The Third National Pay-for-Performance Summit: Many Voices, Little Harmony

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Many health care leaders characterize pay-for-performance (P4P) as the payment engine to improve quality and reduce costs. They find it so compelling and transformative that they advise physicians to get aboard quickly because "the [P4P] train has left the station."[1] I attended the Third National Pay-for-Performance Summit in late February to learn more about this train.

Billed as "the leading national forum on pay for performance to enhance health care access, quality and efficiency," the goal of the summit was "to continue the important ongoing dialogue about the appropriate role and structure of P4P in both the private and public sectors." The Integrated Healthcare Association (IHA), a major proponent of applying the P4P concept to health care, sponsored the summit. IHA describes itself as a leadership group of California health plans, physician groups and health care systems and as the manager of the largest physician incentive program in the United States that provides medical groups with financial rewards based upon performance against quality benchmarks.

The summit featured 123 speakers, a who's who of health care strategists and reformers, and attracted more than 500 attendees. Most attendees worked as executives in health care payment, planning or regulation. Approximately 60 attendees were physicians; many, though, not in clinical practice.

Speakers generally agreed that changes were needed in health care delivery and financing. Many started their talks by referencing U.S. health care spending of $2.2 trillion in 2007, 16.3 percent of the gross domestic product — which is projected to increase to $4.3 trillion and 19.5 percent in 10 years[2] — as well as the quality deficiencies cited by the Institute of Medicine in its landmark publications.[3,4] They usually decried these costs as unaffordable and discriminatory and the market-based health care system as uncoordinated or broken. They disagreed, though, on how specifically to change it.

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A keynote panel of speakers considered the fundamental question, "Is P4P working?" Donald J. Palmisano, M.D., J.D., past president of the American Medical Association, answered, "No." He advocated that patients control their own care, with physicians advising them, and perceived government coercion in P4P programs. Francois de Brantes, CEO of Bridges to Excellence, answered, "Yes." He described patients making quality-based decisions as a "fantasy" and added, "we need something more than 'trust me' from physicians." Steve McDermott, an IHA founder, addressed Dr. Palmisano as "Doctor Don," called him "out of touch" and advised that looking at the return on our current investments in physicians would itself support P4P. Dennis O'Leary, M.D., past president of The Joint Commission, thought that P4P was not working but that other quality drivers were, such as accreditation agencies

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and institutional policies. Richard Norling, CEO of Premier, Inc, countered that data were demonstrating success with P4P at the hospital level. Meredith Rosenthal, Ph.D., Harvard School of Public Health, agreed and cited institutional beta-blocker programs as an example. She observed, though, that U.S. corporations are generally not adopting P4P health care coverage for their employees, and she opined that individual physician performance measures may not be effective.

And so it went. Speakers articulated their views passionately and colorfully. James Robinson, Ph.D., editor-in-chief of *Health Affairs*, advocated for "episode pricing" of health care, something between capitation and fee-for-service. He blamed increasing health care costs on the current physician payment system, because "there's no reward for controlling costs." Thomas Valuck, M.D., J.D., Senior Advisor to the Director at the Centers for Medicare & Medicaid Services, wanted to "transform Medicare from a passive payer to an active purchaser of high-quality, more efficient health care." He advocated for value-based purchasing (the government term for P4P) to improve quality and "avoid unnecessary costs" and stated that the Physician Quality Reporting Initiative is "just getting started."

Other speakers addressed various other aspects of P4P and health care reform. Janet Corrigan, Ph.D., CEO of the National Quality Forum (NQF), complained about the "cacophony of measures from stakeholder groups," although she felt that some performance measurements lead to improvements. She advocated "shared decision-making" through NQF. Margaret O'Kane, President of the National Committee for Quality Assurance, advocated bundling of medical payments and coordination of care by primary care physicians. Karen Davis, president of the Commonwealth Fund, advocated "acute episode global fees" and limiting payment updates for high-cost providers. Karen Murphy, Ph.D., CEO of Physicians Health Alliance, advocated involving specialty physicians in P4P because they account for 70-80 percent of national health care expenditures. Geoffrey Baker, M.B.A., and Suzanne Delbanco, Ph.D., from The Leapfrog Group, reported that 70 percent of their members anticipate expanding the scope and number of physician performance measures. Nancy Nielsen, M.D., president-elect of the American Medical Association, referenced unintended consequences of performance measures and stated that they should first and foremost benefit patients.

Although the summit did not address anesthesia payment issues directly, two anesthesiologists participated as speakers. Marc Lieb, M.D., J.D., chief medical officer for the Arizona Health Care Cost Containment System of the Arizona Medicaid program, presented "Arizona Perspective: Medicaid Value-Based Purchasing: Trends in 2008." Richard Gilbert, M.D., CEO of Southeast Anesthesiology Consultants, described the quality measurement and management system in use in his Charlotte, North Carolina, practice. Using 50 clinical indicators and reporting results frequently to clinicians in scorecards with peer and national comparisons have led to very low rates of adverse outcomes.

A passion for change among summit speakers was obvious. Their varied views, however, illustrated how difficult it will be for political leaders to develop a national health care policy. For the short term, incremental changes seem likely as well as continued development of P4P programs, at least until there is more agreement on what parts of it work. A clear sign of uncertainty about the future was the poll taken of attendees — it asked whether a fourth summit should address P4P, or something else.

References:

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