

**AcademyHealth****Pay-for-Performance: Practical Guidance for Decision-Making and the Latest Evidence****May 16, 2006 @ 2:00 PM**

**Penny Daniels:** Good afternoon, everyone. Welcome to the Pay For Performance Web conference. This Web session will explore key design decisions related to Pay For Performance. We'll share practical guidance and lessons learned as well as hear the very latest evidence on Pay For Performance. This series is sponsored by the Department of Health and Human Services Agency to Healthcare Research and Quality, often referred to by its acronym A-H-R-Q or ARHQ. My name is Penny Daniels and I will be your moderator today.

Now, we have an exciting panel of researchers and purchasers in our studio but before we begin I'd like to tell you a little bit about our format. Dr. Carolyn Clancy, director of ARHQ, couldn't join us in the studio today but we are happy that she was able to prerecord some comments. So we will open with Dr. Clancy's taped overview which introduces ARHQ's role in advancing the evidence and information surrounding Pay For Performance. Then we'll hear live from our panel.

At several points during the discussion we will invite you, our listeners, to join in. You should see right now on your screen some information about how you can send us your questions via phone or computer and if you don't, you will in a moment.



We will also have a period at the end of the panel discussion devoted to your questions and comments.

Now to set the context for today's conference, let's listen to ARHQ director Carolyn Clancy's prerecorded talk. Joe, is the talk rolling? Joe? Joe, our operator.

**Carolyn Clancy:** Good afternoon let I'm Carolyn Clancy, director of the Agency to Healthcare Research and Quality, or ARHQ. Our mission is to improve the quality, safety, efficiency and effectiveness of healthcare for all Americans. Recently there's been a great deal of attention and activity in the area of Pay For Performance, or value-based purchasing. That is to say, financial rewarding high-quality providers as a strategy to improve the quality of care.

Along with this attention have come many questions from purchasers and providers about effective ways to proceed in implementing Pay For Performance strategies.

Today's webcast features two new ARHQ products which I'm very excited to present to you. Each employed a creative approach to best meet the needs of practitioners in the field. The first sought to expedite the cycle of research so that purchasers would have quicker access to findings on Pay For Performance and the second was developed in collaboration with 10 purchasers who identified 20 questions for researchers to address.

More specifically, with the editor of medical care research and review, ARHQ engaged a multidisciplinary team of energetic guest editors, doctors young, Burgess and Berlowitz, in an experiment to expedite the research to of payment to public and private purchasers. The effort involves aggressive systematic outreach

to research teams across the country in an attempt to identify the earliest findings, some based on partial data appropriate for peer review and translation. From conceptualization to publication, the project took only 15 months.

Second ARHQ commissioned a clinician and economist, doctors Dudley and Rosenthal who are both going to join us in this webcast to collaborate in developing Pay For Performance, a Decision Guide for Performers. The decision guide is designed for use by public and private purchasers of healthcare, including health plans who are considering sponsorship of a Pay For Performance initiative. Twenty decisions which were identified by 10 public and private purchasers form the outline of the guide. For each of these key decisions, the guide offers options as well as any available theoretical and empirical evidence.

ARHQ's menu of Pay For Performance investments spans a number of other activities, a few of which I'll mention. First, ARHQ develops and maintains measures. Second, ARHQ annually monitors quality of care in the United States. Third, ARHQ supports evaluations to build the evidence based on Pay For Performance in synthesized research studies.

I'm particularly excited about today's program because it addresses many of your practical questions and challenges. Whether you are considering implementing Pay For Performance or have already implemented it and are now making adjustments to your approach.

One additional note, ARHQ is eager to learn more about what topics interest you as you seek to improve the quality of healthcare in your local markets so that we can continue to bring you programs such as this one

that respond to your interest and needs. So I encourage you to complete the online evaluation at the end of this webcast. Again, a warm welcome to our panelists and to you our audience.

**Penny Daniels:** Thanks again to Dr. Clancy for that introduction. As she noted, there has been a great deal of discussion around Pay For Performance. And are being hotly debated. In today's session researchers R. Adams Dudley, Meredith Rosenthal and Gary Young will provide practical real world insight. They will share the very latest evidence and information available on a range of issues related to design and implementation of Pay For Performance initiatives.

We also have two purchasers with us, Doug Libby and David Kelley who will talk about their experience with these strategies.

Now, before we get this lively discussion going, and it will be lively, let's cover a little bit of business here. If you have any Web-related technical difficulties during this event, please click the help function in your window to troubleshoot your Web connection. If it seems that your slides are not advancing, you may need to restart your browser and log on again. To reach technical support by phone just dial star, zero to be connected to technical assistance.

Now let's turn to our panel of researchers and purchasers. First up is Dr. Gary Young, professor at Boston University School of Public Health. Gary's a member of the University Center for Organization, Leadership and Management Research which is funded by the Department of Veterans Affairs. Gary, as Dr. Clancy said, you were one of the lead editors of recent review supplement devoted to findings on Pay For Performance. Is

there new evidence from a supplement or any other sources to show that Pay For Performance actually includes healthcare plans?

**Gary Young:** You know, Penny, there is. In the supplement itself there's one paper about an academically-based physician at work in Massachusetts that really had some very impressive improvements to several quality measures following its participation in a Pay For Performance program. For one of the quality measures, diabetes eye exams, improvement was approximately 18 percentage points over a two-year period.

Another paper in the supplement compared the quality performance among hospitals in the same hospital system, a regional provider based in Ohio. Now, several of the hospitals in the system were participating in a Medicare Pay For Performance demonstration project and these hospitals showed greater quality improvement than did their counterparts on a number of quality measures that are the focus of the Medicare Pay For Performance program. Measures, for example, relating to treatment for heart attacks and congestive heart failure. Financial incentives appeared to make a difference there.

And there's also data presented in places other than the supplements that also speak to the general success of the Medicare Pay For Performance demonstration in fostering quality improvement for many other participating hospitals as well. And actually beyond the supplement, there was a recently published paper on Pay For Performance in the Journal of the American Medical Association. The lead author is actually one of our panelists here, Meredith Rosenthal. That paper reports improvements, albeit modest ones, in quality for physician quality practices participating in a Pay For Performance program sponsored by the California-based health plan Pacificare.

And while finally my colleagues and I have completed a of a Pay For Performance program in a physician network located in Rochester, New York that also points to at least some modest improvements in quality following the introduction of financial incentives.

So yes, Penny, there is certainly some emerging evidence on the positive effect of Pay For Performance. Now, the studies that I have mentioned all have some important limitations in their methodology and so findings are not yet definitive but really still I think we have some encouraging evidence in support of Pay For Performance.

**Penny Daniels:** Do we have any evidence yet, Gary, that Pay For Performance also saves money?

**Gary Young:** Yeah, not really, no.

**Penny Daniels:** Yeah, no? Which is it?

**Gary Young:** Well, let me say no. There's some hope behind that "No," though.

**Penny Daniels:** Okay.

**Gary Young:** It's a very important question, one that certainly is upper most in the minds of employers or health plans who are sponsoring Pay For Performance programs. However, obtaining the necessary information to conduct a rigorous analysis of whether Pay For Performance saves money is really quite difficult. Still, you know, I'm hopeful that we'll see some progress in this area very soon.

**Penny Daniels:** Okay. Now I'd like to introduce Dr. R. Adams Dudley. He is an associate professor at the Institute For Health Policy Studies at the University of California at San Francisco. Adams, you and Meredith Rosenthal who, of course, is sitting right next to you here in our studio, you coauthored the recent ARHQ

publication Pay For Performance, a Decision Guide For Purchasers. Four purchasers just starting out with Pay For Performance, they may be wondering which they should target first, hospitals or physicians.

