Pay-for-performance
More than rearranging the deck chairs?

Robert and Alma Moreton Lecture
May 21, 2007

Elliott S. Fisher, MD, MPH
Professor of Medicine
Center for the Evaluative Clinical Sciences
Dartmouth Medical School

Senior Associate
VA Outcomes Group
White River Junction, Vermont
Pay-for-performance  
More than rearranging the deck chairs?

Robert and Alma Moreton Lecture  
May 24, 2007

Elliott S. Fisher, MD, MPH  
Professor of Medicine  
Center for the Evaluative Clinical Sciences  
Dartmouth Medical School

Senior Associate  
VA Outcomes Group  
White River Junction, Vermont
Houston, we’ve got a problem…
Houston, we’ve got a problem…

**Challenges we face**

Quality variable -- and often poor

Access to care worsening

Fragmented delivery system

Expensive new technologies on the horizon

Growing physician dissatisfaction

Rising health care costs
Houston, we’ve got a problem…

Think of the United States government as a gigantic insurance company with a sideline business in national defense…

This particular insurance company has made promises to its policy holders that have a current value $20 trillion… in excess of the revenues that it expects to receive…..

It is an accident waiting to happen.

Peter Fisher
Undersecretary of the Treasury
November 2002
Houston, we’ve got a problem…

Think of the United States government as a gigantic insurance company with a sideline business in national defense…

This particular insurance company has made promises to its policy holders that have a current value $20 trillion… $50.5 trillion in excess of the revenues that it expects to receive…..

It is an accident waiting to happen.

Most of the shortfall is due to federal health care programs

David Walker Comptroller General May, 2007
Fiscal Exposure: 50.5
Household Net Worth 53.3
Burden per household $440,000
Houston, we’ve got a problem…

**Challenges we face**

- Quality variable -- and often poor
- Access to care worsening
- Fragmented delivery system
- Expensive new technologies on the horizon
- Collapse of primary care
- Growing physician dissatisfaction
- Rising health care costs threaten our national security

**Current P4P efforts are a bit like rearranging the deck chairs on the Titanic.**

**We need to rethink our approach**
Rethinking Health Care

Spending, quality and the paradox of plenty

Small Area Variations in Health Care Delivery

A population-based health information system can guide planning and regulatory decision-making.

John Wennberg and Alan Gittelsohn

Recent legislation has extended planning and regulatory authority in the health field in a number of important areas. The 1972 amendments to the impact of regulatory decisions on the equality of distribution of resources and dollars and the effectiveness of medical care services.

Science, December 14, 1973; Volume 182, pp 1102-08
Rethinking Health Care

Spending, quality and the paradox of plenty

The Quality of Medical Care in the United States:

A Report on...

The Dartmouth Institute

U.S. Hospital Referral Regions
Variations in practice and spending

Two to three fold variations in spending across regions

- Miami, FL: $11,352
- Los Angeles, CA: $9,752
- San Francisco, CA: $6,408
- Minneapolis, MN: $5,213
Rethinking Health Care

Spending differences among USN&WR “best” academic medical centers

How can the best medical care in the world cost twice as much as the best medical care in the world?

Uwe Reinhardt
Overview

What we now know: The paradox of plenty
What we think we know: Unraveling the paradox
What we need to know: How to foster effective reform

Causes and Consequences of Health Care Intensity
Dartmouth Atlas of Health Care

With support from:
- National Institute on Aging
- Robert Wood Johnson Foundation
- California Healthcare Foundation
- Wellpoint Foundation
- Aetna Foundation
- United Health Foundation
- Commonwealth Fund

Investigators
- Jonathon Skinner, PhD
  Dartmouth Medical School
- Elliott Fisher, MD, MPH
  VA Outcomes Group, Dartmouth
- Denise Anthony, PhD
  Dartmouth College
- Brenda Sirovich, MD, MS
  VA Outcomes Group, Dartmouth
- Elliott Fisher, MD, MPH
  Dartmouth Medical School
- John Wennberg, MD, MPH
  Dartmouth Medical School
- Julie Bynum, MD, MPH
  Dartmouth Medical School
- Eric Holmboe, MD
  American Board of Internal Medicine
- Rebecca Lipner, PhD
  American Board of Internal Medicine
- Amitabh Chandra, PhD
  Harvard University
- David Wennberg, MD, MPH
  Maine Medical Center
- Lee Lucas, PhD
  Maine Medical Center
- Dan Gottlieb, MS
  Dartmouth Medical School
- Amber Barnato, MD, MPH
  University of Pittsburgh
- Therese Stukel, PhD
  University of Toronto
- Brooke Herndon, MD
  Dartmouth Medical School
Variations in spending
What are the implications for health?

