Physician Value-Based Payment Modifier Program:
Experience From Private Sector Physician
Pay-for-Performance Programs
National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time, I would like to welcome everyone to the Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs conference call.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call. I will now turn the call over to Nicole Cooney.

Thank you, ma'am. You may begin.

Introduction

Nicole Cooney: Thank you, Holley. Hello. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'll serve as your moderator for today's National Provider Call. I would like to welcome you all to the Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs.

Today we have three private sector experts who have had experiences implementing physician-level pay-for-performance programs. We will have a question and answer session to allow time for you to provide input and ask questions.

Before we get started, there are a few items that I need to cover. There are four slide presentations for this session which you should have been able to download via the link that was provided on the registration page.

Just so everyone has access, in case you weren't able to get there, they are located at www.physician – sorry – www.cms – "s" as in Sam – .gov/physicianfeedbackprogram. That's all one word. Again, www.cms – "'s" as in Sam – .gov/physicianfeedbackprogram.

You can click – once you're on that page, you click "CMS Teleconferences and Events" which is on the lefthand side of your screen and select the entry for today's call, which is March 14th.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Physician Feedback Program section at the URL that I just referenced.

Once on the page, again, you'll select "Teleconferences and Events" from the tab on the lefthand side of the screen and then find the entry for today's call. All post-call materials will be located here.

I'd also like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers to help prepare slides and remarks for today's presentation.

At this time, I would like to introduce our CMS speaker for today. We are pleased to have with us Dr. Sheila Roman, Senior Medical Officer in the Performance-Based Payment Policy Group in the Center for Medicare.

And now I'd like to ask everyone to open the roman.pdf presentation. And it is my pleasure to turn the call over to Dr. Roman who will introduce our panel of private sector experts and provide background information on today's topic.

Dr. Roman?

Presentation

Dr. Sheila Roman: Thank you, Nicole. And thank you, everybody, for joining us this afternoon for the second of two calls on the Physician Value-Based Payment Modifier program focusing on experience from Private Sector Physician Pay-For-Performance Programs.

I'd like to review with you – and this is on slide two of my short slide deck – the purposes of this call and that is we want to hear from the private sector. I've received input from the private sector on the best practices and lessons learned from Physician Pay-For-Performances.

We want to gain information so that CMS will be complementary to Physician Pay-for-Performance programs in the private sector as CMS develops its

Value-Based Payment Modifier. And we want to obtain from you, the stakeholders, input on current private sector Pay-for-Performance programs.

On the next slide, there's a short agenda of our program. We have three very expert speakers for today and they're listed on the slide in the order that they will be speaking. The first speaking – speaker is Dana Gelb Safran. She's the senior vice president for Performance Measurement and Improvement at the Massachusetts Blue Cross Blue Shield.

Our second speaker is Peter Bowers, and he is the medical director for Payment Innovation at WellPoint. And our third speaker is Cheryl Damberg, senior researcher at the RAND Corporation.

So I think we will hear today several approaches from the private sector on various Pay-For-Performance programs that they have experience with and will share some data with us. And our third presentation will approach this topic from a – more of a research perspective and provide some recommendations for CMS.

After that, we'll be opening the phones for questions from the public and we'll be having a question and answer session with both CMS and our speakers for the day. And then we'll be having some closing comments from CMS. And that should be a pretty packed full hour and a half.

So let me just review for you "What is the Value-Based Payment Modifier?" And this is slide five. The Affordable Care Act of 2010 requires that under the physician fee schedule, Medicare begin using differential payment to physicians or groups of physicians based upon the quality of care furnished compared with the cost of that care.

A physician's Value-Based Payment Modifier will apply to services the physician bills under the Physician Fee Schedule. The statute requires that the Secretary apply the Value-Based Payment Modifier to promote systems-based care.

CMS is planning to discuss potential methodologies for the Value-Based Payment Modifier this year. We are using these Special National Provider Calls to inform us and our stakeholders as we develop these methodologies.

In 2012, CMS is planning to provide to all Physician Quality Reporting System participating physicians confidential physician feedback reports which contain the information that will be used in calculating the value modifier.

On slide six, you'll see a timeline for implementation for the Value-Based Payment Modifier. The initial performance period is slated to begin in 2013, meaning services provided during calendar year 2013 will be used in calculating the 2015 value modifier.

Beginning in 2015, the Value-Based Payment Modifier will be phased in over a two-year period and apply to the physician fee schedule. In 2016, the HHS secretary will continue to apply the Value-Based Payment Modifier. And beginning in 2017, the Value-Based Payment Modifier will apply to most or all physicians who submit claims under the Medicare physician fee schedule.

I'd like to move now to our first speaker, who is Dr. Dana Gelb Safran, Senior Vice President for Performance Measurement and Improvement at Blue Cross Blue Shield. And the title of the talk that she'll be giving in the next 15 to 20 minutes is "Paying for Performance to Improve Quality, Outcomes and Affordability: Good Data and Measures Are Just the Beginning."

Dr. Safran?

Dr. Dana Gelb Safran: Thanks very much, Sheila, and hello, everyone. I'm happy to have this opportunity to talk with you about the work that Blue Cross Massachusetts does to use quality measures to – in an incentive program – a set of incentive programs to help improve the quality and outcomes and safety of care for our members.

If you turn to slide number two in my deck, you'll see a framework that I like to use to think through what are the levers that a health plan has for improving quality and safety for our members using data and measures.

And really, there are, in my mind, only four broad types of things that we, as a plan, can do with data and measures to try to improve care. The first of those is in the yellow circle. We can report information to our providers to show them how they look on various measures compared to a relevant benchmark in the hopes that that will stimulate their interest in improvement.

We can attach financial incentives to those measures in pay-for-performance arrangements. That's the second circle. We can attach reputations to the data or the measures in public reporting. And we can attach market share to the measures and results by building certain measures into our insurance products in a way to give our members incentives to use certain providers over others based on the quality and cost of the care that those providers give.

Those four levers really constitute a continuum from the provider's perspective that is increasingly threatening and distasteful. That is to say, providers, for the most part, don't mind at all when we send them performance reports. They may never even look at them. They also, in our market, are quite accepting of pay-for-performance arrangements and I think have come to value and appreciate those programs.

Once we start reporting the information to the public or in particular incorporating the information into our members' benefits in a way that gives members incentives to use certain providers over others, I think providers have a lot more questions and concerns about those uses of performance measures.