**Adams Dudley:** Well, that has to be a local decision. There isn't one answer that fits nationally for every region. There's some important factors to consider that you have to evaluate both for hospitals and for physicians in your local area and then decide what's the best decision for your community.

The first issue is how our hospitals (are hospitals organized in our market, how are physicians organized in your market. By organization I mean do they come in big lumps, little lumps. Sometimes they are parts of chains, sometimes they are independent hospitals and you have to look around your local market. For example, in Cleveland there are two major chains, the Cleveland Clinic and the associated foundation for the university hospital and its associated hospitals. Those two major chains take up most of the hospitals in the Cleveland area and so if you were sitting in Cleveland thinking about how would I do this, there's someone else there to talk to. The hospitals are organized and you can get a response from a large percentage of the total hospital population just by talking to two organizations.

Similar things might happen or might not happen on the physician side. So in some parts of the country the physician groups are -- the physicians are organized into groups or blocks. In other places you've got practices of one or two or three physicians and you can imagine that trying to work with physicians that are sort of scattered around might be much more difficult than those that come together more easily in groups.

Similarly you have to make a local analysis about cost and quality and how much does the variation that you see in performance on those two measures, how much variation is there on the hospital side and how much

variation is there on the physician side. If it looks like there's a lot of variation on one side or the other, then there might be something you can improve there. If you can get all the people who are on the wrong end of that variation to improve their quality, to match the people who are doing well or to lower their cost to match the people who are doing well, then there's a lot of grist for the mill for that particular group, hospitals or physicians in your area.

And finally, and we'll hear more about this from the people who are going to represent some of the on-the-ground processes today. Their capacity to generate data is terrifically important. If the hospitals have good electronic information systems, then they might be able to generate a bunch of data about their performance and that obviously gets you on the ground running, whereas if they don't, then you may just be stuck and same question has to be answered on the physician side. And I've seen communities where the physicians are way ahead of the hospitals and vice versa.

And finally, you take all that information together, you stir it around in a bucket and you ask yourself, on which side of this equation, the hospital side or the physician side, can I get my best bang for the buck.

**Penny Daniels:** Thank you. And sometimes I think it depends on you sort of do the best you can with what you have, and we're about to hear a little more about that from Doug Libby who is also with us. Doug is the executive director of the Maine Health Management Coalition which is a coalition of purchasers and providers of care. The Maine Coalition has spearheaded a performance initiative called the Pathways to Excellence program. Doug, how did you decide which type of providers to target?

**Douglas Libby:** Well, Penny, we used the typically pragmatic Yankee approach and we selected providers for who we had information through our Pathways to Excellence Program. Our coalition is a statewide

multistakeholder organization and all of our initiatives are governed by a very active, multistakeholder committee. So we selected measures that were either developed by or endorsed by all of the stakeholders, and in our case we selected primary care practices at the site level and hospitals at the individual hospital level since those were the providers for whom we had information and who were able to provide us with information.

I think had we selected providers based on importance to employers, we likely would have selected specialists but we simply did not have enough measures for which we could get data.

**Penny Daniels:** Yeah, and we're going to talk a little more about specialists a little later in this program. So it sounds like you kind of took what you could get. Gary, I have a followup question for you. What is your sense of physician's interest or comfort level in participating in Pay For Performance?

**Gary Young:** Well, actually, Penny, we have a little bit of data that can speak to that. Based on surveys that my research team and I have conducted, I say physicians do appear to be generally comfortable with Pay For Performance at least as a concept. The survey results that you and our audience have before you is really from over 1300 physicians who we randomly selected from California, Massachusetts and Rochester, New York in areas where there's been a significant amount of Pay For Performance activity. And as you can see, the great majority of physicians indicated that they believe physicians should be rewarded financially for providing higher quality of care.

Most of the survey respondents also appeared to believe that financial incentives are an effective way to improve quality, though as you look at the results, they suggest somewhat more ambivalence among the

respondents to the statement than the previous one. But by and large I think we can say that physicians do appear to be comfortable with the concept of Pay For Performance.

**Penny Daniels:** Very interesting. What are your thoughts, Gary, on rewarding individual clinicians versus medical groups?

**Gary Young:** Well, Penny, really I think there are possibly some tradeoffs that need to be better understood. Regarding individual providers or rewarding individual providers offers a direct connection between the money and the performance of the individuals who perhaps are in the best position to influence quality of care.

When the money goes to groups, this connection may be weakened. As a paper in the medical care research and review supplement, a paper actually by members of my research team reported that when medical groups are the recipients of incentive money, they do not necessarily pass it along to individual physicians in ways that are directly related to their performance on the quality measures that really are of interest to program sponsors. However, medical groups have resources that most individuals lack, resources to invest in clinical infrastructure, electronic medical records, disease registries that can help providers achieve sustained improvement in quality measures.

So giving groups the money can help promote these kinds of investments. So really there are some tradeoffs, tradeoffs that need to be more clearly and more closely examined to really identify the optimal recipient for financial incentives in Pay For Performance programs.

**Penny Daniels:** To benefit it sounds like individual clinicians in ways than money, more resources, right?

Okay. At this point I'm going to pause and solicit questions from our audience especially relating to this more recent portion on deciding which providers to target for Pay For Performance.

Now, for those asking your questions by phone, our operator, Joe, will provide instructions now. Joe?

**Operator:** Thanks, Penny. If anyone would like to ask a question, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the question queue. You may press "star," "2" if you would like to remove your question from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment, please, while we poll for questions.

**Penny Daniels:** Okay. And while we're waiting I'd like to say that for those asking questions electronically, please refer to the instructions on your screen. And it will just be a moment or two before we get one of those phone questions. Joe, how are we doing?

**Operator:** Our first question is from Shawn Le Clement. Please proceed with your question.

>> Hi. I would like to know whether the reference at all addressed how physicians feel about compensating physicians relatively less who do not achieve quality targets.

**Penny Daniels:** Good question. Anyone want to take that one?

>> Yeah, we really haven't asked physicians specifically that question but I will tell you that many of the physicians that we've surveyed and many of the physicians that we've conducted focus groups with indicate that they believe that as a concept, Pay For Performance is fine when it's presented as a way of rewarding good performance, a way of recognizing good performance. But most of the physicians that we've spoken with in focus groups and that we've surveyed also indicate that they feel they are already providing very high quality of care and so Pay For Performance is a way of recognizing that very high level of performance that they're already exhibiting.

So I think that the idea of giving physicians a penalty which in fact is built into probably just a minority of the Pay For Performance programs that currently exist probably is not all that appealing to most of the physicians, you know, at this time and it may be something that they may have to get used to in the future depending on some of the trends that we see in these programs. But for the most part, you know, I expected you'd see some hostility to that idea.

**Penny Daniels:** Adams, you had something to add?

**Adams Dudley:** Yeah. Let's be honest, though. There's no new money. So if the incentive program is set up such that some providers get more, then other providers are going to get less. The usual way that I see this in our studies, the way that I see people presenting this is they take the next year's payment update and a component of that is switched over to Pay For Performance. The thing about paying some folks less, the reality that some folks are going to be paid less that you have to be careful about, you want it to be people you really think aren't doing well. One of the things that I have seen is frequently expressed concern is that people who take on more difficult patients, so less well educated patients, patients who have high copays and can't afford the prescriptions and so forth, you don't want those providers who are willing to take on the difficult patients ending up getting penalized. So you do have to be careful about how you do this.

**Penny Daniels:** Yeah, take it into consideration.

**Adams Dudley:** Because the reality is someone's not going to get paid as much and you don't want that to be the traditional safety net taking on the hard cases.

