality Alliance. That's a coalition of medical organizations, ARC, America's Health Insurance Plans, and others. ACP for example has developed policy papers that support pay-for-performance. But it often gets an earful from its members who oppose the positions that the leadership puts forth. Some

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specialty organizations are just getting started to develop measures. And, as a matter of fact, CMS has contracted with a quality improvement organization in Pennsylvania to produce so called gap measures to fill in for those specialties that aren't developing measures for their discipline.

Now, where does this opposition come from? As expected much of it is voiced by solo and small group physicians who comprise half of all practitioners. They lack the capital to implement the data reporting systems, whereas physicians in large groups or HMOs or employed physicians are more supportive because they're more likely to have the infrastructure available to allow more efficient reporting of quality data. And while it's hazardous to generalize, it appears to me that more opposition seems to come from red states than from blue states.

Well, what are these concerns? Most physicians, I believe, accept a reality of accountability, transparency, and the notion that good care should be paid more than bad. But despite this, even supportive physicians have legitimate concerns about P4P. They want assurances that the measures are evidence based and valid and relevant to their practice. Measures developed by the Physicians Consortium, proved by the National Quality Forum, and determined to be reasonable by the AQA should meet these concerns. Most current measures now address the easy part, clinical quality processes. A greater

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challenge comes in measuring and reporting efficiency and patient-centeredness, as well as outcomes because of the difficulty in risk adjusting for severity as Bob pointed out, and the length of time for outcomes to become measurable. Doctor's are concerned about the administrative burden attendant to collecting quality data from paper records. Let me repeat that. Doctors are concerned about the administrative burden attendant to collecting quality data from patient records. The costs of information technology to help with this are daunting to small practices, especially primary care practices upon whose shoulders the majority of current measures fall. They see required reporting as an unfounded mandate in the face of Medicare fee cuts and freezes imposed by the sustainable growth rate formula.

Adverse selection is a legitimate concern. Will physicians try to avoid patients who are difficult manage or non-compliant through every source intensive conditions that will worsen the physician's profile? If a primary care physician is busy and can take only a few new patients, can they resist cherry picking? Will this worsen the problem of racial and ethnic disparities, a very real question? Physicians are worried about efficiency measures being insufficiently risk adjusted so that legitimate utilization is depicted as waste, when multiple physicians are caring for the same patients and agree that a procedure or a service is

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necessary, with the patient agreeing to that. Will those services that are agreed by all be unfairly attributed to single identified physician in a way that lowers the payments even though the services were clearly necessary and appropriate? Group systems have been developed that are able to identify a spell of illness. And they're able to attribute services to specific physicians, but they are far from perfect as MedPAC has shown. And even if the misattribution did not result in economic consequences, doctors worry that their reputation will be damaged by attribution and reporting system errors.

These are all legitimate concerns. They were recognized by the IOM committee on pay-for-performance. It cautioned that government should proceed cautiously so that corrections can be made as unintended consequences become apparent, for there will be unintended consequences. Some of these have become clear in the United Kingdom where physician performance as reported by Bob Galvin in *Health Affairs* was vastly better than anticipated, with the outlay for rewards greatly exceeding the budgeted amount. Doctors appeared to perform to the test, just as everyone else is inclined to do.

Medicine is undergoing a transformation from a cottage industry to an industrial delivery model. And such tectonic change involves pain. Most of the members of the College of Physicians that we hear from, just want to be left alone to

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take care of sick patients. Primary care is hard work and it's becoming harder by the day as the very successes for medicine result in older, more complex patients who want and deserve the services that prolong their life. Worsening a primary care shortage could be another unintended consequence.

I believe that doctors want to improve the care that they provide, but setting up systems to do that entails changes that temporarily decrease productivity, often lower staff moral, and require a capital investment that is virtually impossible for some. Many will require help and patients during the transformation that's occurring. These needs should be in our mind as the nation moves ahead with its efforts to link payment with efforts to include quality. Thank you.

ED HOWARD: Thank you very much, Alan. Now you get a chance to ask questions and make very brief speeches and say, "Don't you agree?" Fill out the green question cards. As you're doing that, let me just offer to any of the panelists, perhaps our starters the chance to offer a comment and get us going to try to discern whatever differences and whatever similarities we've heard.

GAIL WILENSKY: I think actually, although the nuances and flavors are different and important, there are a lot of similarities in that staying where we are is not an option. The start soon, go slow, is how I would rephrase Bob Galvin's admonishment was heard by all of us. I'd like to make just one

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comment on the notion about. Do we need to think of pay-for-performance as being so marginal? And the answer is not for me. Not when we know what we're doing. Now it is different from saying that you will completely restructure the payment system in going from a per diem payment to a DRG, which occurred in the 1980s. But the reason that, at least at the moment, the amounts are regarded as relatively small is because of the need to engage in active learning to evolve the measurement system to see the responses to be comfortable that you're doing proper case adjustments and either rewarding compliance by individuals as they do in the Bridges to Excellence or making some adjustments for difficult populations so that you don't in fact increase the likelihood they won't be able to get care. But the smallness of the measure is more a reflection of where we are in the evolution.