And I'll tell you that as somebody who has dedicated my career to measurement and improvement, personally my preference is if we could get our provider network to a state of perfectly reliable care for every patient – every time, safe, affordable, effective, patient-centered – using just those first two circles, to me, that's the ideal.

The next slide lays out for you a set of principles that we adopted in January of 2007, that guide our decision about when a measure is ready to be used in any of the high-stakes ways that were outlined on the previous slide. So I

would characterize the second, third, and fourth of the circles I talked about previously, all of those are high stakes from a provider's perspective.

And so, a measure needs to satisfy these criteria in order for us to feel comfortable that that measure belongs in a pay-for-performance public reporting or product design. And you'll notice that this set of criteria really includes a blend of what I like to refer to as both the art and science of good performance measurement.

So there are some things here that are, you know, very statistically oriented, the science of good measurement, things like adequate sample size to get reliable information at whatever your unit of analysis is, in this case a physician or physician group or a hospital. Those kinds of things are critical but the art is also important. Things like the last criteria and that physicians in our network and hospitals in our network should be exposed to the data and measures for some period of time and have the opportunity to improve before the measure moves to a high-stakes use like pay-for-performance or public reporting.

If you move to the next slide, what I try to summarize for you here is the set of incentive programs that we have across our network. And pretty much every physician in our network is part of a pay-for-performance arrangement with Blue Cross and has been for many years. The way that the measures themselves are incorporated into the program, the way we set targets, the types of things that we incentivize have evolved particularly since that January 2007 point where we adopted that set of criteria on the previous slide.

But this is, I think, a nice way to summarize the fact that really we have three broad programs. On the left you can see we have an incentive program for our PCPs, and a broad set of measures in that program including 20 measures that encompass ambulatory care, including process measures, outcome measures and patient experience measures and then some measures of efficiency for primary care physicians.

The number of physicians participating in that program has diminished over time and continues to diminish as we grow a program in our network called

the Alternative Quality Contract. I'll speak about the AQC in a couple of moments but you can see that right now two-thirds of our primary care physicians participate in the AQC, and therefore are subject to the pay-for-performance incentive program that's part of that contract model.

Seventy-plus percent of our specialists at this point, the slide gets out of date quickly because of how quickly the AQC model has been growing, but over 11,000 of our specialists and many of our hospitals are part of an AQC contract and the measures there include ambulatory and hospital measures, much more detail on that in a couple of slides.

And then while I know for this conversation we're really focused on the physician side. I wanted to have folks understand that we also have for every hospital in our network a hospital incentive program that similarly has a broad set of clinical process, clinical outcome, and patient experience measures and that all of our hospitals participate in.

If you move to the next slide this is just a summary of our PCP incentive program and how that program began in 2000 and how it's evolved over time. I think in the interest of time, folks have access to this information now so I think I'll skip over the details here and focus your attention on the AQC because much of what we do in the AQC model in terms of incentives and specific measures is identical to what we now have in our PCP IP program.

We've really worked very hard to align those two programs. Although the dollars that can be earned in PCP IP are substantially less than the dollars that can be earned in the AQC. The only thing on this slide number five that I'd call your attention to is that at the very bottom, you can see just a few years ago in 2008 the vast majority of PCPs in our network were part of PCP IP but as the AQC has grown that's shifted quite dramatically, and, in fact, in 2012 there will be under a thousand PCPs left in that PCP IP program.

So this next slide is a way to summarize the AQC model. Folks who aren't familiar with the AQC should know that it's a model that we introduced in 2009 as an alternative contract model voluntary for providers in our network. And what's different about it from our traditional contract is that the provider

organization that comes into this model agrees to be accountable for the full continuum of care, everything from pre-natal care to end-of-life care regardless of whether they themselves provide that care. And that means they're accountable for both the cost and the quality of care provided across that continuum.

They're also paid based on a global budget and that's what's reflected by the dotted line that goes across the middle of the graph there. That global budget is set based on that individual provider's own patient population and what their historical rate of spending for the population has been. This gives them the confidence when they start the contract that they have every bit of resources available to them on day one of this contract that they had available to them when they had fee-for-service incentives but they now have the incentives to identify where there could be savings in their budget, where there are wasteful uses of resources that could be taken out of the system because they share in the savings when they identify those.

But most pertinent to this conversation is that the AQC model includes a very large pay-for-performance component and that's what's reflected by that top, sort of light green shading that is there in the graph.

The organizations have the opportunity to earn a very substantial sum on top of their global budget based on their performance on a broad set of quality and outcome measures. The next slide details what those measures are.

And you can see that there are ambulatory measures – I'm sorry, this is slide seven for those who might have joined late. Ambulatory measures and hospital measures, and that on both of those settings there is a set of clinical process measures, clinical outcome measures, and patient experience measures.

One of the things that I call your attention to with the red circle in the ambulatory outcome measures segment is that those measures count more than the other measures. They are triple weighted and that's because the organizations that were the early adopters pointed out that this is some of the

most important work; that is, managing these patients' conditions to keep them under good control.

And so, these measures count more. One of the changes that we're making over time and that I think will be important for CMS to consider is when you are creating incentives on the outcome measures, the process measures that correspond, so for example the A-1C testing that is necessary in order to achieve A-1C control, the cholesterol testing that's necessary to achieve cholesterol control.

It's not clear that you should necessarily pay an incentive on the testing once you're paying an incentive on the control. We have and you'll see that. You can see each of those testing measures listed under process has had a weight of one but we've seen how the performance on those testing measures has been consistently very, very high because the organizations are so committed to getting to good results on the outcome measures.

And we're of course thrilled and they are succeeding quite dramatically in ways that you'll see in subsequent slides. I'm thrilled that they're doing that on the outcome measures. It just calls into question what role paying for process needs to play once you are paying for outcome.

The next slide is to illustrate the way that the payment model on the incentives works, there is a range for every measure, there is a range of performance targets, we call them gates ranging from gate one to gate five. And at gate five levels of performance, the organizations have the opportunity to earn up to an additional 10 percent on their budget. At gate one performance they're earning an additional two percent and that performance incentive payments are graduated in between so that every single increment of improvement is worth additional dollars.

That has been a very, very important feature of the model. It's also been very, very important that we have maintained the performance targets over the full five-year contract period. That's been important because organizations then are able to plan their resources. They know what the targets are, they know what the gate five, which is the highest level of performance that can be

achieved in the population, and they can plan to get there over a period of years.

Whereas a model that might every year change what the targets are can be demoralizing and actually undercut the performance improvements.