Study population -- Medicare enrollees
- Acute myocardial infarction n = 159,393
- Colorectal Cancer n = 195,429
- Hip Fracture n = 614,503
- Medicare Current Beneficiary Survey n = 18,190

Study design -- natural experiment:
- Divided populations into five equal groups according to practice intensity of region of residence
- Practice intensity measured in different population (other Medicare enrollees in last six months of life)
Variations in spending

**Content of care -- three categories**

| Effective care                  | Evidence-based services that all patients should receive. No tradeoffs involved.
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute revascularization for AMI</strong></td>
<td></td>
</tr>
<tr>
<td>Preference-sensitive care</td>
<td>Treatment choices that entail tradeoffs among risks and benefits. Patients’ values and preferences should determine treatment choice.</td>
</tr>
<tr>
<td><strong>CABG for stable angina</strong></td>
<td></td>
</tr>
<tr>
<td>Supply-sensitive services</td>
<td>Services where utilization is strongly associated with local supply of health care resources</td>
</tr>
<tr>
<td></td>
<td>Frequency of MD visits, specialist consultations</td>
</tr>
<tr>
<td></td>
<td>use of hospital or ICU as a site of care, tests, imaging and minor procedures</td>
</tr>
</tbody>
</table>

Wennberg, Skinner and Fisher, Geography and the Debate over Medicare Reform
Health Affairs, web exclusives, February 13, 2002
**Ratio of Use Rates in High vs Low Spending Regions -- in similar patients**

*If red dot is to right, high spending regions get MORE*

**Effective Care: technical quality**
Reperfusion in 12 hours (Heart attack)

- **Low Spending**: 55.8
- **High Spending**: 49.8

- **Lower** in High Spending Regions
- **Higher** in High Spending Regions
Ratio of Use Rates in High vs Low Spending Regions -- in similar patients
*If red dot is to right, high spending regions get MORE*

**Effective Care: technical quality**
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)
Ratio of Use Rates in High vs Low Spending Regions -- in similar patients

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- Pneumococcal Immunization (ever)

**Preference Sensitive Care: elective surgery**
- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

Lower in High Spending Regions

Higher in High Spending Regions

Slide 17
Ratio of Use Rates in High vs Low Spending Regions -- in similar patients

If red dot is to right, high spending regions get MORE

Effective Care: *technical quality*
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Preference Sensitive Care: *elective surgery*
- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

Supply sensitive services: *often avoidable care*
- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Evaluation and Management (visits)
- Imaging
- Diagnostic Tests

Lower in High Spending Regions

Higher in High Spending Regions
The paradox of plenty

What do higher spending regions -- and systems -- get?

Content / Quality of Care\(^1,2\)

- Technical quality worse
- No more elective surgery
- More hospital stays, visits, specialist use, tests

Health Outcomes\(^1,2\)

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(2) Health Affairs web exclusives, October 7, 2004
(3) Health Affairs, web exclusives, Nov 16, 2005
(4) Health Affairs web exclusives, Feb 7, 2006
The paradox of plenty
*What do higher spending regions -- and systems -- get?*

| Content / Quality of Care\(^1,2\) | Technical quality worse  
|                                     | No more elective surgery  
|                                     | More hospital stays, visits, specialist use, tests |
| Health Outcomes\(^1,2\)            | Slightly higher mortality  
|                                     | No better function |
| Physician’s perceptions\(^5\)      | Worse communication among physicians  
|                                     | Greater difficulty ensuring continuity of care  
|                                     | Greater difficulty providing high quality care  
|                                     | Greater perception of scarcity |
| Patient-perceived quality\(^1,3\)  | Lower satisfaction with hospital care  
|                                     | Worse access to primary care |
| Trends over time\(^4\)             | Greater growth in per-capita resource use  
|                                     | Lower gains in survival (following AMI) |

(2) Health Affairs web exclusives, October 7, 2004  
(3) Health Affairs, web exclusives, Nov 16, 2005  
(4) Health Affairs web exclusives, Feb 7, 2006  
Pop Quiz

If all US regions could adopt the practice patterns of the most conservative US regions (such as N. California or Rochester, NY) which of the following statements would apply?