And we might want to really think hard about, do we want to adopt another system like RBRBS that's never been tried or have gone through pilots and demonstration and just switch from one to the other? I think that was an interesting example of solving some problems and putting in place a whole lot of others and reminds us how hard it is if want to have a de novo payment system go in place. So there is something to be said for starting soon, but recognizing that you can only go as far as the information allows you to and the politics allow you to.

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BOB BARRINSON: I guess where I am just a little more pessimistic that we will have the robust measures without very standard electronic health records. And even there I get concerned about gaming data that gets put in the electronic record if in fact a substantial part of the payment is going to be based on the provision or on performance under measures. So where I think there is a disagreement here is sort of the assumption that the goal should be to have lots and lots of measures covering every domain. I'm a little worried that we will have everybody teaching to the test, that it's easy to say we'll have good measures, but if you don't think it's likely that you're going to have good measures.

GAIL WILENSKY: You go to where the money is. And I think one of the things; I agree that there are some difficulties, particularly with regard to primary care. But one of the interesting issues is thinking about the distorted distribution of money between specialists and primary care, between numbers, between specialists and primary care, where the numbers become a little easier to deal with. And there are some examples of colleges that have been very active, particularly the Society for Thoracic Surgeons in moving ahead measures, others where they're very little and that is going to take a while to get done. But it's not going to happen if we don't put some pressure, financial and otherwise on this [inaudible].

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BOB BARRINSON: On that one, the issues on procedures are appropriateness, was it done correctly following evidenced guidelines and was the technical skill up to standard? I refer you to a, I think, *New England Journal* piece that I read about in *The New York Times* yesterday. I haven't seen yet, about gastroenterologists doing colonoscopies and the number of polyps they find is directly proportional to the minutes they spend bringing the scope back. And there are gastroenterologists getting paid a colonoscopy fee for spending two minutes. And guess what? They come up with fewer polyps. If you could convince me that administrative databases will be able to capture, was the procedure appropriate. And do we know enough about the quality of what happened in the operating room or in the procedure that we can get that? Then fine, I'm somewhat skeptical in that what we'll be left with are measures of; did you give antibiotics before surgery, in other words peripheral issues.

So I think this is very, sort of detail discussion based. Again, there've been 20 years of work with habit surgery and risk adjusting habit surgery that fact that might exist there doesn't mean to me that it's inevitable that it can be there for ENT or orthopedists. But I'm happy to have that discussion.

ED HOWARD: Bob Galvin?

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ROBERT GALVIN, M.D.: I'm going back to my guideposts, which is analysis paralysis and use common sense. This is a great debate and we have to have. But I wish some of you could talk to the physicians who are Bridges to Excellence, it's 4,000 in it now, where we have good measures. We don't need risk adjustment. They're making more money. Diabetics are getting 20-percent better care. And payers are paying less. And so while we have the debate about where can we apply it and a very important one, if we know something works, let's do it. It's better for the patients.

ED HOWARD: Yes, we have a question. Would you identify yourself?

JULIE CANTER-WINEBERG: Yes, I'm Julie Canter-Wineberg [misspelled?] with Boston Scientific and I have a clarifying question. There's alphabet soup of groups out there working on P4P. Can you explain how, and keeping in mind the bill that was passed last week in both private sector programs like Bridges for Excellence to Bridges to Excellence in a Medicare, something goes from a clinical guideline to being a measure that a physician would be required to use and the roles of the voluntary reporting program Medicare has, the Ambulatory Quality Alliance, the Physicians Consortium and the NQF and kind of how the process goes? And do they all have to play a role in each step of the process?

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GAIL WILENSKY: I don't know if you're asking what's in the legislation. And the answer is, I don't know, but presumably CRS and CBL will be opining on that shortly. If it's outside of what's in that piece of legislation that is an important issue as to how you get some consistency in terms of measurement. And again at least the Institute of Medicines opinion on this was that you need to have a national coordinating board that would bring together the various groups as they are doing now on a voluntary basis. But to agree on national performance measures, one that would be outside of CMS, report to the secretary, it or something like it so that you have agreement with all of the appropriate involved groups that are now going on coming together to have a single performance measure. But I do not know what was in the bill that was just passed.

ALAN NELSON: As I mentioned in my remarks, the Physicians Consortium develops the measure. The National Quality Forum blesses it for being valid. And the Ambulatory Quality Alliance, or AQA, brings together ARC, payers and the professions and recommends it as being ready for prime time in terms of practicality, relevance, and so forth. At least that is the process that is generally accepted by physicians' organizations as making sense.

ED HOWARD: If there's anybody, by the way, in the audience from any of the organizations that took part in the

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actual drafting of the legislation or someone who has actually read the legislation and would like to explain it, we'd be delighted to have that. And I believe we have a volunteer.

JIM HON: I wasn't involved in the drafting, but I've certainly read about eight versions of it.

ED HOWARD: And you are?