**Penny Daniels:** That's true. We have another question on the phone now. Joe? Joe, are you there?

**Operator:** Our next question is from Barbara McNaney with New Mexico Oncology. Please proceed with your question.

>> Thank you. My question was partly addressed by the previous speaker who commented that if people lose money from being at the bottom end of the Pay For Performance that we may have some significant loss in our infrastructure in people who are in less well -- less affluent, less well educated areas. But my concern as you look at doing groups versus doing individuals is while it's much easier to do groups who can afford IT, much of the healthcare in the country is delivered in small practices and I was wondering how you were going to assign the benefit of, say, a good hemoglobin A1C to someone who may be sharing the care of that patient with multiple physicians and also as a question, you said that you were getting a positive reception. Yet at the last AMA meeting there was a great deal of discussion about the fact that people felt that this was really not ready for prime time because the tough questions of allocating quality to various physicians and accounting for the differences in ability of compliance, et cetera, have not yet been addressed.

**Penny Daniels:** Okay. Thank you, Barbara. That was a multiple part question. Who is going to jump in here?

>> Gary, you want to that take the positive reception and then I'll talk about attribution?

**Meredith Rosenthal:** This is Meredith. I just want to make one comment. I do think toward the end of your comments, Barbara, you referenced a point which is particularly pertinent for when Medicare starts to develop its own Pay For Performance program and thinking about Medicare beneficiaries in particular who may have many physicians, particularly those with chronic illnesses and how a Pay For Performance program there will address the issue of there are six different physicians; who's responsible for making sure that person gets her mammogram.

This is an issue that I know the folks at CMS and the Institute of Medicine and others who are advising CMS are struggling with looking at data, trying to figure out how you do attribute patients to physicians when there

really isn't an HMO structure where there's a natural connection between a physician and patient. It's certainly an unresolved issue but not, I would say, one that seems unresolvable and there's a good deal of research going into that right now.

**Penny Daniels:** It does speak to how very complex this whole issue is. There are so many different moving parts to it. Adams, did you have something to add on that?

**Adams Dudley:** No, I think Meredith covered it. I guess I'll get to the positive reception thing. Of course there is not universally positive feelings, but the reality is, I'm a physician myself and I run intensive care units in California sometimes when I'm not doing research and so, you know, both at the hospital level and the physician level this is going to happen and it's going to be the last industry in the country in which it hasn't happened. If you think about it, if you wanted to have your house painted and you asked them to paint it blue and you came home and it was painted orange, you wouldn't pay anything. Or if they painted over the windows, you wouldn't pay anything. And so what people are just asking us on the provider side, to be like every other -- to be responsible in a way that every other industry has to be responsible, and we as providers have to come up with a good way to do that.

**Penny Daniels:** Okay. We have an electronic question right now, I believe, a question coming in. Do we? Does Pay For Performance -- someone has asked, does Pay For Performance work for ancillary providers. >> Well, presently programs have not targeted ancillary providers as the individuals to receive payments. Now actually there is some interest that I'm seeing in the provider community about taking Pay For Performance programs and using them to target provider teams that would include ancillary providers. I think a very interesting concept, it's one that would probably present some important challenges in terms of feasibility but I think really if fact there is some real interest in the provider community and using provider

teams, again including ancillary providers as the unit of accountability, if you will, or the unit that will receive payments for achieving free specified quality targets.

**Penny Daniels:** Okay. Gary, thank you very much for that answer. I think we have so many questions, people queuing up, a lot of people on this call, but we're going to move on now to a little bit from Dr. Meredith Rosenthal, associate professor in the Department of Health, Policy and Management at the Harvard University School of Public Health in Boston. We will get back to those questions in just a few moments. But in the meantime, Meredith, developing a robust measure set is really critical to all of these undertakings. What do purchasers need to think about as they choose quality measures?

>> Thank you, Penny. First let me just underscore, is probably the most important decision a purchaser needs to make when thinking about Pay For Performance not only because the measures, of course, will define what things the providers actually put effort into improving but also because it's really critical for getting buy-in among hospitals and physicians and so this is a place where some dialogue between the providers and the payor really makes a lot of sense, and with that as the backdrop I'd just like to know sort of three key considerations. The first would be really to start by looking to national measure sets. These are the measure sets that have been validated and have gotten quite a bit of acceptance in the provider community and so this is a natural place to go to look for measures that will have some face validity. The second factor, of course, will be thinking about the cost of data collection, and certain measures are more amenable to existing data.

So, for example, you can look at process measures of quality using your billing data and if cost is a big consideration, that will be a concern. Of course, that needs to be weighed against the value of what those measures are capturing for you. If your real concern is with patient experience, then you are going to have to go out and collect survey data and that might be expensive. The final consideration is really thinking about

the objective to prepare and making sure that the measures really reflect the balance of concerns related to cost and quality in particular. We hear a lot from purchasers being very concerned about making sure Pay For Performance is at least budget neutral but ideally budget saving as most of the perspective is focused on right now and so that means not just assuming that quality measures, for example measures of underuse which are typically captured, not just assuming that those are going to pay for themselves with cost offsets but looking directly to efficiency measures, possibly measures of overuse of services as well. So those three things.

National measure sets, think about the data source and the cost of getting the data. And finally, tradeoffs in catching quality and cost concerns in your objectives.

**Penny Daniels:** Okay. And you have a list, don't you, of the national -- here they are, the national measure sets.

>> Thank you, Penny. Here's a slide with some of the important national measure sets that purchasers may want to look to for example measures.

**Penny Daniels:** Okay. Very good. We'll keep that up there for a moment as we ask Adams, what are your thoughts about selecting nationally adopted measures versus developing local indicators.

**Adams Dudley:** Well, that is a great list up there. The JCHO and NCQA measures. Those are the ones, JCHA accredits hospitals. Because of their power of accreditation, people have to do their measure sets. So when you're trying to make decisions about what you might want to measure in your local area, you have a national local choice to make. The issue with the accrediting by these measures is that they are all being done already, they are validated and widely accepted. Real problem is that there just aren't very many of

them and so almost everyone, and actually I think Doug Libby's going to give us some great examples of that soon,. Almost everyone ends up going beyond the national measure sets.

In between the accrediting bodies are national organizations like the national quality for -- also the CDC measures that we saw in the last budget, the national quality forum was set up by congress to bring together consumers, purchasers and providers to identify key areas in which to make measurements. So the benefit of using their measures or their measure areas is that everyone has said they're important. There's a social consensus there. The down side is they don't give you detailed specifications and you can't really measure anything without giving detailed specifications.

If you want hospitals to measure in maternity, which national quality forum has said is important, you have to tell them exactly which patients, which patients are excluded. You might exclude twins and triplets and so forth. And exactly what to pull out of charts or out of administrative data. All the other national measure sets are not precisely defined. Some are further along than others.

So what you end up with usually is locally developed measures where hopefully you bring the providers together. That gets you the buy-in that Meredith was talking about.

The down side to this is that it does take work to bring providers together. You can almost always find people who are expert in your area, in your physical, in your geographic area but you have to get them together and have them do some actual work to say, okay, this is exactly how we're going to measure it. Doug, don't you have some great local stuff?

>> Yes, Adams. We actually use some of both kinds of measures but wherever possible, we certainly defaulted to measures developed by the nationally recognized entities that were on Meredith's list.

We have -- why don't I just run through the measures quickly and tell you which were local and which were national. We have measured primary care practices in three categories, the first being systems in place to manage chronic diseases by a survey and when we did this, there was not a nationally available survey. So we essentially created one through our multistakeholder committee.

We also looked at compliance with guidelines and for those we instantly went to the (inaudible) measures and we certainly used a national standard there and we also measured some outcomes of care where we followed again national guidelines, those developed by both NCQA and the Bridges to Excellence program. So a little bit of both on the primary care side.