I'm going to actually skip, in the interest of time, slide nine and talk to you just a little bit before I turn it over about the types of improvements that we have seen. We have seen under this model more dramatic improvements and quality than I have seen in my 20-plus years of working in the field of quality measurement and improvement.

Slide 11, I think, is a very nice way to summarize that and show it to you in graphic form. On the left side of slide nine, what I'm showing you is performance on preventive care. On the right side performance on chronic care management, the process measures part of chronic care management. And the Y axis here is that gate one to gate five level of performance that I was just speaking about.

What you can see is the original cohort of groups that came into the AQC model in 2009 are the dark blue bars, and you can see that in 2009 they took an enormous leap forward in their performance on both preventive screenings and on the chronic care management and continue – either maintained or continued to further that improvement in their second year, 2010.

Next to them, you can see the 2010 cohort. When they came in, [they] made a dramatic improvement in performance and have maintained their gains. And you can see that in the non-AQC segment of the network, very little is changing in the way of performance improvement.

So these incentives, using measures that are known and accepted, and also the data and support that we provide to organizations to help them with performance, all of these ingredients I think are contributing to what amounts to really dramatic and impressive quality improvements that we're seeing through this model.

Slide 12 shows you the outcomes side of this, which is even more impressive in my view. These are the measures that I mentioned are triple weighted, it's just some of those outcome measures. But you can see that even in year one and even more so in year two, these groups were getting close to that Gate 5 level of performance on these measures, Gate 5 representing the best that can be achieved in a population of patients.

So imagine patient – practices consistently getting to the best possible levels of control, not just doing the test but getting their patients under good control when they have serious chronic conditions like diabetes, congestive heart failure, hypertension, cardiovascular disease. It's a very important and very impressive aspect of what these groups are accomplishing.

And then, finally, slide 13 is showing you the improvements that we saw over this time period in patient experiences. Now, in this respect, we don't see the AQC groups far outpacing the rest of the network in their rate of improvement, although you can see that the 2009 cohort did achieve further improvement compared to non-AQC groups in the green compared to the 2010 AQC cohort in the turquoise.

But what's been important here is there were a lot of folks who were very concerned that a model like the AQC where there is a budget at the heart of the payment model would lead patients to feel overly managed, would lead to a revisiting of the 1990s experience of managed care where patients felt that they were being denied services and that care wasn't being handled properly.

So what you can see here is that's not happening. In fact, the reverse seems to be happening. These patients seem to be experiencing care that they feel even better about than they did before the AQC.

And we understand that, you know, part of what is driving that is that the way that the organizations have been achieving the substantial improvements on the quality measures that I was highlighting earlier is by engaging patients in new and different ways, by reaching out to their patients in between visits to find out how they're doing, to find out if they were able to get the prescription

that was recommended for them, if they're having any troubling side effects, if they're managing their condition, and what things they're struggling with.

These types of between-visit outreaches from the practices have patients feeling like they're receiving concierge care without paying a concierge fee and have been a really important advance.

Sheila or Nicole, let me check back in with you about time because I can stop there if we need to.

Nicole Cooney: Hi, this is Nicole. Actually, I do think we're going to have to move on, Dr. Safran, but thank you very much.

Dr. Dana Gelb Safran: You're welcome. The remaining slides give people the information about the financial side of the AQC. So if you're interested in those results, they're there and there's also a *New England Journal of Medicine* article from September 2011 that summarizes both the quality and financial results of the AQC.

Polling

Nicole Cooney: OK, thank you again.

At this time, we're going to pause for just a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there may be moments of silence while we tabulate the results.

Holley, we're ready to start the polling.

Holley: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the

room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you in the room listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling. Please hold while we complete the polling.

This does conclude the polling session. I'll now turn the call over to Dr. Sheila Roman.

Presentation (Continued)

Dr. Sheila Roman: Thank you, Holley.

Our next speaker is Dr. Peter Bowers. He is medical director for payment innovation at WellPoint and he'll be – the title of his segment of this presentation is "Physician Pay-for-Performance: Foundation for Primary Care Transformation." I'll turn the program over now to Dr. Bowers.

Dr. Peter Bowers: Thanks, Sheila. And while everyone is opening the deck, that's entitled, I think, under my last name, Bowers, I wanted to, you know, follow up on just a few brief comments before jumping into this in that similar to our Blues brethren in Massachusetts, we too have been on this journey of transformation that takes multiple, sort of, approaches to happen and realize.

I do want to go to slide two to just talk about briefly some of the host of different things before we get into a physician P4P in some of the other subjects that I think are relevant for the conversation today.

So just by way of background, WellPoint owns 14 blue plans under the Anthem branding. So like our colleagues in Massachusetts, we have multiple markets. And what we have noted in particular as we seek transformation and improvement of quality and cost in our 14 markets is that they all start from

different places. And dealing with some of that variation I think is going to be incredibly relevant for CMS as they envision moving forward in this space.

But on slide two, there are a host of ways to create innovative solutions for transformation of the delivery system and we are going to be focusing on our time together in the next few minutes on the lower lefthand side, we will call it P4P, or what's called AQI, which is our physician pay-for-performance program. QHIP is our hospital P4P program; I'll talk briefly about that towards the end.

But fundamentally, both of those programs are getting at transformation to get accountable care delivery. And the next generation of this, building on our physician P4P programs, is really going to be something called – we call PC2 or patient-centered primary care, which is you ought to think of as next generation patient-centered medical home.

And all of our efforts that I'll be sharing in the next sort of dozen slides or so on physician, in particular primary care P4P programs is put a ceiling – creating the right environment and soil to improve the primary care network so that it gets ready for patient-centric primary care transformation.

That concept is actually quite easy, the challenge actually as you think about that is taking this to scale across all of the networks, all 14, as well as across the whole delivery system. It's a non-trivial thing but real transformation is going to require fundamental practice change. This is not going to be an isolation of just changing, giving more data or just changing benefit design or just changing how we pay, it takes all of these in concert to get real transformation. And I think that's something that's fundamentally very important. All of this will get to accountable care delivery across the spectrum and it ideally, eventually offer pay-for-service and onto global payments, as you can see on that slide.

I'm going to go ahead to slide three very briefly as I focus on our primary care quality incentive program, which is our P4P for PCPs. And you can see the list of primary care specialties that are in scope. We do have other non-primary care physician performance programs for cardiology, endocrinology,

and OB-GYN but I'm going to focus on primary care for the purposes of this talk, and I'm going to go ahead to slide 14 – or slide four, rather.