JIM HON: Jim Hon [misspelled?] from CRS. So Bob, your check's in the mail. The explanation of what happens in the legislation that was passed last year, for 2007 the measures are going to be the ones that are currently in place for the PVRP, the Physician Voluntary Reporting Program, that's currently a CMS demo. So that's what's going to happen for 2007. CMS has up until March to finalize that set of measures and then they have until July to refine the measures. They can't add or drop after March but they can refine the measures up until July. And then physician bonus payments would be based on the care provided between July 1st and December 31st of 2007. That's for 2007, 2008 there are going to be a completely new set of measures and they will be determined by November 15th and the legislation says that it has to go through a consensus processes, including things like the NQF or the AQA. But it doesn't specifically determine which measures and what the process should be.

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ED HOWARD: And anyone here from CMS would like to speculate on what you do with that stuff? Okay. Thank you very much.

JOHN DAVID WHITE: Hey there, John David White [misspelled?] with Premier. I just wanted to see if any of you all could speak to the Premier/CMS demo. Some of the results we've found from the first year of data and almost in context of CMS coming up with a plan coming out hopefully this fall for a pay-for-performance plan. In our demonstration project some of the results are 250 hospitals engaging in this demonstration project have raised quality 8-percent higher than the rest of all hospitals in the country. And some of the implications for if we expanded that to all hospitals, the billions of dollars that could be saved and then over 5,600 lives being saved. Can you speak to the results and how you see that transfers over to physician pay-for-performance?

GAIL WILENSKY: I applauded Premier for volunteering this pilot program and CMS for undertaking it, but it strikes me that there are some differences which usually happen with first wave of innovation, which is what this is. And at least as I understand, a couple of the distinctions between the Premier program and the Physician Group practice demo that followed it is that it is focusing on quality. It is not focusing on trying to combine measures or having a first step

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screen that you have to meet, a quality screen and then you look at savings or vice versa.

So while I think it was interesting that it looks like those that were, as I understand it, that were in the higher tier of quality also appeared to be having lower savings. I think you will see as further work goes on, an attempt to try to have a more explicit combination of both quality and efficiency in terms of the distribution. And as I understand it, that is what happens with the Physician Group practice demo, which is you only are able to distribute some of the savings if you achieve a certain level of savings and if you pass the quality bar. So I expect that you will see this going on. And I don't say that in any way as a criticism. It's just first innovators go through the first step and I think that what we're seeing now in the demos that will be starting in 2007 a whole range of very interesting ideas having it more than just large group practices, having these little bitty group practices in urban and rural areas. The gain sharing that starts in 2007 to let non-aligned physicians and hospital share a gain. So I think you're seeing lots of activity.

JOHN DAVID WHITE: Yes. On the Premier demo, one of the reasons that cost wasn't explicitly addressed is that under the DRG system hospitals that are more efficient get to keep the difference between the payment rate and the lower cost. So if there's an automatic, at least for at the case level, an

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automatic reward for efficiency. There's still the matter of avoided readmissions, which weren't focused on in the Premier demo and I suspect we'd want focus on in a broader demo.

BOB BARRINSON: If I could say two things, well maybe three things. One is I didn't have a chance to talk about it, but on my list I had hospitals ranked as a three plus on the scale. The positive reasons are that hospitals are accountable organizations. They've got management structures that can actually respond to these incentives. And from the work that I've been doing with the Center for Studying Health System Change, where we've asked hospital personnel about the responses to reporting and we had some Premier hospitals. They described some positive spillover effect. That it actually changes a hospital culture such that physicians begin to get accustomed to having data reviewed. All of that is positive.

My negative concern relates to the fact that study that I cited from this Wednesday were exactly those measures and it doesn't produce better outcomes. We are taking measures that have been subject to clinical trials and very specific circumstances and now think they're going to work in the real world. I think we should be doing it but I'm basically preaching some humility about what we think we're getting out of the Premier demo.

And the second point, or the fourth point, wherever I am, is that if – Stuart just made a point, which is exactly

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what I want to say. If in we've got a problem with an incentive for too many readmissions, why wouldn't we change the payment system to hospitals so that you don't get a full DRG if there's a readmission within seven days, 14 days, the data can tell us where it should be. In fact I want to tell this very brief story. When I was at HICVA CMS, the OIG did a study identifying something like \$70 or 80 million dollars of spending for same day readmissions. And made it a big deal. I didn't think \$70 million out of \$90 billion was all that much, but there was an issue about readmissions on the same day. And what they wanted was that the PROs, now the QIOs, should review every one of those cases. And my response was, "Why don't we just not pay for that readmission and change the incentive?" And so my point is, you need to get the incentives right. But getting the incentives right doesn't necessarily require you to be measuring and distinguishing across hospitals. And that's the point I want to leave.

STUART GUTERMAN: Let me just make a couple points on the couple of issues that have been raised. On the magnitude, one of the points I like to make on the hospital side people talk about 1-percent on the hospital side not recognize that is a lot of money. One-percent of Medicare hospital payments is a billion dollars a year. And I suspect that if you had a headline that said, "CMS starts one billion dollar annual

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quality improvement program," that would make a big splash. That's 1-percent of hospital payments.