On the hospital side we actually measured four categories, the first being patient satisfaction and for that we used the standardized survey from a national vendor? In patient safety we use some of each. We use the national leapfrog survey to measure patient safety but we also create a locally developed survey that focused. We created that specifically in response to our largely rural market and the desire by our smaller hospital to be able to demonstrate the safety of the good medication systems they had in the non-CPOE environment. So there we used one national and one locally developed measurement that politically, political performance we use the national measures that hospitals are reporting to CMC and JCAO and on the cost side we again used a methodology that measures unit cost from our administrative database. So a little of both we use throughout both programs.

**Adams Dudley:** Penny, this is Adams, if I may. A couple of points. One is that on both sides Doug and the rest of the people in Maine decided that they wanted to add some local measures to the national measures. I would make the point although Doug has called them home grown, I'm sure that a lot of work went into developing them and making sure that they were valid. That's a safe statement, isn't it, Doug? You brought together experts?

**Douglas Libby:** Absolutely, Adams, years of work.

>> Yeah. And so they tried. Doug said we tried to use national measures and yet they found that for -- and who wouldn't want to measure medication safety and cost.

I would add another example from my own personal experience. I'm running a project, on the patient experience side the national question, measure set is only 16 questions. And there are no questions about the availability of translators, which is a huge issue in California. So when we're doing our project in California, we added some questions about translators. And there just are frequently going to be local issues that you need to have local measures for.

**Penny Daniels:** And you mentioned also, Adams, that by getting local provider input, and I would think that would help you get buy-in if you get that local input on the measures.

>> Doug, has it helped with yours? With your stuff?

**Douglas Libby:** Oh, absolutely, absolutely. We convened a group of pharmacists and nurses from our member hospitals to help develop our medication spotlight survey.

**Penny Daniels:** Okay. I want to turn the discussion to measures for specialists which seems to be a very interesting topic for a lot of people. But before I do, I'd like to tell our listeners that we've gotten a lot of questions about where these slides will be available that you're seeing on your screen. And following this

web cast we will make them available on the national Web conference website and we will give you that website address toward the end of this conference. So just stay tuned for that.

Now, Gary, let me turn to you. What about measures for specialists?

**Gary Young:** Yeah, it actually presents a very important challenge for future Pay For Performance programs. There's really right now a lot of interest in extending Pay For Performance to specialists but there's also a lack of relevant quality measures that demonstrate a reliability and validity and as Adams noted, we just don't have a lot of nationally available data sets, quality, sets of quality measures to draw from. Now, the most con program that focuses on primary care physicians for which the availability of the so- called heated measures which have embedded by the community over many years greatly enhances these programs' feasibility but we don't have anything really comparable to, as the specialists, no readily available national set of quality measures to draw from. So this really represents an important challenge that we need to address if we're going to extend these programs to specialists in the future.

**Penny Daniels:** Okay. Thanks, Gary.

Let's pause now once again and take a few more questions from our audience. This time we'll talk about the issue of selecting measures. So Joe, our operator, are you there? Can we go -- do we have a queue up on the phone?

**Operator:** As a reminder if you'd like to ask a question, please press "star," "1" on your telephone keypad.

Our next question is from Kenneth Henrikson with advocate Health Centers.

>> Yes, hi. I wanted to address the observation that was just made about specialist measures. I recognize the challenge that's associated with finding national measures. If there was a business need to do so would you have some suggestions on how to go about doing that until some national measures become available?

**Penny Daniels:** Adams?

**Adams Dudley:** This is Adams again. There are numerous efforts going on around the country. What I have seen happen in several instances is purchasers, in all cases I can think of that come to the top of my head, health plans, looking around and saying, well, where do we have a pretty decent size market share. And then going to an important specialty group within that market in which they are a major player. So for example, there's a program in Seattle between a health plan and a large oncology group. They went to the oncology group and said, okay, they don't have anything nationally. Let's talk about what you'd be willing to measure, what you think you can get out and what you think you need to work on.

**Penny Daniels:** Okay. Thank you, Adams. We have another question on the phone, Joe? Who's next? Do we have a phone question?

**Operator:** Our next question is from David Selig with Community There Network.

>> Yes, I understand the discussion concerning the criteria and the selection of the parameters to be measured. Is there anything that you might be able to comment on regarding the electronic medical records systems themselves as it relates to data collection and reporting?

**Meredith Rosenthal:** Well, certainly -- this is Meredith. Certainly where electronic medical records exist that will lead to much lower data acquisition costs, particularly for good clinical data whereas in most parts of the country we really have to go to chart review to get clinical data. But, you know, if we're talking about a program broadly, in most markets in the U.S., even in fairly sophisticated markets like Boston, for example, electronic medical records are just not that pervasive and so it's very much a question, I think these days, of

thinking about investing today in those resources so that tomorrow we can have better data and more accessible data. Does that address your question?

>> It even has become a Pay For Performance measure in some instances, getting people -- Dave's nodding his head. Do you want to talk about that? -- getting people to invest in Pay For Performance through electronic medical records?

**David Kelley:** Yes, actually that's part of our hospital Pay For Performance in that we're encouraging hospital systems and providers to use electronic medical records in our fee for service, Pay For Performance program we're actually, we have one large health system that wants to transmit data to us that we're willing to pay for and that's worked very nicely.

>> And I think actually that goes back to the earlier question, Penny, that you raised about the tradeoff, about rewarding individual providers versus groups in that here again, when you're rewarding groups or larger institutions, hospitals, you have an entity that can make those kinds of investments in technology whereas individual providers you often lack that opportunity.

**Penny Daniels:** Okay. Thank you, Gary, for adding that. Let's take one more question now, an electronic question. For some of the national measure sets, this person asked, a number of hospitals may have reached a high degree of compliance. So how then can they differentiate providers well? Adams?

**Adams Dudley:** Yes, this actually is a really common limitation of the national measure set, particularly those used by the accrediting bodies. Everyone's already given aspirin to their people who are having heart attacks, or at least they sure ought to be. For the accrediting measures, the accreditation measures, most hospitals have protocols when a patient's admitted with that and you go through and you make sure that all the things that are in the accreditation measures are done. So it's a common limitation. I think there are at least two potential responses. One is to identify additional measures in that subset of patients. So one of the

main sub sets of hospital patients is pneumonia patients and you could add, for example, a lot of those people end up on ventilators, breathing machines. You could add ventilator-related questions so that when they're going through those charts already, they get some additional information about a new but related topic. And the other is to open entire new areas of investigation but that takes you into -- both of those paths take you into the local measures development.

**Penny Daniels:** Okay. Let's -- we'll get back to questions, your questions in just a few moments but first let's hear once again from another purchaser. Dr. David Kelley you actually just heard from a moment ago. He answered one of our questions. Let's introduce you now, Dave. He is the Chief Medical Officer in the Office of Medical Assistance at the Pennsylvania Department of Public Welfare. I understand that Pennsylvania Medicaid currently provides coverage for 1.8 million Medicaid recipients. That's 17% of the state's population. Pennsylvania Medicaid is undertaking a number of Pay For Performance activities. And David, how's it going? How's it working? Are you seeing more quality? Are you saving any money?

**David Kelley:** Thanks, Penny. I think with all of our programs it's much too soon to know any of those questions. We currently, the Pennsylvania Medical Assistance program currently has developed three specific Pay For Performance programs. First is a hospital-based program targeted to reward hospitals that both improved care but also focused on patient safety. That program took us two years to develop that. We just recently in March made the first round of payments and we really only now have the first round of assessments. So are we going to get a return on investment or are we going to see an improvement in the quality of care? We're not going to have that answer until probably next year.

With our managed care plans we actually picked, targeted 10 heaviest measures and basically we're going to be looking at the 2006 heaviest results which will be out this summer. So by this fall we will actually see it. If we've seen some quality improvement at the managed care plan level.