I mentioned earlier that we have 14 markets, and I will share with you that the program I'm discussing has been in effect in four of our markets – Virginia, Connecticut, New Hampshire, and Maine – for nearly a decade. And it has changed significantly over that time much like the experience you heard in Massachusetts.

The additional markets that you see here listed have migrated onto this program in the last couple of years. All of the other markets also have some form of physician P4P, they just are slightly differenced or nuanced based on history and/or market, you know, sort of legacy programs. And so all of this gives us some deep, broad experience about what physician P4P looks like for primary care.

On slide five, just very briefly, and we'll get into some details about how this works in our current program is, basically, this flows through our fee schedule in today's environment.

Towards the end of this one, I'll talk about our PC2 program. You'll see that that will be shifting significantly. Part of this is operational efficiency. We're able to do this regardless of whether it's fully insured or ASL funding, that it's a bump in the fee schedule in following years. I'll have the slide coming about how that looks. You have baseline measurements that have you an increase based on how you perform.

And the philosophy here, which is important I think for the shapers of the CMS program, is that we don't just reward the high performers, there also is a component to this that even if there are performers or physicians in the group that we don't think are in the high performing today, we want to make sure that there is an incentive alignment for their improvement to get better from where they are.

Ideally, fundamentally, we would like to be able to do a check presentation, taking on behavioral economics but just operationally it's been incredibly challenging. I think that's probably relevant for CMS.

So if you go to slide six, this is the overview of our PCP physician framework as we have built it. This has morphed significantly over time. I will tell you, there are sort of four domains that are looked at for measurement and you can see the first is clinical quality measures, and I'll be going into deep sort of dives in each of these four areas in the next couple of slides. Second will be clinical improvement or patient-centered measures. Three, resource measures. And four, care systems measures, which are basically technology use and adoption, needing that we know that we want to be able to do that.

If we go to slide seven, let me jump into some of those details in the interest of time so you'll get a flavor for what this does. So the summary of measures with that, and I'll show you what that scorecard looks like at the end of that as I share you about each measure of all four components, but the first one, the clinical quality measures and external recognition really boil down to very common metrics that are familiar to all of you. These are nationally endorsed, HEDIS, NQF, et cetera.

Measures are run by our subsidiary called Resolution Health. It is run predominantly off of claims data, as you might imagine. That is done very transparently so that the individual metrics are not a black box for providers. They can see precisely how they scored based on those measures.

And the clinical quality measures are broken up into both preventive and care management measures. And if you go to slide eight, you can see these are very similar to some of the measures that are shown on Dana's slide in a composite faction, the preventive, you know, these are very familiar to folks on this call.

The care management is of slightly greater weight because we know, again, based on evolution of the program, we have shifted that over time because it gives more traction and effectiveness.

So when we go on to slide nine in the second category, external recognition, we want to emphasize the improvement of clinical quality of care. And so you can do that by either using DTE or NCQA recognition and these are, you know, standardized, national endorsed external to WellPoint Anthem for process improvement and sort of QI improvement or thinking about quality improvement in practice. And these are admittedly somewhat baby steps, but in thinking about the masses, this has been something that has been well received and this has been a sort of late addition onto the program.

If we get into slide 10 on the resource measures, the overall cost performance index, this is a recent addition, it gets into similar to what Dana described in the AQI type of space where you're thinking of total cost of care, total population health management types of approach that are across the care delivery spectrum, not just in a primary care physician's office. Some of that is easier controlled in the PCP's practice and yet we know that the whole has to be influenced as much as possible and that is a shared process that they can't do just on their own, of course, and that will be coming in concert to other programs and initiatives to support that overall and get better alignment.

Clearly, generic performance improvement based on benchmarking, et cetera, continues to be and has been since the beginning of this, a real significant value proposition in thinking about the program.

We have added recognition for, again, doing clinical improvement. This is while small weighting something that we have added of late so that again the quality improvement becomes part of a provider network's DNA, if you will, to thinking about not just taking care of the patients in the room, but thinking about the larger system, process improvement within their practice.

We think that's really important for getting to patient-centered delivery models either in full-blown ACO or in patient-centered primary care that we'll be talking about just a second that we just launched in the last couple of – we announced in the last couple of months. And we'll be rolling out in our markets, about half of our markets this year and the balance of the markets in 2013.

The fourth domain, care systems, of 30 points provides an acknowledgment that we need to move on to care delivery systems that are increasingly digitalized so that you can't just continue to work with paper product, you know, paper products. You can see on the last meaningful uses there. We have some electronic e-prescribing certification incentives that can be adopted.

AIM is our radiology benefit management subsidiary. If you are signed up so that you will work through that Web-based portal there are points awarded for that. Availity is a multi-payer. You can talk about benefit and eligible – eligibility adoption. When someone signs in into the practice that we have incentive, we also push our gaps in care messaging there nowadays.

So technology adaption has been pretty broad trying to get people engaged to, you know, make the necessary shifts, running into meaningful use, which clearly is going to really move the market.

If you take a look on slide 12, here's our overall composite of the P4P scorecard. I will share with you that each group practice has the ability to look at their composite score by physician precisely how they measured and how their points are tracked so that that is an extremely transparent process.

We have actually, you know, you can't really win in this space entirely but we have done it in an extremely transparent fashion to the point of people complaining that it's actually too detailed. So I think that in doing this as transparency and full transparency about how people are being scored and then how that ties directly to the dollars that flow is really a critical hallmark over the program which you think has been very important.

Slide 13, I think very briefly. What we have done is looking at measurement periods, which is typically an ongoing evolution year by year, we look at the preceding year, OK, its entirety. In second quarter, the reports are available so they can see what that looks like, and the reward period in dollars begin to flow from the following 7-1.

So the dollar's in flow on a six-month off cycle, if you will, and so the bump and the fee schedule based on their performance and that's gives you that timeframe. So it's looking backward to do the measurement and its prospective payments from the dates that I described right there.

Slide 14 is something that's very important. We do introduce changes to the program in a format that is reporting only, meaning that the dollars and the scoring are not tied to these measures as we get the primary care physicians comfortable with what the metrics look like. So it's usually a year or two so that they can understand the lay of the land before it actually gets into the dollars, so to speak.

This is an example of resource measures. That is currently what it looks like. It does get after some of the, you know, hot items today. All cost, readmission, you can see on the third bullet. So it isn't tied directly to it but we know that these are coming. And while it isn't solely owned by the PCPs, it is something that clearly is going to be important and something that they are, share in that responsibility for, you know, help delivering that promise.