On physicians, those of you who are hill staffers probably have the scars to show that 1-percent of payments is a lot of money to providers. And if you don't know now, you will in the future. There are a lot of very vicious fights about 1-percent more or less the payments on the provider level. So I suspect it is a bigger incentive than we think. And I would point to the provision in the MMA that provided 0.4-percent. Point four-percent for payments for reporting quality measures and the hospital compliance with that program went from about 10-percent to about 98-percent based on 0.4-percent of payments.

Secondly, on measures I was a little troubled by the finding that the AMI measures didn't seem to correlate well with outcomes. But I think it says as much about our ability to accurately measure outcomes and to understand the process that produces better outcomes as anything else. But the question I would ask in response is, if you look at the list of AMI measures, which of those things would you not want hospitals to do? Giving an aspirin to a heart attack patient when they come in? Do you want them not to do that? The fact that they do that should be something that you want to see happen.

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And thirdly on the readmissions, I believe that the Deficit Reduction Act of '05 had at least a small step in the direction of not paying for readmissions for the same DRGs as the sector to identify some DRGs. So -

BOB BARRINSON: If I could just very briefly, just on the one point, this is where I have a little sympathy with Pete Stark [misspelled?] who says, "This is what people should be doing anyway." Giving an aspirin in a heart attack should be a condition of participation. They should be part of the JACO and CMS oversight. The real action in heart attacks is getting people in to lighted [misspelled?] therapy, clot dissolution therapy within 90 minutes of the onset of symptoms. And if that fails, getting people into perkupaneous [misspelled?], angioplasty, or stent production. Currently 3-percent of Americans having a heart attack get that within the recommended timeframes. If we were really serious about caring for our AMI patients, that's where we would be focusing our attention, not on getting hospitals to give aspirin. That should be a requirement. If we want to start by making it a pay-for-performance, that's a nice place to start. But that's not where we should finish. And so maybe we don't disagree. I think there's some judgments as to where you think the bang for the buck is.

STUART GUTERMAN: I'd point out we're right now paying for reporting and I dissent that you don't know if they're

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doing it or not doing it unless you're getting the information however.

BOB BARRINSON: Okay.

ED HOWARD: We've got some people lined up. Let me just say in passing, Gail Wilensky had a plane to catch. She wasn't trying to run away from the controversy. And let me just say on her behalf, Stu mentioned gain sharing and in fact there was a very good paper we didn't have time to get into your packets published in *Health Affairs*, by Gail on gain sharing. I think it was December 5th. So you might take a look at that. Yes, I believe you were first at the microphone. You want to go ahead?

JENNIFER LUBELL: Hi, Jennifer Lubell at *Modern Healthcare*. I was wondering if you could provide some comments on what we can expect next year in Congress and on a regulatory front. I mean we have a new democratic Congress. How much attention do you think they're going to pay to pay-for-performance? And just a little bit more on these demonstration projects and whether this is going to end up in a requirement for physicians for pay-for-performance?

ED HOWARD: Dems and demos, anybody? Anybody in the audience who would like to speculate? Mr. Starch Staff in the audience? Bob?

ROBERT GALVIN, M.D.: Yes, I don't have the answer. That's another one where someone tells you that they know what

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they're going to be doing in Congress next year, don't believe them. But I do think what's interesting from the point of view of those of us who've been pushing this transparency agenda, the incentive agenda, is there really is a new population coming into Congress, many of whom have not spend a long time understand health care. And so it isn't clear to me or any of us who've been thinking about this that it's going to be business as usual. And we don't know what the impact is going to be of kind of driving this agenda, again in Congress. Clearly there's going to be more focus on hearings and regulations and fraud and abuse and how this shakes out, I think we don't know. And we're all spending time talking about the people who've been driving some of these initiatives, trying to understand kind of how to educate and how to make some of the points we made today. But the reason I answered the question is I don't think it's yesterday's Washington anymore. And so I think we'll see.

ED HOWARD: George?

GEORGE GREENBURG: Yes, I'm George Greenburg [misspelled?] from Health and Human Services Office of the Secretary. I just had a factual question. I was reading the legislation yesterday and we spent quite a bit of time in the hospital regs, developing a system that was statistically valid so that when we were paying for reporting we were paying for valid reporting. And so hospitals would only get the bonus if

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they met a statistically valid standard for accurate reporting and the QIOs would be involved and abstracting a certain number of cases to produce the sample that that would be measured against. But on the physician side, I didn't see any provision for looking at the accuracy of what was reported. So we were paying potentially for non-valid data. Is that true? Or have I read it wrong? Did I miss something? I'm just curious.

ED HOWARD: Jim, you have any – Jim?

MALE SPEAKER: There is a very short provision in there that says that the secretary does have the authority to validate and it gives us an example for instance drawing samples to validate. But it's very short.