1. U.S. health care spending would decline by over 30%.

2. The projected deficit in the Medicare Trust fund would be postponed by at least 25 years.

3. We could send 30% of the U.S. health care workforce to Africa and -- in theory -- improve the health of both continents.

4. All of the above.
Major points

*What I know:* Higher spending across regions and physician groups is largely due to overuse of *supply-sensitive services* -- hospital and ICU stays, MD visits, specialist consults; *and* -- *at the margin* -- *more is worse.*
What might be going on?
Some general attributes of U.S. healthcare

Assumption that more is better
What might be going on?

*Some general attributes of U.S. healthcare*

Assumption that more is better

Inadequate information on risks and benefits

VIOXX PROVIDES POWERFUL 24-HOUR RELIEF OF ARTHRITIS

“The clams were the only ones that benefited from my arthritis. Sorry guys, I’m back.”
What might be going on?

*Some general attributes of U.S. healthcare*

Assumption that more is better

Inadequate information on risks and benefits

Growing tension between science and professionalism -- and -- market approach (health care as a commodity)

---

Larson et al. *Advertising by Academic Medical Centers*; Arch Int Med: 2005; 165: 645-51
Regional Differences in Practice and Spending

What are the underlying causes?

Patient preferences?¹,²

- Slight preference for specialist care in high spending
- No difference for tests (if MD says not needed)
- No difference in preferences for aggressive EOL care

Malpractice environment³,⁴

- Explains less than 10% of state differences in spending
- Little impact on growth in utilization across states

Capacity / payment system⁵

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¹ Pritchard et al. *J Am Geriatric Society*; 46:1242-1250, 199
² Anthony et al, under review
⁴ Baicker, Chandra, NBER Working Paper W10709

Slide 26
Regional Differences in Practice and Spending

What are the underlying causes?

Capacity and payment

[Map showing regional differences in Medicare spending]
Regional Differences in Practice and Spending

What are the underlying causes?

Capacity and payment

- Hospital Beds: 32% higher for High region vs Low region
- Medical Specialists: 65% higher for High region vs Low region
Regional Differences in Practice and Spending

*What are the underlying causes?*

**Capacity and payment**

*Whatever capacity is in place will be fully utilized*

---

Slide 29

![Graph showing the relationship between cardiologists per 100,000 residents and visits per 1,000 Medicare enrollees. The graph includes a scatter plot with a trend line and the R² value of 0.49.](attachment:image.png)
Regional Differences in Practice and Spending

*What are the underlying causes?*

**Capacity and payment**

Percutaneous Coronary Interventions
Age-sex-race adjusted rate per 1000 enrollees in 2003

*Current payment system rewards volume and new (high margin) procedures*
Regional Differences in Practice and Spending

What are the underlying causes?

Capacity and payment

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New York Times, August 18, 2006
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- Explains less than 10% of state differences in spending
- Little impact on growth in utilization across states

**Capacity / payment system**
- *Capacity strongly correlated, but explains less than 50%*
- Payment system ensures all stay busy

(1) Pritchard et al. *J Am Geriatric Society*; 46:1242-1250, 199
(2) Anthony et al, under review
(4) Baicker, Chandra, NBER Working Paper W10709
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- Payment system ensures all stay busy

Clinical judgment\(^6,7\)

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(1) Pritchard et al. *J Am Geriatric Society*; 46:1242-1250, 199
(2) Anthony et al, under review
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Physician propensity to intervene

*Primary Care Physician Surveys*

<table>
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<tr>
<th>Percent of patients for whom physicians would recommend the intervention in low and high spending regions in each scenario:</th>
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<th>High Spending Regions</th>
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<td>93</td>
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### Physician propensity to intervene