And I'm going to transition on the next couple of slides in the final few minutes about our two slides on our hospital P4P program that works in concert with our primary care P4P program. And so the acronym in our world is QHIP. You may have seen some coverage of this over the past year or two. We came out last spring with a pretty public stance that any increased payment to hospitals in open contracts will be tied to inking and signing a quality improvement contract.

With that, we now have over 60 percent of admissions happen in a QHIP bed or facility. We have had extremely high adoption rate as we have tied any increase of hospital to this. That's the new rules of the game in this new environment. Well north of 90 percent of our open contracts have inked contracts in these domains.

You can see the total number of facilities participating in QHIP. All of our markets are coming on board now with the transition of California recently

about the transitions going on in that marketplace in this hospital reporting space.

Briefly on slide 16, these are hospital measures. These again are pretty familiar. They're in NQS, some IHI, HCAP, STS, and ACC. These are nationally associated or nationally vetted programs. Like our physician program, we have measures that they so-called get used to before the dollars get attached to that. And with that, it's been very successful getting input and feedback from the hospitals. It's been a very effective program as well as our primary care has.

My last two slides, starting on slides 17 and 18, gets into what, where we think we've been on this journey for, you know, nearly 10 years in some of our markets and why? Where is this really heading strategically? Well, it's about, as you heard from Dana, accountable care delivery.

And fundamentally, while we are extremely supportive and enthusiastic about ACO contracts, we know that it is fairly finite about those delivery systems ready to do that today. And when we look across our delivery system in the U.S., primary care is an essential agreement, essential ingredient to delivering on the promise of transformation.

With that, we have initiated our patient-centered primary care initiative which is really harnessing P4P, but taking it to value. Beyond just financial incentives for change, this gets at cost and quality. And this is fundamentally different about how we're going to support primary care physicians. Not just with financial, it's a different contract. It's a different data flow.

It is also figuring out how to best support each other, about what plan, resources we have from total population health management to supporting the fact that no one can be more effective in a doctor-patient relationship than a primary care physician. So fundamentally, this is a really important approach for us and there's a lot of activity coming.

I think on my final slide, I'd just like to talk a little bit more detail about the four domains that are fundamental for this and really build upon our P4P

programs. And this, from the CMS world, you could be thinking about how this dovetails with the CPCI initiatives that are also going on in the CMMI.

Patient-centered primary care fundamentally is about getting off of fee-for-service and getting into valued-based reimbursement. I think that that is going to be a slow process. There are probably some components of base fee for service with a blend of risk sharing upside in particular in the start, as well as expanding to PMPM on risk-adjusted global payments.

Expanded access is going to be very important as we get our limited primary care physicians in the United States to work at the top of their license and be the first contact of care.

We have to get away from being stuck on face-to-face visit and get into asynchronous communication and getting people the care they need at the right time and the right level of care. Clearly, care management and aligning and figuring out who does what best is a three to five-year journey that we're going to go on with the network, to figure out how best to support getting what the right services are.

The last bit of this is not just about changing – exchanging claims information, pushing from a plan to a provider on their patient panel, but also getting clinical information coming back to the plan in a very meaningful way, taking meaningful use but also to the next level so that we can get the true value proposition.

Sharing information on total cost of care, looking at where the waste is in the system in the multiple levels of care beyond just the primary care physicians and hospital. We all know that there are significant amount of spend that's really is not as effective as it could be going on in our delivery system. Some of that is within the specialty network, some of that is within institutions, some of that is across all of the spectrum. That said, this is exactly the type of value proposition that we think primary care is really very well-suited to directly influence and improve upon.

So with that, I'm going to, in the interest of time, pass this back over to you, Sheila.

Dr. Sheila Roman: Good. Thank you very much, Peter. And we're going to move right into the last speaker. That's Dr. Cheryl Damberg, who is a senior researcher at the RAND Corporation, and she will be speaking on key design considerations in physician value-based purchasing.

Dr. Cheryl Damberg: Great. Thank you, Sheila. So I'm going to move the conversation back up of few thousand feet and talk about some of these more general design principles based on evidence that has emerged both from healthcare as well as the implementation of value-based purchasing and other business sectors, as well as information that we know from research studies looking at behavioral responses to incentives.

So if you're looking at your slide deck, I'm on slide two. So as I noted, we'll try to move quickly through talking about what has been learned from these other business sectors that might inform the work that's going on in this space for Medicare.

And in particular, I want to zero in on some key design elements, namely, the incentives, the measures, both the types of measures selected and their underlying properties. And then talk a little bit about the complexity of the design of these programs and then the distribution of awards.

Going on to slide three – so some of the work that we've done here at RAND looking at pay-for-performance and value-based purchasing in other sectors has really sort of found that there are a set of optimal circumstances for doing these types of programs and the structure of them.

Namely, that there is a goal that's widely shared, that the measures used in these programs are unambiguous and easy to observe, which, we know, sometimes can be very challenging in healthcare. That the incentives are meaningful to those being incentivized and that there are few competing interests or other requirements that maybe confuse the incentive structure.

One of the things that I've noted in healthcare is that many organizations use multiple types of incentives to signal behavior of physicians and that can be very challenging for the physician to understand what to respond to. And then lastly, that there are adequate resources to design, implement, and operate these types of programs. And not surprisingly, all of these conditions are rarely met.

On to slide four, so there are a number of basic design issues that need to be considered in terms of figuring out whose behavior you're trying to change, the type and size of incentives, and then the set of measures that you're going to use to assess performance.

And I should note that contextual factors really matter in this space because we know the environment of, say, a hospital is very different than individual physician practice. And those contextual factors can really play out in terms of people's responses to the incentive and the types of measures you apply.

I should note that related to the work on the size of incentives or the magnitude. This evidence basis is rather thin here in terms of what the exact size of the incentive needs to be to induce the behavior you want.

Sometimes we see a good response with small incentives and then in other cases, larger incentives are required to change the behavior in a way that you desire. There are some complexities in this space in part because as you increase the magnitude of the incentives you can induce some unintended consequences.

Onto slide five. So the types of measures that are used to quantify performance can vary across a lot of different dimensions. And I've listed some of them here such as the feasibility and the availability and the cost of, you know, capturing the measures or generating the measures, these contextual issues that I just noted, and the degree of controllability by the monitored party.