BOB BARRINSON: Can I make a comment because I did raise in my remarks a concern about self-reporting from physicians? I think again there's a difference between hospitals who have compliance officers who have everybody and his or her cousin looking at the medical record. And I have reasons to believe there's likely to be valid data, at least no explicit attempts to gain because we have now some experience with all of that. One there's a literature on physicians giving misinformation to insurance companies on behalf of their patients is the argument. But it basically is distorting the information that they have available who for a purpose. Now let's not do 2-percent, let's do 20-percent like Gail was suggesting we might want to be going to for a process in which

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at least some physicians think it's a bureaucratic intrusion into their practices. This is the way they now have to make their money. I am quite concerned about the data that will show up in the medical record. But some of it is even not intentional cheating. As simple a clinical intervention as taking a blood pressure, the literature shows great variation from different readers of blood pressures that there's a five to ten millimeter of mercury difference, this is without any financial incentives attached. I've been to medical offices and had my blood pressure taken. Half the time they use a normal size blood pressure cuff and half the time they use a large blood pressure cuff, even though I'm not large. And it produces a significant blood pressure reading difference. So we now have pay-for-performance in the U.K. based on acceptable blood pressures. I think we might see blood pressures getting better in the response to pay-for-performance.

And again I don't want to paint physicians in this case over simplistically as just being bad guys. It's all in the context of how it's being introduced. There is error inevitable. There is not standardized information for something as simple as a blood pressure reading. I can imagine the other things that we want to say, "That's what we should be rewarding." I think physicians' medical records are a completely different world from what you're getting from a hospital or what you're getting from a health plan's

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performance on heedist [misspelled?] measures. And I think we need to know a lot more about that before we start putting real money there.

ED HOWARD: Bob Galvin, you want to comment on that?

ROBERT GALVIN, M.D.: There is actually good experience about that from the U.K. They have the world's biggest P4P program that they started several years ago where they actually increased their overall health budget up to about 10-percent of their GPs. Some of them ended up increasing their salary by 40 to 50,000 dollars doing the exchange. And there's an article that out, I believe it was in *The New England Journal* probably this summer that was really on gaming. And there was an editorial about it. And it's worth reading because they have real experience in this. And what found is what you always find in these kind of scoring, kind of once you set measures and either they're publicly released or there's money, there's always going to be gaming. So I don't think the idea is there going to be or not going to be. The issue is how do you manage it and how do you audit it? So the article is worth reading. It was only about 5-percent of the practices that really kind of bent the numbers quite a bit. But there was other noise in the system and they were actually going to address it by increasing their audits. But it is nice experience from another country and they did it their fee-for-service system

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just for their GPs. And so there's something to be learned as we go ahead.

ED HOWARD: Yes, sir?

ERIC WHEATUM: I'm Eric Wheatum [misspelled?]. I'm with the GAO. I wanted to bring to the attention of the panelists an interesting discussion yesterday at the National Economists Club where the issue was quality measurement and quality adjustments and measuring a price in the states for health care. And I thought it would be interesting for folks to know that economists, who are engaged in this sort of research and are developing and maintaining our price indices are actually beginning to use some of these quality measures, say particularly over the PPI. There has a movement to use that in hospital care. And there also was a lively discussion among the academics involved there of whether say, process measures should used or whether outcomes based quality measures should be used in measuring the price of rises in medical care. There's some interesting work at BEA going on in this area. This of course isn't a vital issue because as we know all the PPSs and Medicare and other programs rely on these measures of inflation.

Then I have a question on the efficiency issue. My own recent experience has been that when looking for a definition of efficiency in the literature out there, I'm having difficulty finding a lot of them, anybody who actually really

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spells it out. There are a few, but everybody seems to talk about efficiency. But there are precious few definitions of it. I wondered if anyone on the panel would care to provide one?

ROBERT GALVIN, M.D.: Well, I would say that fools rush in where angels fear to tread on that one. But I don't think there is an accepted one. And I just think that's the way it is. I can tell you the private sector through Leapfrog Group has adopted the Premier model and has added a measure of efficiency to it. So it kind of took a stand. It's rudimentary. But it's out there. I will tell you there's a lot going on in trying to measure efficiency. So there are a number of task forces organized around it. But I think this is one that if you actually did a Google search that said, "efficiency measures in health care that are accurate," you would get nothing. So I don't think we know.

ED HOWARD: Bob, the AQA labored mightily and I've seen their definition. So at least it's been blessed by American health insurance plans, by a group of professional organizations, and ARC. And I think it's on their website. If there's somebody here from AQA you can correct me if I'm wrong. But in either event it appeared to me to be a very comprehensive and reasonable and to some degree then would come from a fairly broad consensus. Yes, sir?

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DR. PETRONCIOCAY: Yes, I'm Dr. Petronciocay [misspelled?], a family physician in the trenches from a blue state. My question is to the panel, if you have a patient as a truck driver that would have type 2 diabetes, and this gentleman, if it were followed with the guidelines that are recommended by the ADA as opposed to ACE, that individual if they were treated with the new medication, the viata [misspelled?], would qualify to continue driving, would not be pulled from his job according to the ADA rules of using insulin. My question is, if the requirements and the guidelines that are being used right now, that person would no longer be employed. The question I have of that is, do we want to go down that road? And is that the wise choice for that individual who now will be non-employed? And I can see, as Dr. Barrinson had mentioned earlier, that I think you're going to see gaming in the system. So I pose that question to the panel about the diabetic man and the guidelines.