*Primary Care Physician Surveys*

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<table>
<thead>
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<td>93</td>
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<tr>
<td>MRI for back pain and mildly abnormal nerve function</td>
<td>69</td>
<td>82</td>
<td>yes</td>
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Sirovich *Archives of Internal Medicine*. 165(19):2252-6, 2005 Oct 24
Sirovich, *Journal of General Internal Medicine, Suppl May 2006*
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<tr>
<td>MRI for back pain and mildly abnormal nerve function</td>
<td>69</td>
<td>82</td>
<td>yes</td>
</tr>
<tr>
<td>Drug treatment of high cholesterol with no other risk factors</td>
<td>44</td>
<td>53</td>
<td>yes</td>
</tr>
<tr>
<td>Urology referral for mild symptoms of prostatic enlargement</td>
<td>23</td>
<td>32</td>
<td>yes</td>
</tr>
<tr>
<td>Prostate cancer screening test for 60 year old white male</td>
<td>68</td>
<td>78</td>
<td>yes</td>
</tr>
<tr>
<td>Visit for patient with isolated high blood pressure in 3 months or less</td>
<td>22</td>
<td>49</td>
<td>yes</td>
</tr>
</tbody>
</table>

Sirovich *Archives of Internal Medicine*. 165(19):2252-6, 2005 Oct 24  
Sirovich, *Journal of General Internal Medicine, Suppl* May 2006  
Slide 37
Regional Differences in Practice and Spending
What are the underlying causes?

Patient preferences?\(^1,2\)  
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- No difference for tests (if MD says not needed)
- No difference in preferences for aggressive EOL care

Malpractice environment\(^3,4\)  
- Explains less than 10% of state differences in spending
- Little impact on growth in utilization across states

Capacity / payment system\(^5\)  
- Capacity strongly correlated, but explains less than 50%
- Payment system ensures all stay busy

Clinical judgment\(^6,7\)  
- No difference in decisions with strong evidence
- More likely to intervene in “gray” areas
  (when to see patient, when to refer, when to admit)

(1) Pritchard et al. *J Am Geriatric Society*; 46:1242-1250, 199
(2) Anthony et al, under review
(4) Baicker, Chandra, NBER Working Paper W10709
Clinical evidence (e.g. RCTs, guidelines) and principles of professionalism are critically important but limited influence on clinical decision-making.

Physicians practice within a local organizational context and policy environment that profoundly influences their decision-making. Payment system ensures that existing (and new capacity) is fully utilized. Capacity helps determine local culture.

Consequence: reasonable individual clinical and local decisions lead, in aggregate, to higher utilization rates, greater costs -- and inadvertently -- worse outcomes.
How could health outcomes be worse?

More Medical Care

Settings

Mechanisms

Avoiding the Unintended Consequences of Growth in Medical Care
How Might More Be Worse?

How could health outcomes be worse?

- More Medical Care
- More Diagnosis
  - Pseudodisease
  - Labeling

**Mechanisms**

- Emphasizes high survival with screening and possible benefit (no mention of risks)
- Acknowledges that screening not “currently” recommended for lung cancer
- No mention of ongoing trial
How could health outcomes be worse?

- More Medical Care
  - More Diagnosis
    - Settings
    - Mechanisms
      - Pseudodisease
      - Labeling
    - Harms
How could health outcomes be worse?

Settings
- More Medical Care
  - More Diagnosis
  - More Treatment

Mechanisms
- More Medical Care
  - Settings
  - Mechanisms
    - Pseudodisease
    - Labeling
    - Lower treatment thresholds
      - Tampering

Harms

How could health outcomes be worse?

More Medical Care

More Treatment

Doctors Reap Millions for Anemia Drugs

Harms
How could health outcomes be worse?

EXHIBIT 6
Average Percentage Of Patients Seeing Ten Or More Different Physicians In The First Year Of Care Within Academic Medical Center (AMC) Hospitals In Each Intensity Group

<table>
<thead>
<tr>
<th>Percent</th>
<th>Quintile of intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Lowest quintile</td>
</tr>
<tr>
<td>24</td>
<td>Middle quintiles</td>
</tr>
<tr>
<td>18</td>
<td>Highest quintile</td>
</tr>
</tbody>
</table>

- Hip fracture
- Colorectal cancer
- Acute myocardial infarction

SOURCE: Authors’ analyses of Medicare claims data.