And then lastly in our fee for service program we have a program that's geared to the primary care physicians and it's geared mainly around the quality of care and participation in five diseases in our disease management program. And again, that program is relatively new, just started in November of last year. We just made our first round of payments in March. So the bottom line is it's just much too soon to know, you know, how well is it working, are we getting a return on our investment.

**Penny Daniels:** Okay. But you will have some results this fall it sounds like, on your managed care?

>> Especially with the managed care plan.

**Penny Daniels:** Okay. That's something that we'll sure to be staying tuned to hear about. Meredith, I understand there are different ways to structure bonuses and rewards. Can you tell us a little bit about that?

**Meredith Rosenthal:** Yes, Penny. So let me start. Some payors, talking about sort of the basic structure of scoring and rewarding providers. Some payors choose just to reward, say, the top 10%, the top 25% of the network. And so this is sort of like going to a test that's going to be graded on a curve. The provider has not great information about what kind of effort is going to be needed to get the bonus and so this leads to a lot of uncertainty and the worry is it will leave them to underinvest in quality improvement because they really, their performance isn't the only factor. It also matters how well everybody else does. So another approach would be to set a fixed benchmark, say everybody has to have at least 75% compliance with some clinical guideline and then reward all the providers who do at least that well. The problem with that is that providers tend to be all across the board. Some are doing very well, some are already doing better than the benchmark, and it

leads to very uneven incentives. So not everyone has to improve to get the bonus and some people have to improve by so much to get the bonus that it's just not going to be worthwhile. So another way of framing the nature of sort of scoring and rewarding for Pay For Performance would be to think about trying to pay for good care wherever it happens. And paying in proportion to performance.

So in a very simple example would be to say let's assume that we're going to pay \$100 for every diabetic patient whose care meets these five criteria and so that means that for every patient who gets good care, the provider will get some additional payment and therefore it always makes sense to improve, no matter what level you start out at.

**Penny Daniels:** So that seems more achievable, Meredith, and it would give people more incentive to actually try.

**Meredith Rosenthal:** That's right, Penny. It creates an even incentive no matter where providers are in terms of their own performance right now as opposed to the other two strategies which present a fair amount of uncertainty and unevenness in the incentive.

**Penny Daniels:** Okay. David, how did you design bonuses in your program?

**David Kelley:** Well, for all three programs we decided that we were going to focus mainly on national quality measures. We really didn't want to get into parameters that were clinically controversial or difficult to measure. Also we made early on a philosophical decision that we were not going to involve penalties in any of our programs.

And then lastly, being a public program, it was essential that we involve our key stakeholders. For example, with our hospital Pay For Performance program, we met with our hospitals over approximately a two year

period of time, sat down and developed commonly accepted parameters and again after two years of that, we actually had our first payout a month ago. So I think that another key thing for us was to make sure that there are absolutely no penalties because -- especially with the providers and especially on the hospital side, as well as our fee for service program. If you even talk about penalties, physicians simply turn off and don't want to listen.

**Penny Daniels:** So we want to do the carrot, not the stick.

>> Absolutely.

**Penny Daniels:** It works better. I'm sitting here listening to all this and I'm thinking that there have to be a lot of purchasers out there thinking to themselves, where are we going to find the money for Pay For Performance. Doug, Doug Libby, where do you find the money? What do you think? How did you find the money?

Douglas Libby: Well, Penny, that's always the \$64,000 question and in our case or at least the case of our hospital incentives and rewards program, it became a million dollar question. I think the key is that we were first of all blessed with a group of enlightened employers who felt really strongly that it was important to demonstrate that they were willing to walk the talk, that they were willing to begin to buy on quality and not just on price.

They also felt strongly that they wanted to make a statement that they really were dissatisfied with the current perverse incentives and the reimbursement system that rewards units of service rather than outcomes and quality.

And our hospitals, those who invested heavily in quality were starting to ask where's the beef. So I think those were some of the backdrop but I think a real key factor for us was that both hospitals and employers committed to funding a bonus pool and as you can see in the slide, our hospital participants contributed what we called a performance guarantee in the form of 1% of the revenue they collected from the participating employers. And the employers contributed what they called a performance bonus in the form of 1% of the total dollars that they spent purchasing services from the participating hospitals.

So I think the hospital's willingness to put some money at risk was a very motivating factor for the employers to step up to the plate.

**Penny Daniels:** Okay. Well, there's a question of money that's so interesting and so important. I'm going to once again open it up to our audience for their reaction and questions. The first question we will take will come from the phone. So we go back to our operator. Joe.

**Operator:** As a reminder, ladies and gentlemen, if you'd like to ask a question, please press "star," "1" on your telephone keypad.

**Penny Daniels:** We have a little bit of lag time while Joe queues up the next questioner. That's the state of technology. What can I say. Hey, Joe, do we have someone?

**Operator:** The next question is from Shawn Le Clement. Please proceed with your question.

>> Yes, this is a question for Meredith Rosenthal. On the last slide she showed on how to pay providers. The question is it seems the recommended approach was to pay for all patients whose care conforms to guidelines. But it seems that in order to do that, you would really have to review all charts, which is different, for example, than say the Bridges to Excellence which only requires that you do a randomly selected number. So the burden seems quite a bit more onerous. Could you speak to that and how that's being approached?

**Meredith Rosenthal:** Yes, thank you, Shawn. I think that's a good point. The Bridges to Excellence program for people who -- well, for people who have been living under a rock, it essentially looks at a random sample of charts to see how physicians are doing on a set of processed structure and outcome measures and then sort of gives that physician a gold star if they do well and the physician then is eligible for additional payments for all their subsequent patients over a given period of time and this means that if the physician decides to slack off -- not that this would happen -- the year after, they're essentially reaping the rewards for past performance.

Now, clearly the Bridges to Excellence program is a very well designed program and it's motivated very much by wanting to use clinical data but wanting to collect it in a feasible way. So there is really a tension there. If you think about a model using either electronically available data streams, either clinical data that they're available electronically which we just said was not very likely but billing data where you do have the universe and the population, that would be a much more applicable model. It's a real tradeoff, though, because what you get are sort of incentives, to get the accreditation essentially from bridges but not any better. And I think it's a concern particularly moving forward over time that there will be sort of a lack of recruitment overall.

One other thing to note about Bridges, though, they sort of build in natural steps where you can incrementally do better. So there are some built-in models for improvement.

I sort of talk about this model of paying for every patient that gets good care as the extreme but there are a lot of sort of intermediate compromises where you can build in incentives for improvement without going all the way to looking at the care of every patient.

>> Well, the simplest thing you can do is exactly what Bridges does which is to just sample and assume. I mean, the point of sampling is that you are assuming the sample roughly represents what's going on. So you could take a percentage of the patients and measure their performance and if you get 75%, that means you get more payment than if you have good performance on 80%.

So the core concept of Meredith's recommendation is that there aren't these thresholds, there aren't these levels where there are these major changes in your payment for going from 69 to 70% but rather that you have a continuous thing. So if you measure 20 patients, it goes up in 5% increments where you get additional payments for each 5% increment.

**Penny Daniels:** Okay. Let's take a question from Doris Lock. It's an electronic question. Doris would like us to talk about the use of absolute increases that exceed a threshold versus relative increases in performance, how to reward the high performer who's already at 80 to 90% of their goal as opposed to the poor performer, how do you reward them who moves from 10 to 30% toward the goal. David, did you have something you wanted to say about that?

**David Kelley:** I'll use the example of our Pay For Performance with our managed care plans. We have several plans that are near or at the 90th percentile benchmark were some of the heaviest parameters and their reward is much higher. We also protect, if they slip a little bit and are just a little bit off the 90th percentile because they're still a fairly well performing plan, we continue to reward them. Whereas on the lower end we look more for an absolute increase in improvement and I think with a lot of ours, we look for like a 10% increase if you're really, really at the bottom.