ROBERT GALVIN, M.D.: I wasn't sure I understood.

DR. PETRONCIOCAY: Right. It's his job. Right.

ROBERT GALVIN, M.D.: It sounds really important. I missed – I'm not sure, I think we're all a little missed one point, which is help us again if he went on a new medication then that would hurt the quality measures?

DR. PETRONCIOCAY: Correct. The viata is not approved because it's so new.

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ROBERT GALVIN, M.D.: Okay.

DR. PETRONCIOYAY: And it decreases the person's weight. It decreases their insulin requirements. They're not on insulin. It is overall not a hypoglycemic used unless with a sulphonurea. If you use the new guidelines or the guidelines that are accepted now by the ADA that not accepted, that would require the person to go on insulin, would remove them and pull them off the highway as a truck driver because you can't drive on the highway if you're on insulin according the federal regulations. And my question is, is that what does the doctor do? Does the doctor do the right thing and but them on the viata? Or does he follow the new guidelines that are recommended that are coming up on line which are already out of date already? And in addition to that they're not liable for them. So -

ALAN NELSON, M.D.: I can explain. Gaming for the benefit of the patient as Bob Barrinson was describing.

DR. PETRONCIOYAY: Right. And what happens is that individual as I said, well the doctor has to decide which way he's going to go for the patient, what is best for him. Now I as a physician, I'm going to try and do what's best for the patient. But I'm going to take the hit at the end of the year for the system if I do what's right for the patient. And I refer to what Dr. Barrinson mentioned what that the VA study in

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Houston, Texas, actually referred to the gaming that was done by the VA itself.

ROBERT GALVIN, M.D.: I could explain that if you like. Actually the U.K. dealt with that.

DR. PETRONCIOYAY: Pardon me?

ROBERT GALVIN, M.D.: Because I think it's a great point. And the U.K. allowed their GPs to do what they call kind of make exceptions. So in other words they gave them discretion around whatever cases they needed to, to basically say, "If I followed the guidelines there's good evidence that I will share with you that I won't be doing the right thing for the patients." And so what the NHS said is, "Yes that can happen. And we don't want physicians or patients to be in that situation and therefore we're going to build discretion of the physician in." In fact that's where the gaming took place. A couple of the practices had exceptions at about 90-percent of their patients. Whereas the idea was it ought to be in the single digits percent.

But I think if you get to – you don't want to pay for conformance. You want to pay for performance. And so we haven't had the dialog yet because it hasn't been instituted. But I think one way they addressed it was to say, "How do we build in physician discretion in just a case like this?" And they built into the system those exceptions. That's just one

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way they handle it, which I thought was pretty smart. And the physicians liked it over there.

DR. PETRONCIOYAY: The other issue is that the guidelines are guidelines only and they're exempt. So even if I follow the guidelines, the guidelines have a disclaimer that they're not liable if I follow the guidelines and something goes wrong. So I have a problem with that legally because of the fact that they're quote "guidelines," but the originators of these criteria are really exempt, they're not liable. So I have a problem with that as a physician in the trenches.

BOB BARRINSON: I make two points. One is the distinction between guidelines and in this case it sounds like it has some legal implications as to whether your patient can drive or not. That's not really where we are in the pay-for-performance area. To me, however you treat your patient with diabetes, if you hemoglobin A1c is under seven, you should be getting all the points possible. And again I think that's a terrific measure and I would be using it in pay-for-performance for physicians tomorrow. I've said we should be doing stuff opportunistically and that's an area that we should be doing. You're raising a much more complicated issue about guidelines.

The second point though where guidelines and measures come together is that fact for the most part we do not have good measures for those Medicare beneficiaries with multiple chronic conditions. There was a fabulous paper a year or so

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ago by Boyd Adall [misspelled?] from the Hopkins Group on the fact patients, if you follow practice guidelines for diabetes and congestive heart failure and some renal disease and throw in a few other things, you would be killing your patient or driving down their quality of life. And that we need to urgently develop measures and guidelines related to that population. And so to me again that says the fact that you have a measure doesn't mean you necessarily want to use it. You want to be very selective. Measures should be meeting a whole bunch of criteria. And that's what bothers me about this whole thing, which is the assumption that we will just have 400 robust measures that do what we want them to do. I just think is wrong.

ROBERT GALVIN, M.D.: Let me also point out that I'd remind you; we're paying for performance now. There's gaming going on in the system now. Unless someone's willing to say that we're really not getting the 25-percent waste in the system that it's just a reporting artifact because of the incentives that exist in the system now. We are putting very bad incentives on the table now. And they're bad both for the Medicare program and other payers, and also for the patients in many cases. And so what we're talking about is helping to put a set of right measures on the table. And of course when you're talking about going from wrong to right, you have to do some thinking about what constitutes right. And there's plenty

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of work that needs to be done. But there are some things that we already know that really people should be doing.

ED HOWARD: So correct the bad incentives.

DR. PETRONCIOY: Thank you.