Fisher et al. Health Affairs October 7, 2004 web exclusives
How could health outcomes be worse?

- More Medical Care
- More Diagnosis -> More to do -> More Treatment

**Settings**

**Mechanisms**
- Pseudodisease Labeling
- Distraction Complexity
- Lower treatment thresholds Tampering

**Harms**
- More worry and disability
- More unnecessary treatment
- More mistakes
- More adverse events
“There, there it is again—the invisible hand of the marketplace giving us the finger.”
Major points

*What I know:* Higher spending across regions and physician groups is largely due to overuse of *supply-sensitive services* -- hospital and ICU stays, MD visits, specialist consults; *and* -- *at the margin* -- *more is worse.*

*What I think I know:* Overuse is largely a consequence of reasonable differences in clinical judgment that emerge in response to local organizational attributes (capacity, clinical culture) and financial incentives that promote unnecessary growth and more care.
Why might this be important?

*Highlights the challenges confronting current P4P initiatives*

**Level of measurement: individual providers**
- Reinforces current fragmentation and lack of coordination
- Attribution and small numbers a serious problem
- Data collection at individual MD level (n = 500,000) a challenge

**Scope of measurement: technical quality**
- Narrow focus on technical quality, guideline adherence
- Measures ignore problem of clinical judgment, patient preferences
- No measures of many important dimensions: health outcomes, costs of care, care coordination, care transitions

**Implementation: difficult for majority of physicians**

**Unintended consequences: cause more harm than good?**
- If inadequate risk adjustment, physicians will avoid sick patients
- Safety net providers could be less likely to receive rewards
- Emphasis on financial incentives could further undermine core professional values (already threatened by commercializaton)
But do we have a choice?

Institute of Medicine recommended moving forward with P4P

The current payment system is “toxic” -- a key cause of our problems
- Reinforces fragmentation and lack of coordination
- The driving force behind rising costs and overuse
- In many settings -- rewards bad care, punishes good care.

Implementation of P4P can be seen as a path to fundamental payment reform -- if specific principles guide implementation
- Comprehensive performance measures: outcomes, costs
- Encourage shared accountability among all responsible providers
- Rigorous, ongoing evaluation to allow mid-course corrections

But this is more easily said than done…
Some thoughts on moving forward

*We need to consider underlying causes of rising costs, poor quality*

<table>
<thead>
<tr>
<th>Underlying cause</th>
<th>General Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to recognize key role of <em>local</em> system (capacity, clinical culture) as driver</td>
<td>Foster development of local organizations (delivery systems) accountable for care (with incentives to limit future growth)</td>
</tr>
<tr>
<td>Assumption that more is better</td>
<td>Balanced information on risks / benefits</td>
</tr>
<tr>
<td>Equating less care with rationing</td>
<td>Comprehensive performance measures</td>
</tr>
<tr>
<td>Payment system that rewards more care, increased capacity, high margin treatments, entrepreneurial behavior</td>
<td>Reform of payment system (long term)</td>
</tr>
<tr>
<td></td>
<td>Shared savings as interim approach</td>
</tr>
</tbody>
</table>
Organizational accountability

Key attributes of an ACO and how they might be defined

Essential attributes of an Accountable Care Organization

- Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system
- Sufficient size to support comprehensive performance measurement
- Capable of prospectively planning budgets and resource needs

Potential Accountable Care Organizations

- Large multi-specialty group practices that own their own hospitals
  (Mayo, Virginia Mason, Group Health)
- Physician-Hospital Organizations / Practice Networks
  (Middlesex Health System)
- Hospitals that own physician groups
  (Intermountain Healthcare, many rural hospitals)
- Extended Hospital Medical Staff (virtual multi-specialty groups)*
  - Feasible to define: all MDs and beneficiaries are “affiliated” with a hospital
  - High loyalty: 72% of E&M by 1<sup>st</sup> EHMS; another 10% by single 2<sup>nd</sup> EHMS