And also, this issue of how resistant are the measures to manipulation by the entity that's being measured? So in any kind of program that's looking to incentivize providers, one has to assess these various properties and make some tradeoffs in those decisions.

In slide six, so the measures are important because they really are the things that you're asking providers to focus on and what things you're potentially asking them to ignore.

And the other thing in the measure space is that for some output measures, it's important that you account for relevant social, physical, or demographic characteristics of the populations being served; otherwise, it's a threat to the validity of that measure. And in the healthcare space, this is critically important as we really move towards measuring outcomes.

The other thing to call out in the measure space is that people focus on either attainment or improvement and they also focus on issues such as measuring providers' relative performance to each other or hitting some absolute threshold.

And I think there's general consensus out there that measures that focus on a single absolute threshold are not, sort of, the best measures to put in place. And for a number of reasons, they both have statistical problems or issues that need to be considered.

But the issue is that for those entities or individuals that are low achievers, if you set some fairly high target, they have no prospect for achieving that target, so getting their engagement can be challenging.

And then high achievers don't really have any incentives to strive for further improvement once they've hit that threshold. So one of the alternatives that are used is looking at multi-threshold scores and looking at year-over-year improvement.

I'm switching now to slide seven. So now, I'm looking at some works that Ateev Mehrotra, who's here at RAND, and Melony Sorbero and I did, trying to draw some lessons from the behavioral economics.

And I've started talking about these issues related to how you structure the incentive in the last slide. But here, the takeaway is that oftentimes, a series of small incentives is bigger – is better or achieves a better behavioral response than providing one large incentive or one lump sum payment.

I've already covered the second point in terms of this issue around setting a number of tiered thresholds as being better than one single threshold. And because I have other slides that I'd like to focus on – I'll move on, since we covered this in the last slide.

In slide eight, the other things that play out, related to structuring incentives are reducing the lag time between the actual delivery of care and the receipt of those incentives. I know, in many of these programs, there can be a lag time of up to a year, year and a half before the party being incentivized receives money for performance that was done, say a year, year and a half ago, that tends to work less well than sort of in the moment.

The other thing that many have tried in the incentive space is the use of withholds and that's generally perceived by individuals as a loss in income. Now this tends to achieve a better response because you clearly have the party's attention. But sometimes, it can create a negative response on the part of the provider to the extent that those withholds are quite large in size.

The other thing to note about the incentive structure is that some of these incentive structures can be quite complicated. And so, individuals often have a hard time processing these very complex decisions about "what do I have to change," and "how much do I have to change it by," and "if there are three things that I have to, you know, figure into the math," "I can't quite figure out what I'm supposed to do to have any impact on the metric that you're holding me accountable for." So trying to think carefully about the complexity of the incentive design is a critical design feature.

Moving on to slide nine. I know we've all heard about teaching to the test and this is especially important in the healthcare delivery space where we're asking providers to do many different tasks, but yet our measurement dashboard tends to focus on a very narrow portion of any providers' output for processes.

So we kind of need to look at ways to guard against opportunities for teaching to the test and narrowing the focus of what physicians focus on, by ensuring that we have an extensive or broad dashboard.

And again, in terms of these design features, there is this tension between too many measures, so that it complicates a physician's life and ensuring that the dashboard is broad enough such that we try to mitigate this effect of teaching to the test.

Slide 10 I'm not going to speak to – we've talked about some of these already. I would call your attention to the study that's at the bottom where this is discussed. And what I'd like to do is move on to slide 11.

So the other thing in the measure space that's very important is some of these measurement issues or properties. And at the end of the day, in all of these value-based purchasing programs, providers have to be classified.

And so, one of the things you need to be careful about is ensuring that the misclassification rate is not too high, so that we're not inadvertently putting, say, a provider in a five star rating who really deserves to be in one star category, or vice versa.

And any of these programs, whether you use confidence intervals or setting an absolute threshold, they do categorize providers. And so, it's important to look at the underlying properties as measures and one of the key properties that has been evaluated, and Dana Safran, who's on this call has done a lot of work in this space, is looking at the reliability of the measure.

And I'm going to show you a couple of slides that help you understand what we mean by this. But reliability is an attempt to create a measure that says,

"How much truth signal do you have in your measure rather than random error or noise?"

And the reliability is dependent on how big the sample size is. And that can vary provider to provider as you go about this measurement. And then secondly, how much variation there is between providers.

The other things that factor into misclassification, besides the reliability of the measure is how many cut points you have in your program as well as to how close any particular provider is to that cut point.

Going on to slide 12. So – this is really to illustrate that as you do measurement, by looking at the top of the slide, when providers are all bunched together on, say, a particular measure, it's hard to distinguish who is better.

So the lower graph shows that if providers have a broader distribution of performance, it's easier to try to understand who is better and who is not. On slide 13, so I mentioned a moment ago the issue of noise or error in the estimate.

Any time we do measurement, we have some amount of error in that estimate, whether it's you getting on the scale in the morning, trying to figure out your body weight or in this space of measuring physician performance.

And so, what we want to try to have in our measures is a smaller amount of error. And if you look at the bottom graphic, you can see that the dotted circle around the estimate of performance is small, in which case, we can distinguish the performance between those two providers.

If you look at the graphic at the top of the slide, where the error around the estimate overlaps, it's hard to distinguish their performance. And I would call your attention to a recently released report that goes into much more detail around these issues, if you're interested.

On to slide 14, so I'm not going to spend a lot of time here other than to note some providers are likely to have small numbers of patients. And one of the

ways in which you can address the small numbers problem to try to discriminate performance is by generating composite measures and these can increase the reliability of a measure.

However, in this space of selecting measures, reliability assumes that the measure is valid. So that if case-mix adjustment is needed, it's happening, so that's the issue around validity. And there are other validity issues that should be considered, again, those are documented in detail in the report that was on the previous slide.

If you go to slide 15, I'm going to illustrate how compositing can help, and this is drawn from data from California where there's an effort underway, and Ted Von Glahn who was on the last open-door session presented some information from the California Physician Performance Initiative and this slide draws from that work.

And what you can see – so these are individual measures for diabetes care, so HbA1c screening, LDL screening, the medication monitoring, the eye exam. And the dotted red line, that's over the 70, that's the minimum threshold that we're looking at for reliability. So things below that, we're saying, we're getting kind of more noise than signal on any provider's estimate.

And what you see here is for any of the individual measures, most physicians are not being scored reliably at a 0.7 or higher. But once we create the composite measure, which is at the top of this graphic, this really improves our ability to get a good signal on a provider's performance. And you see that most providers can be measured in a reliable way.