ED HOWARD: We have a few minutes. We have a couple questions on cards. I want to reiterate my request that you fill out those evaluation forms. This is a question that I guess primarily directed to Alan Nelson. You talked Alan about the relationship between P4P and potential adverse selection. The questioner asks, "What is the solution to the potential problem of worsening racial and ethnic disparities because of the adverse selection that might result from P4P?"

ALAN NELSON, M.D.: I was chair of the IOM committee that developed the report on equal treatment. And so we spent a great deal of time talking about racial and ethnic disparities. On one hand, one of our conclusions was that greater adherence to practice guidelines, best practices, was one of the strategies that would reduce racial and ethnic disparities. And I think that's a very valid position to take. I raised a notion that if there are some categories of patients who for whatever reason may be less compliant or have multiple chronic illnesses which will be resource intensive and conceivably could worsen a physician's profile in terms of resource use, that if we aren't able to very well risk-adjust and the economic consequences would be to the physician's

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detriment, you could reasonable expect that physicians would be selecting healthier, more affluent, easier to care for patients. And that would worsen the prospect for racial and ethnic disparities. And I think that both of those lines of thinking have some value.

My comments aren't intended to stop P4P in its tracks. It's to raise again something that we have to think about ahead of time and try and make sure that we recognize that some patients are harder to take care of than others and that we try and correct for that in the way P4P is designed.

ED HOWARD: Alan, and maybe other panel members would like to weigh in also, let me just follow up on that, if I can. One of the other aspects of that part of this discussion that you mentioned was the potential impact on providers who disproportionately serve disparities prone populations, if you will. And it gets back, at least in part, to something that several of you mentioned and that is the desire to have a P4P system that rewards both achievement and improvement. And I wonder if you have any comments along those lines for the right balance to try to make sure that you get the right provider incentives for the population of providers that serves racial and ethnic minority populations.

ALAN NELSON, M.D.: The IOM committee recommended that both be considered, that is rewards go to those who improve care was well as to those who were at a sufficiently high and

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sustained level even though they didn't have much capacity to improve. Both of these dimensions should be recognized in the rewards system. But we didn't go into any kind of discussion in depth on how much should be one or the other. What was the second part of your comment, Ed?

ED HOWARD: No, think it sounded like there were two parts. I didn't say it very well. Bob Barrinson?

BOB BARRINSON: I would just say you'd probably want to do both, but this is an area that can be informed by data. Meredith Rosenthal had a nice piece looking at how the response within Pacific Care and found the bigger for the intervention would have been on improvement. Again, I don't want come across as being a naysayer. I think there are many places we should be doing pay-for-performance and we should be looking at. Apparently according to Meredith, most of the programs are pay-for-attainment, not improvement. But we should be subjecting what's going on out there to evaluation and learn from the results.

One thing we're doing a project for the Commonwealth Fund right now on pay-for-performance of health plans in New York Medicaid and one of the interesting findings there, which were the plans that were doing badly on particular measures wanted not to be a negative outlier. And so they wanted to improve that performance even though they weren't going to get a bonus for it. And so the important to keep in mind on this

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one is that pay-for-performance is not being done in isolation. It is being done with public reporting of performance. And so in fact at least the state's view was that they are getting improvement in their model, which doesn't explicitly pay for improvement. I think we need a lot more real world sort of studies like that to sort of get a much better empirical base on how to make these design judgments going forward.

ALAN NELSON, M.D.: I wanted to beat Bob Barrinson's drum for a minute and address the fact that there are other fundamental changes in the way health care is financed and delivered in this country, beyond pay-for-performance do deal with issues of racial and ethnic disparities and more efficient care. Among those being the advanced medical home concept, which changes the payment system and rewards with a retainer those physicians who assume primary care responsibility and manage patients care with interventions that are other than face-to-face encounters. That is they responds to e-mails, telephone consultations, and part of their payment is based on this responsibility that they accept to manage the patient's care in a more efficient fashion. Then with an additional payment going based on their productivity in terms the number of encounters and the work that they do. This to me has a great deal of promise in, number one, evening the balance between incomes for primary care physicians and other

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specialties. Number two, to raise the tide under all boats including the racial and ethnic dimension.

ED HOWARD: Bob Galvin, did you have a comment?

ROBERT GALVIN, M.D.: I would just point out, I think it's an important question and it is one of the big challenges of paying based on performance. And I think what the IOM Committee did was look out there, saw that as a problem, saw that almost all of the programs were based on a tournament model, meaning you attain something or you got it or you didn't. And that that was going to drive this problem worse and that is one of the reasons we came out and said, "No, you need to do improvement and attainment. And the money for improvement should be as substantial." It's an example and Gail mentioned the learning system because I think everyone realizes what a big change this is in a very, very big system. And the idea of building in a learning system as we go, if this does in fact does begin to get adopted was a very big piece of that report and this is a good example of kind of a midcourse correction or hearing a problem and being able to adjust to it.