*Fisher et al.  Health Affairs web exclusives, December 5, 2006
Performance Measurement

Advantages of focusing on medical groups or hospital - staff

Performance measurement more tractable at ACO level

- Can include all physicians who contribute to care within frame of measurement immediately -- with adequate sample sizes
- More practical (5000 entities to audit, vs 500,000)

Scope of measurement could include *all aspects relevant to patients*

- Effective care: more precise and stable measures of technical quality
- Supply-sensitive care: longitudinal costs and quality
- Structural measures:
  - traditional (e.g. electronic health records, CPOE)
  - new dimensions: transparency on incentives, potential conflicts of interest

Establishes a viable locus of accountability and needed resources

- No other logical candidate for decisions on capacity
- ACOs would have resources to finance electronic health records for associated physicians and implement quality improvement initiatives
Payment reform
Challenges and opportunities

Barriers to comprehensive payment reform are substantial
- Public opposition to capitation; provider concern about bearing risk
- Development of other prospective payment approaches years away

Might “shared savings” approaches help in the interim?
- Key notion: establish target growth rate; reward physician groups that achieve per-beneficiary spending growth below the target with portion of savings
- Theory being tested in the Physician Group Practice demonstration
- Has important advantages:
  - Preserves fee-for-service payment (a plus for patients and MDs)
  - Provides incentive to avoid increases in capacity (and to reduce capacity where feasible); and to improve care in domains previously ignored: care coordination, end-of-life care
  - Can be done with existing claims data
Payment reform
Per-beneficiary spending in EHMS (n = 4772) sorted into quintiles by magnitude of per-beneficiary growth (1999-2003)

<table>
<thead>
<tr>
<th>Absolute increase per benef.</th>
<th>Percent increase 99-03**</th>
<th>Average Annual Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$936</td>
<td>46%</td>
<td>9.9%</td>
</tr>
<tr>
<td>$675</td>
<td>33%</td>
<td>7.3%</td>
</tr>
<tr>
<td>$551</td>
<td>27%</td>
<td>6.1%</td>
</tr>
<tr>
<td>$431</td>
<td>21%</td>
<td>4.8%</td>
</tr>
<tr>
<td>$198</td>
<td>10%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

* Using standardized payments, using 2003 RVU
** Percent increase calculated relative to average 1999 per-beneficiary spending
Underlying cause: lack of organizational accountability

Per-beneficiary spending in EHMS by BETOS category (highest and lowest quintiles of per-beneficiary growth (1999-2003))

Differences in growth likely due to:
- active recruitment of physicians
- physician location decisions
- expansion of facilities (imaging)

Control of spending will require altering incentives for growth

Each Quintile includes approximately 20% of the Medicare population
“Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician....”

Entails commitments to ten professional responsibilities

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relations with patients
- Improving quality of care
- Improving access to care
- Just distribution of finite resources
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibilities
Room for hope?
Medical Professionalism: A Physician Charter

“Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician….”

Could provide framework for public reporting at organizational level

- Professional competence
- Honesty with patients
- Patient confidentiality
- Improving access to care
- Just distribution of finite resources
- Scientific knowledge
- Maintaining appropriate relations with patients
- Maintaining trust by managing conflicts of interest
- Improving quality of care
- Professional responsibilities
Down the road, we hope that all providers involved in treating the same patient can share in any bonus for improved care efficiency and outcomes. The ultimate goal of P4P is to unify providers around what is best for the patient, eliminating the lack of coordination and segmentation so commonplace today and allowing quality to take center stage.

*American College of Radiology*

“ACR’s Pay for Performance (P4P) Initiatives
Where We Are and Where We’re Going”
Major points

What I know: Higher spending across regions and physician groups is largely due to overuse of supply-sensitive services -- hospital and ICU stays, MD visits, specialist consults; and -- at the margin -- more is worse.

What I think I know: Overuse is largely a consequence of reasonable differences in clinical judgment that emerge in response to local organizational attributes (capacity, clinical culture) and a national policy and culture that promotes growth and more care.

What I’d like to know: How to shift the focus of the health care system from simply “delivering care” to improving health and reducing suffering.
Houston.... We’ve got a problem.