One of the parameters, one of the pivotal points in our program is that if you don't hit above the 50th percentile, you receive no payment.

**Penny Daniels:** So in other words, are you saying the poor performer who moves from 10 to 30%, they wouldn't get anything even though they've gone up 20 percentage points?

>> Not under our program.

**Penny Daniels:** Okay. That's interesting.

>> And again the premise is that we were unwilling to pay additional money for mediocre care or average care.

**Penny Daniels:** Okay. Even if it's improving. Meredith?

**Meredith Rosenthal:** I think David has expressed something, I find that most purchasers feel in the depths of their souls, that there needs to be some kind of minimum cut-off. There are a lot of ways of mixing up your program to build in these kinds of concerns and so, for example, if you wanted to be sure that everyone has some incentive to improve but that you have a minimum threshold, you can still set that threshold and then say that incrementally everything above that threshold will get more of a bonus. So it is sort of a withhold model, this kind of thing works very easily. That's essentially what a withhold is.

**Adams Dudley:** But Meredith, isn't it your core concept that you're expressing there is that if you do pay the person goes from 10 to 30%, you're still only paying them 30%. So you're still, Dave, you would still only be paying for the good care. So they would get far less than the person who had 90%, but the introduction of that, you must be in the top half to get any payment. If someone's really mired down at the bottom, it takes away their incentive to try and swim upstream to get into the top 50%. Isn't that what you're saying?

**Meredith Rosenthal:** That's absolutely true, Adams. I think again, these are tough decisions. I know a lot of purchasers feel more strongly that they want to not reward those providers.

>> Yeah, and I think it's very interesting because as pay for performance moves forward, the concept we're beginning to see really sort of a wonderful array of models. There's one program that I've studied in New York that actually ranks physicians each year, sort of a tournament style approach where there really is no safe territory. Each year physicians are ranked on a variety of quality measures and no matter how well you do in any given year, you're not guaranteed a financial reward the following year because once again, it's just back to a tournament approach. So there's a whole variety of models and, you know, hopefully as we have more experience, we'll get a sense of how to combine these different concepts to create a program that most effectively achieves the goals we want to achieve.

**Penny Daniels:** Okay. We're going to take more questions, we're going to open it up to all questions in just a few moments but first I want to go around the four -- five of you and just ask very quickly anything to add, summary, last thoughts before we take, open it up to questions? Meredith, you want to go first?

**Meredith Rosenthal:** Okay, Penny, I have two things. One, I would say the one thing that we're learning from looking that's all these experiments going on around the country is that it's really important to involve providers, physicians, hospitals, whoever else is being targeted by the program, early and often. So get them involved in measure selection in particular is a very productive place to involve providers, where they really need to have some input.

The second thing would be, think about what it is that you're trying to do with your Pay For Performance program and make sure the way that you've designed your bonuses or withholds or whatever they are is really aligned with what your goals are. If you say the word "Improvement" when someone asks you what your goals are, then you really need to make sure that what you're actually rewarding is improvement and not just historic past investments in quality improvement, historic past performance.

**Penny Daniels:** Okay. Good information. Doug Libby, last thoughts?

**Douglas Libby:** I guess I would just simply underscore Meredith's earlier comments about the importance of measures and buy-in to measures and methodology and that really is a collaborative process with a long trust mark. I wouldn't worry too much about the details of dollars, structure of payments. I think provider groups are somewhat tolerant of an imperfect rewards process or bonus process, especially when the dollars remain low, but they will not, nor should they tolerate poor or inaccurate performance measures.

**Penny Daniels:** Okay. Gary?

**Gary Young:** Yeah. Just to say that I think Pay For Performance represents potentially a wonderful mechanism for improving quality. The message is very clear from the discussion that there's a lot that we don't know yet and hopefully we're going to see a lot of experimentation over the next few years and get a better sense of how it's best to design and implement these programs and we all need to be open -minded and adventuresome in how we go forward with this.

**Penny Daniels:** Let me remind our listeners that we are far from finished. We are going to get a few last thoughts but then we are going to open it up to questions. So David Kelley, give us a quick wrap-up of what you think is most important to remember.

**David Kelley:** Again I think that you need to define your program around positive rewards, not penalties. I think as a public purchaser, we definitely need to involve our stakeholders. And one of the key things that we're learning is that we have an incentive plan for our managed care organizations. We would like to see in a way a linkage to the same sets of providers so that perhaps the 10 hottest measurements that we're paying our health plans on, perhaps we need to role that out and link that to our PCP network. So that's one thing that we're considering so that everyone's incentives are aligned.

**Penny Daniels:** Okay. And Adams, last thoughts.

**Adams Dudley:** So many. Are we getting to public reporting later?

**Penny Daniels:** Are we getting to public reporting? Yeah, we are getting to public reporting.

**Adams Dudley:** So I'll talk about that later. First one thing to the purchasers out there about involving providers. You don't involve them just because that's what will help you get acceptance. I think you want to involve them for a very positive reason and that is they're better than you are at developing measures. They know more than you do. So in our project where we're trying to measure hospital performance in California, even though I'm a physician, I'm not an obstetrician and when we got to obstetrics, the providers helped us a ton in coming up with a better measure. We were thinking about complicated risk adjustment and all sorts of things and they said, you know what, if you just focus on the first-time moms having just a single baby instead of twins or more than that, you don't have to worry about the risk adjustment you and you might be able to measure it just from administrative data. Boy, was that a load off our back. So there's a real positive reason to involve the providers beyond just getting their acceptance.

And the second point would be you must evaluate your program. You will get it wrong. It's just too -- you know, if there were easy, there would be the model out there that you could just lift off the shelf. I mean, Dave, don't you agree it's almost certain you've gotten something wrong?

>> Absolutely.

>> Not that there's anything wrong with Dave, very smart, very nice guy, well intentioned but it's just not possible to get it right out of the gate and so you have to then have a plan for how you're going to know. One of the key things I think you want to look at is what I call immigrants and emigrants, people who are switching practices, switching hospitals. If you've got the risk adjustment wrong, for example, the sick patients being thrown off the boat by the providers and so you want to look and see if there's certain connotation that's big

shipped out. Or if you don't have the translator issue dealt with and it's a major problem, then patients who don't speak English are a real burden to providers and you might see them concentrating in a small number of practices and that will tell you you have to do something about it.

**Penny Daniels:** Okay. And I promise I will ask you in just a little while about public reporting. Promise. But right now we are going to take more questions from our audience.

So before we get to that, I have a few administrative details I must take care of. Sorry to bore you. But we have to do. I'll get to your questions in just a moment.

First, we have some information about the resources we've been talking about in this program. It's on your screen right now, or it will be in just a moment, how to obtain some of the resources we have been talking about. Okay. There you go, on your screen, information about how to obtain some of the resources we've been talking about in the report. It will also be available on the website for this conference. So you can look there as well. You'll find information on how to get the AHRQ-supported tool Pay For Performance, the Decision Guide For Purchasers. And also how to order the special supplement of the Medical Care Research and Review.

Okay. Now, getting to more information about questions. While you're asking a question on the air, please do not use your speakerphone. We love those things, don't we? But online it is much harder to understand what you're saying.

Now, please note that if you prefer not to use your name when you talk with us, that's okay but we would like to know what state you're from and the name of your organization if possible. So please give us though details regardless of how you're sending your question.

As you're formulating your questions or queuing up on the phone, I'd like to say a few words about our sponsor, ARHQ. The mission of ARHQ is to support and conduct healthcare services research designed to improve the outcome and quality of healthcare, reduce its costs, address patient safety and medical errors issues, and broaden access to effective services.