Slide 16, so what I'd like to do as I'm closing out the presentation is talk about the two remaining issues around complexity and also around setting cut points or comparisons.

So, I'm drawing this information from some preliminary work that's been going on in California to design a value-based purchasing program. And initially, the stakeholders were thinking about possibly holding providers accountable for both attainment and improvement, using three different cost

metrics, so the total cost of care attained, a trend that is based on CPI plus some percent, and then also the individual provider's year-over-year trend.

Now, I mentioned earlier in the presentation that complexity makes it challenging for providers to figure out where to engage and how to respond. And so, when you have these three different cost metrics, it can make it very difficult for physicians to get that line-of-sight and it may diminish the incentivizing power of the incentive. Because ultimately, what you want is a clear incentive structure such that providers understand where they need to change their behavior and they can internalize that. So a simpler model can actually reward both attainment and improvement and so one consideration is to scale this back from three components to two components.

The next slide – 17 is an illustration of how we modeled the total cost of care for these different providers and how bonuses would potentially be awarded depending on what you were comparing the provider against.

So, the top part of this graphic looks at setting targets on a market-by-market basis. So the analogy here would be to say if Medicare decided to structure their incentive programs by state.

And the lower part of the graphic looks at setting up statewide targets against which the providers in this market would have to achieve or have their total cost of care metric compared against.

And what the graph illustrates is how the incentive payments would be distributed across the providers in terms of their underlying total cost of care. And what you see in the top graphic is that if you were to set market-based targets, so let's say, I'm in Sacramento as a provider and I'm comparing against the average total cost of care in that market.

That – what we would end up doing is paying out to providers who have a higher total cost of care. Once we take that comparison down to a statewide average total cost of care, what ends up happening is we're rewarding more of the groups who have a lower total cost of care and we're guarding against rewarding groups or providers that have higher total cost of care.

So the takeaway here is as a value-based purchasing program thinks about where to establish comparison targets, it will have significant implications on how incentive dollars are distributed.

And in this case, had the party looked at market targets, it may have reduced the power of the incentive to reduce cost within a region because we know that certain regions are much higher cost than others.

So to conclude, I think some of the key design considerations to think about more broadly are, you know, are incentives sufficiently large to induce the behavior changes that are desired while protecting against not making them so large that they may induce unintended consequences.

Secondly, is the design simple enough such the providers can follow what they're being asked to do? Third, this point about creating overly narrow market definitions, you run the risk of rewarding, say, high cost providers.

And then, I think other key considerations are to what extent will the program punish certain types of providers who care for, say, more challenging patient populations and are there strategies that can be deployed to try to mitigate or moderate these effects either through stratification of the results on the back end or some front-end risk adjustment.

And then, lastly, I think always a key consideration is showing providers where they stand relative to each other. Transparency of information is in itself a powerful incentive.

So, Sheila, with that, I'll close.

Dr. Sheila Roman: Thank you very much.

And I think right now, we'll go right to the phones – and so, Holley, if you will set that up for us and we'll take questions from the participants.

Question and Answer Session

Operator: Thank you. To ask a question, press star, followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound

key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to ensure clarity.

Please note, your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Nicole Cooney: And this is Nicole. Sorry, Holley, I just want to jump in real quick to remind everybody that the call is being recorded and transcribed, and if you could limit your question to one, we'd appreciate it in the interest of time.

Operator: And your first question comes from the line of Victoria Stewart.

Victoria Stewart: Hi. My name is Victoria Stewart. I'm with Dr. David A. Parks. Hi everybody. Thanks for this presentation. It's really good.

What I want to know – and my first question – actually I have seven questions. But my first question is – how will I be notified with feedback reporting? It says in the handout that physicians will be provided feedback reports, but I'm not sure how that's going to happen – that was not addressed in the presentation.

Dr. Sheila Roman: OK. Right now, we are scaling up our physician reporting to the nation. This year, we have given physician feedback reports to a four-state region. And next year, our plan is to send physician feedback reports to all physicians who are participating in PQRS, our Physician Quality Reporting System, so that all of the physicians who participate in that program will receive the physician feedback report. And in the years to follow, we'll be scaling up further and on a pretty steep curve.

Victoria Stewart: Will that be coming to me via the Web site or will that be coming in the mail? How would that be sent to me so I know to look for that?

Pam Cheetham: Actually, we're not sure how we're going to disseminate in future years. It may very well be that you will receive an e-mail notification sending you to the secured link to download the report.

That's what we've been doing this year. The chances are very good that's what we'll do in the future.

Victoria Stewart: OK. So, if I'm not...

Nicole Cooney: Thank you so much. I'm sorry. This is Nicole. Thank you so much for your question. I'm going to have to move on to the next caller so I can get to as many callers as possible.

If you'd like to get back in the queue, you can press star, one and if we can, we'll get to you for your additional questions. Thank you.

Holley, next question, please.

Operator: Your next question comes from the line of Donna Kinney.

Donna Kinney: This is Donna Kinney of the Texas Medical Association. And I was particularly interested in the final comment that Ms. Damberg made about the problem of trying to avoid penalizing physicians who are serving populations that are more difficult in terms of adherence. How exactly can Medicare go about designing a system so that it does not do that?

Dr. Sheila Roman: Yes. Cheryl, do you want to give a response and then, you know, we'll speak on our end?

Dr. Cheryl Damberg: Sure. I think it partly depends on sort of what's going on and how much of it is as a function of patient characteristics versus underlying provider delivery differences. And that approach kind of needs to be done on a measure-by-measure basis, sort of considering both of those factors.

But as my slide notes, there are several different ways in which you can go about doing this and we've been doing some exploratory work around some data we have in California. In certain cases, you can do case mix adjustments and that is sort of standard in some of the measures such as the CAPS measures.

And then, in other cases, you might do what I call back-end stratification. So you might display the results and say, for example, you could envision creating some reward designs that would pay differently based on some agreed upon strata, and maybe the strata is based on, I don't know, education and income or a region or, you know, whatever variable you think is really a key consideration.

But that whole process requires some back-and-forth and understanding, sort of what's the underlying problem. We know in, say, the CAPS surveys that there are substantial regional differences. However, if you look within regions that are poor-performing, you do have providers who have similar mixes to other providers with very challenging patient populations that tend to have very high scores.

So, in that situation, it seems like it's less about, say, race, ethnicity, or language, and more about the structure of the care delivery system and kind of what goes on in the care delivery process.