STUART GUTERMAN: Okay, I think we have a closing question that is an appropriate closing question, that I think will elicit a lot of response of behalf of the panelists. The submitted question was, "Is pay-for-performance distracting Congress and Medicare officials from the larger issue of reforming the way physicians are paid?" And I'll use the co-

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moderator's prerogative to take a first crack at this and let the others take their cracks.

I think the important issue here that you all need to take away from this discussion is that there are lots of issues to be considered. But the criticisms of one way or another of approaching the issue of pay-for-performance should be taken as identification of issues that you all need to consider when you're considering what to do about this particularly for the Medicare program and the other public programs rather than a statement that you don't want to pay for things you want to see happen. The question is whether you can properly define what you see happening or what you want to see happening and whether you can properly attach payment to it. But it shouldn't be taken as obviating the need for reforming the payment system because our fee-for-service payment system has plenty of problems. And any new system is going to need to reflect a similar set of incentives, that is paying for what you want to see happen. For instance, the major alternative to fee-for-service is capitation. But in a capitated system, you're all familiar with the assertions that capitation provides plenty of incentive to stint on care and quality. So you need to have quality measures and that's one of the reasons that they [inaudible] were put in place. You need to have quality measures to be able to monitor that too. In any system, you devise you need to have a way of building in incentives to do

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the things that you want to do. So it has the potential for distracting Congress and Medicare officials. One of the reasons we had this session was to be able to put the issues on the table but not to distract you from one or the other. But to sort of make you aware of the fact that there are things to consider in both and you have your work cut out for you. So why don't we go -

ROBERT GALVIN, M.D.: Yes, I think - I suspect the answer might be the same. I think if the question is, should Congress and should CMS and should the public sector focus on fundamental changes in the payment system or performance based payment. I think the answer is yes. And I think the reason the answer is yes is I think kind of a monochromatic payment system, like the one we've had, is probably way to simplistic for what we're looking for in overall payment. So I would move against the idea that it's either or, or that it's black or white and answer that question yes.

BOB BARRINSON: I had a line on one of my slides saying "Opportunity Costs." People have only so much energy and attention span and then we are also dealing with real outlays of funds and what the staff does. When Mrs. Johnson and Mr. Thomas and Mark McCullen and the AMA are all talking about an SGR quality reporting tradeoff, they are not talking about fixing what is broken about the RBRBS system. I would love in

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10 years for us to have a new payment system for physicians.

That will take 10 years. It needs demonstrations.

There are documented problems right now with how our RBRBS is functioning. Kevin Hayes from MedPAC is right there. They put in their report things that need to happen which involve expenditures and it involves taking on some entrenched interests that don't want to see some of that change. Nobody's having that discussion, while everybody's talking about these quality measures. It would be nice to say we can do it all. In the real world the question is, when we relieve the SGR thing, which I think next year we will have to do, what is it that we're asking for in exchange for that? And I would not be putting quality-reporting number one on my list. I would be putting a real commitment to finding the resources to fix what's broken in the RBRBS payment system. And then if there's some energy left over then let's do the quality measures.

ALAN NELSON, M.D.: I wonder if there is adequate recognition in Congress of the fact that pay-for-performance as it's currently designed is going to drive up the volume of services provided? Because so many of the measures right now are calling for things that aren't being done. Preventive services that aren't being delivered, blood tests that aren't being done for patients and so forth, cholesterol and so forth. And that if we come up and substantially raise the compliance in patient care for those measures, then don't gripe because

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the volume of services goes up. Rejoice because good services are going up and trying to separate those from wasteful services, unnecessary imaging, you go on and on with what kind of services might be wasteful, virtual total body examinations for starters.

But in either event, better recognize that there's a fiscal note in quality improvement and be willing to pay for it. Recognize that the real money, the crux of the issue for Congress is in efficiency rewarding efficiency. That is enormously more difficult because of the point I made about attributing who's responsible for the services. If a patient has an operation, is it the primary care physician who recommended it? Is it the specialty consultant who recommended it also? Or is it the surgeon? Who gets the blame or the praise for that? And you're a long ways from working that out in a way that makes sense.

ROBERT GALVIN, M.D.: Well, since I seem to be the glass half-full person on the stage, let me make a couple of comments. I think first is really to Bob's concern that there's only so much energy in the real world. Just this past year Congress dealt with the evaluation and management fees, the core system, and paying for quality reporting. So I think it just happened that you can do both of these at the same time. And in terms of Alan, he is right. I do think it is going raise volume in some areas. But remember, this IOM

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report, it was hidden in what Gail said that we ought not to pay for performance unless we balance effectiveness with efficiency and patient satisfaction. It needs to be a three-legged stool. And if all you start with is effectiveness, you'll get an increase in volume, maybe. And that's why you have to be addressing efficiency and satisfaction and patient experience at the same time.

ED HOWARD: Well, this has been an extraordinarily interesting discussion. I know I learned an awful lot. And I hope you did too. I want to thank the Commonwealth Fund, both Stu and Karen Davis and their colleagues for helping us put this thing together in such a thoughtful way, our own staff has been exceptionally good at this briefing. Thank you for sitting through some really tough stuff and ask you to join me in thanking our panel for an incredibly good discussion.

[END RECORDING]