We would appreciate any feedback you have on this Web conference at the end of today's broadcast. A brief evaluation page will appear on your screen with easy-to-follow instructions. These evaluations are very helpful to us in planning programs in the future. So please do give us your feedback.

Okay. We are going now to the first question, electronic question. Are we? Okay, there it is. Is this the question we want to do? Okay. I have to tell you out there, all you listeners, we have a lot of people in this room here in this studio who are really involved in bringing you this webcast. So thanks to all of them. And sometimes they keep changing the question on me but thanks to them anyway.

Okay. How do we adequately address risk adjustment issues and truly reward provider performance. Risk adjustment, we've been alluding to it the entire webcast. Who wants to jump in and go for that one?

>> Well, --

**Penny Daniels:** Let's not all jump in at once.

>> Well, I'm sure a few of us have something to say on this topic. Right now as we've mentioned during the discussion, a lot of the programs are focusing on heaviest measures and they are what we call process-oriented measures and there's some debate about this but I think there's probably some sense that they don't really need to be risk-adjusted because they are focusing on process. What you're doing as opposed to any outcomes.

Now, as we move forward, pay performance, perhaps extend to specialists and begin to think about perhaps using outcome measures, I think risk adjustment's going to become a much bigger issue and I think probably Adams, who is really an expert in this area, might have more to comment on that. But certainly I think risk adjustment's likely to become a greater concern as we move forward Pay For Performance in the future.

**Penny Daniels:** Okay. Thank you, Gary. We have a question now on public reporting. See, I told you. I told you I promised to. Adams will, of course, take this question. The question specifically is can you talk about the importance of making public the results of any pay for performance program. Judith Hibbard's analysis of the Wisconsin hospital reporting program indicated that providers respond much better to quality improvement in response to public report rather than confidential reports. Adams, I would add also, could you have any advice on which they should do, people should do first, a public report card initiative or Pay For Performance? What do you think?

>> Well, so a couple of issues. Can we get the slides up? A couple of slides. Oh, yeah. So the slide here will show, Gary mentioned some of the data that providers have responded to Pay For Performance, but there's also data that public reporting is working that the questioner mentioned Judith Hibbard's study in Wisconsin that shows if you give hospitals a public report, or you give them a report and then you also put it in the newspaper, they respond to it much better than if you just give them the exact same data about what their

performance is but no one else knows about it. So the fact of making information public does improve response.

In addition to New York, Patrick Romano and colleagues looked at Medicare patients, Medicare fee for service patients. Those people are free to choose any hospital. They don't have a health plan that tells them this is the network. And after New York's coronary artery bypass grafting reports come out that say the mortality rate is low here and high here, those patients are more likely to go to the low mortality rate hospitals. So getting public reporting information out does have some impact. However, when you go to the other slide, my group, we looked at purchasers, every purchaser-supported public report card in the country and this was a while ago. Shows how long I've been doing this now. I'm getting old. But this is way before there was any P4P and actually what the hospitals who had been subject to those programs said was, hey, when the public reports first came out, recognition was good, we were all excited about it, we wanted to work hard to get recognized. After a while, though, there has to be some dollars to support it. So I think what you have to do, since there's some uncertainty about developing performance measures, in some way I would give people some lead-in time, some pilot time. You develop the measures, you let them see how they're doing and you may publicly report them or you may have a year where you publicly report them. Then public reporting might be the next step and then dollars associated with that, be the final step. That's one way to perhaps bring them in. A lot of people are interested in doing it together but you might get people more comfortable with the measures by slowly changing the magnitude of the incentive behind it.

>> So eventually, though, we want you to show them the money.

>> Yes. If you just keep putting out data interest wings, it seems.

**Penny Daniels:** Okay. Our next question is coming from the phone lines. Joe, do we have someone asking a question on the phone?

**Operator:** Yes. Before we take our next question I'd like to remind everybody if you'd like to ask a question, you need to press "star," "1" on your telephone keypad. The next question is from Nina change with the Ohio Job and Family Services.

>> Hi, actually my question was addressed, risk adjustment, sort of summation.

**Penny Daniels:** Risk adjustment? Are you saying we already asked the question?

>> Yes.

**Penny Daniels:** Okay. So we'll pass you up. Thank you for trying. Joe, do we have somebody else on the phone?

**Operator:** The next question is from Celia Gomes with Rhode Island Health Association.

>> Yes, good afternoon and thank you. One thing we alluded to with all the panelists is large physician practices and small physician practices. We really didn't talk about the practices in particular community health centers that we have about 1400 of them throughout the nation that serves the underserved, those with inadequate insurance and those with no insurance at all. And I just am concerned that whatever a system or incentive program is out there would adequately, you know, reimburse the health center, the many types of patients that come into the centers today. So a couple of the panelists, including Dave and Meredith did turn to saying, you know, rewarding for performance. If not, I think I tend to think there may be an incentive for the well financed or larger physician practices who want to change their patient mix to a more homogenous type of a practice.

**Penny Daniels:** Okay. That's a very good question. David, do you want to address that?

**David Kelley:** Yes. Being a Medicaid program, our agencies, federally qualified centers are key stakeholders and we're very involved in our Pay For Performance programs who are primary care providers and I don't want to get into the details of that program but we looked at things like -- we literally pay every time a provider fills out a clinic care form, they get paid \$60. We're making those value judgments about how well controlled someone's blood pressure is or what their hemoglobin A1C is. The fact that those centers deal with very difficult patients that are very complex, we wanted to reward them with filling out that chronic care form because we felt that would help to better coordinate care. And again that's something that's very easy for the providers and the FQAC to do.

We also, because many of them don't have electronic medical records, we developed what we called a widget-based system. We paid, if Mrs. Smith got a hemoglobin A1C done, you would get \$17. So it was a very widget-based system. So we designed it because that program is mainly in rural areas and it's underserved.

**Penny Daniels:** So do you actually have a different system then for those programs than you do for the other providers?

>> The other providers within our managed care plans, each managed care plan has their own individual programs and again, my comment I made earlier about us taking our ten heaviest parameters that we do with our health plans, one of our ideas is to make that more uniform and concentrate on all the plans in those 10 parameters but we're still in the design process of that. Go ahead.

>> What are you going to do if some of your SQHCs are in your bottom 50% where you don't pay any extra? Essentially what would then be happening is there's no payment to those people who already have the most difficult population.

>> Again in our program, in that particular part of the program there is no relative value or relative scale. The other thing that, for those that are on the line that know a lot about FQACs, the payment mechanism's actually quite different. So you have to be somewhat careful, and we had to actually get CMS approval to do these types of payments to those types of centers.

>> Okay.

**Penny Daniels:** So it's more this widget program that you described is more along the lines of what, Meredith, you had in your third way of structuring the bonuses and rewards?

**Meredith Rosenthal:** I think that's right. I think that's what it sounds like, yep.

**Penny Daniels:** And you said that was a better way of doing it?

>> Well, particularly if you are thinking about, this is an issue that comes up with a lot of payors and they are thinking about this from the payor perspective. I think the questioner may be thinking about it from the community health center perspective. But as you look across your network, there is going to be a diversity of providers and a diversity of patients and one really good way I think to making sure that those providers who treat vulnerable patients aren't penalized is to stay away from Pay For Performance structures that, for example, only reward the top 10% and throw everyone in the same peer group. That's clearly going to disadvantage providers of vulnerable patients who have more transportation problems, more access problems and focusing again on trying to provide incentives to get good care to everyone.

>> Okay.