Dr. Dana Gelb Safran: This is Dana. I'd just like to add on to what Cheryl was saying in terms of what our experiences have been in the AQC on this matter. Because the issue of whether there were practices that were going to the – I'll describe them as – disadvantaged in the incentive program because of serving populations that are disadvantaged.

It was a very serious concern. At the same time, it felt philosophically challenging to decide to lower the performance targets for certain populations and say that a lower standard of care is acceptable for them.

So in the end, what we decided to do was to keep those gates that I talked about, those performance target survey measures, the same across all the AQC groups. And one of the most surprising findings out of this work so far is that the organizations that have performed most favorably on the quality measures both in year one and year two were the organizations that disproportionately are serving a low socioeconomic population or lower socioeconomic population than the rest of the network.

And that told us something really, really important and I think, you know, one of my – the favorite thing that (Tom Secrest), who is a leader in disparities research has said, "The problem of disparity is not a problem of treating patients differently. It's a problem of treating every patient the same."

And I think some of what we've learned is that these organizations, in order to achieve very high standards of quality and outcomes for a population that's different from others, have to intervene in different ways, but they are doing that very successfully and, you know, being rewarded for it in a program.

So I think we have to balance those issues of where we want to change the requirement or expectations of providers versus allow them to rise to the occasion and customize care to serve the population that they serve.

Nicole Cooney: Thank you so much for your question.

At this point, I need to move on to the next caller.

Holley, can I take the next question, please?

Operator: Sure. Your next question comes from the line of Allan Ausman.

Allan Ausman: Hi, Allan Ausman, Memorial Eye Institute.

For those of us that are specialists, understanding that everything here is primary care oriented, I assume that we begin with the bundled – if I'll look at Dr. Bowers' transformation models that the specialists begin to become involved at the bundled and ACO points on his models.

Dr. Peter Bowers: So, I appreciate that question. I think that's probably for me, Sheila.

Just briefly, I think that as you look at patient-centered delivery models, medical home, et cetera, the concept that you raise is really talking about creating a medical neighborhood.

And I think that the principles of care coordination, seamless communication, you know, non-episodic, continuous care, you know, no fragmentation – is exactly how I would look at it if you're not in primary care today.

So my clinical training is in pediatric cardiology. And if I were thinking about what I know about our patient-centered delivery models, I would be fundamentally changing how I practice in terms of level of communication across the delivery spectrum, not just with the family that I'd be treating, but also with the referring primary care physicians so that across the delivery spectrum whether it was inpatient, in my practice, cath lab; you name it.

Whatever is going on there is not going to be fragmented. And there are, you know, strategies about how to do that, I think. That would be what my thoughts would be about creating a medical neighborhood and moving forward.

Truthfully, I think that all of these are foundational for ACO whether it's a formal, legal structure or not. It's about accountable care delivery.

It's a good question.

Allan Ausman: Thank you.

Nicole Cooney: OK. Thank you so much.

Next question, please, Holley?

Operator: Your next question comes is a follow-up from the line of Victoria Stewart.

Victoria Stewart: So, thanks. My next question is – can a physician be in both the PCP/IP program and the AQC at the same time?

Dr Dana Gelb Safran: No, they can't. They're in one or the other.

Victoria Stewart: Now, how do we determine which one we're in?

Dr Dana Gelb Safran: If the physician is part of an organization that contracts with us through the AQC, then that's the incentive program that they're in. And if they're not

in any AQC or other kind of organization-level incentive program with us, then they're in our PCP/IP.

Victoria Stewart: Do you guys have an e-mail address I can use to write down my questions and then have that clarified some more?

Dr Dana Gelb Safran: Sure. I think the conference organizers can provide that.

Dr Sheila Roman: Yes. And I just want to be clear to the questioner that that's specific Massachusetts Blue Cross Blue Shield programs and not to CMS or to any of the other programs that you've heard described.

Victoria Stewart: OK. So do you want me to e-mail then to the (cmsnpcblttech.com) address?

Nicole Cooney: No. Actually, if you want to e-mail your question to the e-mail address that's on slide eight of Dr. Roman's presentation, it's qrur@cms.hhs.gov.

Victoria Stewart: And you said slide eight?

Nicole Cooney: Yes, ma'am.

Victoria Stewart: Dr. Roman?

Nicole Cooney: Yes, ma'am.

Victoria Stewart: Thanks.

Nicole Cooney: Next question, please, Holley.

Operator: At this time, there are no further questions.

Nicole Cooney: All right. Just again for that – the e-mail address for any outstanding questions or comments, it's on slide eight of Dr. Roman's presentation – qrur@cms.hhs.gov.

And now, I'll turn it back over to Dr. Roman for the closing.

Dr. Sheila Roman: Yes. I'd like to thank our speakers. I think they provided a lot of very valuable information for CMS today.

We'll probably be sending you some specific questions that we have that we would like answered, but I think we're, at this point, almost over time. So, I won't go into them on this call. But thank you very much for your presentation.

For the participants, I'd really like to emphasize that we are looking for input from our stakeholders as we develop the value modifier. We would like your input and in particular, suggestions for measures in both cost and quality that should be part of the value modifier and would like input on methodology.

And we'll be having a call at the end of April that we are planning to speak about attribution of costs and quality to physicians and we'll be also planning – we're also planning another call in May to talk about the status of the Medicare-specific episode grouper for cost.

So we'll be looking for a lot of input from you as we progress down our development of the Value-Based Payment Modifier and I'll remind you that we will be putting forth some of our ideas in the upcoming rule that will be published around July 1st.

Nicole Cooney: So, just to take over where Dr. Roman left off, in order to provide that input, again, you can send it to qrur@cms.hhs.gov.

On slide 10 of Dr. Roman's presentation, you'll find information and a URL to evaluate your experience with today's National Provider Call. Evaluations are anonymous and strictly confidential.

All registrants for today's call will also receive a reminder e-mail within two business days regarding the opportunity to evaluate this call. We appreciate your feedback.

We'd like to thank everyone for participating in today's call. An audio recording and transcript will be posted to the Physician's Feedback Program page on the CMS Web site. That URL is on slide nine of Dr. Roman's presentation.

Again, my name is Nicole Cooney and it's been a pleasure serving as your moderator today. I would like to thank Dr. Sheila Roman, Dr. Dana Safran, Dr. Peter Bowers, and Dr. Cheryl Damberg for their participation.

Have a great day, everyone.

Operator: Thank you for your participation. You may now disconnect.

END