>> Sounds like Dave's being very careful about this, but the issue is, one of the frustrations that I personally have and I'm a provider is that every single provider you talk to says they have sicker patients. So that, after a while you get tone -- you get where you can't hear that anymore but the reality is that someone out there

does have sicker patients and what you don't want to do is hammer those people who really have more difficult patients.

**Penny Daniels:** So these are some of the things we have to take into consideration as we move forward. Let's take another question on the phone. Joe, who do you have?

**Operator:** The next question is from Barbara McNaney with New Mexico Oncology.

>> Hello again. Sorry to ask two questions. I was a little concerned when I heard the discussion about the outcome measures of payment and the idea that you would only pay for good outcomes because having never met a perfect provider or a perfect patient, we know that no matter how hard, say, a surgeon tries, you can only get the infection rate down to a certain level. So how are you going to distinguish between the classic poor performance that causes a bad outcome and just the bad outcomes that seem to be unavoidable. It worries me that you will have patients sent elsewhere if they have a high risk of having a bad outcome if you're not going to reimburse the physician at all for that.

>> Well, I think that's -- we were making the point earlier about possibly the greater need for risk adjustment as we move forward with the Pay For Performance programs that focus on outcome-based measures as opposed to process-based measures.

>> Absolutely.

>> And certainly right. So I mean, I think that the provider community, the para community would feel more strongly about using risk adjustment in that context.

Also obviously you want to make sure that you have sufficient numbers for the provider that you are looking at in terms of the number of patients that they have, to reduce the likelihood that there is just a chance effect, some random measurement error that's playing a role in a provider's particular performance. So risk

adjustment and making sure that you have sufficient numbers, you know, becomes very, very important considerations in designing programs where outcome-based measures are the focus of the program as opposed to process-based measures.

>> The other thing I would do, I haven't seen this yet but I think that when we go to report performance in particular, this is where public reporting might actually bolster or Pay For Performance things. So you are paying people for outcomes and you want a risk adjust the best you can. You want even patients that are perceived to be difficult by the providers and they might think the risk adjustment isn't quite good enough. What you ought to have also, just take advantage of the fact that providers really want to be competitive and want to think they're the best or at least tell everyone they're the best. I think we should add to it, public reporting about who's willing to take on the most difficult patients so that if there are people out there that are cherry-picking and avoiding patients, then that becomes known. And if there are people that are willing to take on the most difficult patients, that would be a tremendous point of provider pride. Yeah, we take the tough patients. And so I think the two can work together in this one example and several others.

**Penny Daniels:** Okay. We have a question now, an electronic question. Very interesting. We've been talking about this all the time. Why do you need to choose a physician hospital Pay For Performance program? Is there a way for interconnectivity? Doug Libby, I wonder if you want to take a stab at this one. We haven't heard from you for a while. By the way for the audience Doug is on the phone. The rest of us are here in the studio. So if it sounds like we're not hearing from Doug enough, it's because he's not here. Doug, are you there?

**Douglas Libby:** I am.

**Penny Daniels:** Good. You want to take a stab at this question?

**Douglas Libby:** Well, we did develop both primary care and hospital performance bonus programs but I must say they are not interconnected. They kind of think of this as a then diagram and take it back to the theme, it's really the specialists that form that connection and I think if we get into a specialist performance measurement and bonus program is where there really will be a lot of overlap between hospital measures and specialty measures. So we did really not connect. We did both but we did not connect the two.

**Penny Daniels:** Okay. David, do you have something to add?

**David Kelley:** In our program in our fee for service program with our physicians, we kind of linked it to the hospital Pay For Performance program. The hospitals who looked at related readmissions for four diseases, they were chronic diseases. Four of those five were the same diseases that we were focused on in our Pay For Performance program with our primary care physicians and we conceptually tried to make that linkage. When we had discussions with the hospitals, we said you need to integrate what you are doing with the physicians out in the community because we're going to be developing a disease management program around five programs. We're going to pick four and we're going to measure you on those four. So you really need to integrate with the community physicians to prevent those related readmissions.

>> That's cool. That's a great idea. That's a great idea.

**Penny Daniels:** That is a great idea and it's a good kind. Okay. We're going to take one last question now. Never fear, though, because we have other ways of answering your questions. We have a lot of questions backed up here. But we'll take one last question on the phone right now. Joe?

**Operator:** The next question is from Kenneth Patrick with Blue Cross/Blue Shield. Please proceed with your question.

>> Hi. Yeah, you know, we have probably about, oh, 65% of our commercial account are self-funded and in listening to the discussion about pay, you know, no positive way and not in a negative, I think the majority of

the ones that we've dealt with would not find that very acceptable. They're all for actually being for higher quality but they really want to see something on the lower end that says, you know, if you don't make it above this threshold, then, you know, we really don't want our employees going to those physicians. So I wondered if anyone has had any experience with that.

**Meredith Rosenthal:** Well, this is Meredith. Again I spent a lot of time talking to your self-insured clients as well and I think that this is a reality. And I think one interesting strategy is to think about Pay For Performance as a tool for quality improvement perhaps and then think about something like benefit design, a tiered benefit design, for example, as an alternative strategy. If you're the employer of the health plan wanting to channel patients to better providers, it seems like if you really are looking to improve quality for all providers in the network, meaning that you're not looking to shrink your network that you need to think about providing incentives to those low performing providers. I do think again there's a certain tension to it and, you know, framing these as bonuses as opposed to penalties can be, I think, a real limitation for the purchasers. But as Adams suggested earlier, if you think about taking this new money year over year and saying we're going to reserve that only for the high -performing providers and allocate it in that way, you can achieve some of the goals of using carrots, as David had suggested earlier but also meeting purchasers' concerns that why am I spending more money when there's still a lot of low quality care out there.

**Penny Daniels:** Okay. Unfortunately we've run out of time. So for those of you who still have questions, and I know a lot of you have unanswered questions, you can submit any additional questions on the national Pay For Performance Web conference website which you see on your slide and we will answer those questions for you.

Now, in terms of just kind of summing up here, I don't want to give less obviously because we don't have time for that but is it fair to say that a lot more research needs to be done? We have a lot of answers but we still have a lot of questions? Yeah? I see nodding heads here. Okay.

>> You're talking to researchers

**Penny Daniels:** Right. Well, yeah. No, a lot of work has been done and I think we still have a lot of work to do. Very interesting topic and very important, of course.

I would very much like to thank all of our panelists. You've been great and wonderful and very good. Of course, you have so much knowledge between you and it's wonderful that you came and shared it with us. Thank you. I'd like to thank all of you who joined us on the phone and also on the computers and I would like to thank all of the people in the studio who helped make this possible. We have a lot of people, as I told you before, here who are behind the scenes making this Web conference possible. I'd like to thank them.

So as we wind down now, let me mention again that information about how to access the publications we've talked about during this audio conference is also available at that Web conference website you see on your screen. A Web streamed archive of today's call and a written transcript will be posted to the site in the next couple of days. This Web conference will also be archived on AHRQ's website in the future. So definitely look for that.

And finally, before you log off today, please don't forget to give us your feedback on the evaluation page which will appear on your screen when we close out this webcast. For those of you who have been on the phone and not using your computers, please stay on the line because Joe the operator will ask you to

respond to the same evaluation questions using the keypad on your telephone. There's the evaluation form on your screen right now.

Once again we welcome your comments because we want to use these comments in forming our decisions on future Web conferences so we can provide you with the very best information and the very best possible package that we can. Thanks again to all of our presenters, all of you and everyone who's been on this web conference today. Good afternoon.

**Operator:** Ladies and gentlemen, for those of you who are now completing the evaluation online, please use your telephone keypad to answer the following questions. Were your expectations in increasing your knowledge of this topic met in this Web conference. Press "star," "1" if it did not meet my expectations. Met my expectations, press "star," "2". Exceeded my expectations, press star 3.