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 Special National Provider Call Series Physician Pay For Performance Industry Best Practices 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. Hi everyone, 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'd like to welcome you to the Physician Value-Based Payment Modifier Program Experience From Private Sector Physician Pay For Performance Programs National Provider Call.

Today we have three private sector experts who have had experiences in implementing physician level pay per performance program. We will have a question and answer session, and that will allow time for you to provide input and ask questions. Before we get started, there are a few items that I'd like to cover.

There is a slide presentation for this session. At 12:30 p.m. Eastern Time, a link to this presentation was e-mailed to all registrants. If you did not receive this e-mail, please check your Spam or Junk Mail folders for an e-mail from the CMS National Provider Call Resource Box.

This call is being recorded and transcribed, and all your recordings and written transcripts will be posted to the CMS Physician Feedback Program webpage. The URL for this page is located on the final slide of today's

presentation. Once you're on the page, select teleconference, the teleconferences and events tab on the left 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've submitted questions when you registered for today's call. Your questions were shared with our 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 it's 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?

Dr. Sheila Roman: Thanks, Nicole, and welcome everybody. It's a pleasure to have you with us today on this first of two calls where we'll be having experts from the private sector with experience in pay for performance speak to us about lessons learned and best practices from the field. And I'd like to draw your attention now to slide two and talk a little bit about the purpose of this Special National Provider Call. This call is to provide CMS with input on best practices and lessons learned from the physician pay for performance programs in the private sector.

As you know we will – we are mandated by statute to put into place the value-based payment modifier starting in 2015. So we're using these calls to gain information so that CMS will have up-to-date knowledge of what the private sector is doing in this area and so that when we develop our program, we will be as complimentary as we can be to physician pay for performance programs in the private sector.

And in – additionally, we welcome all of you because these calls, as you all know, are also to allow us to obtain input from you as stakeholders on current private sector pay for performance programs. On slide three, you'll see the agenda for today's program. And, basically, I'll introduce each of our expert speakers right before their presentations. We will have three presentations

and then CMS will ask several questions and then we will open up the phone for general questions and answers from the public. I'm going to provide a little bit of background on the value modifier and you can turn to slide – to slide five, what is the value-based payment modifier?

As I mentioned, the Affordable Care Act of 2010 requires that under the physician fee schedule, Medicare begin using a differential payment to physicians or groups of physicians based upon the quality of care furnished compared with costs. A physician's value-based payment modifier will apply to services the physician billed under the physician fee schedule.

The statute also requires that the secretary applies a 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 Call to inform us and our stakeholders as we develop this methodology.

In 2012, CMS is planning to provide to all sufficient quality reporting system participating physicians, in other words, those physicians who successfully participate in the physician quality reporting system program a confidential physician feedback report which will contain the information that will be used in calculating the value modifier. On slide six, there is a timeline for the implementation for the value-based payment modifier. And briefly, the initial performance period is slated to begin in 2013, meaning that 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. In 2016, the Secretary of Health and Human Services will continue his or her efforts to apply the value-based payment modifier to specific physicians and/or groups of physicians that he or she deemed appropriate. Beginning in 2017, the value-based payment modifier will apply to most, or all, physicians who submit claims under the Medicare physician fee schedule.

And I'd like to move right into our first speaker's talk, the first talk is titled Using Physician's Pay For Performance to Improve Physician Care, and our

speaker is R. Adams Dudley, MD, MBA, Professor of Medicine and Health Policy at the University of California in San Francisco. And so I'll turn the program over to Adams, thank you.

Presentation

Adams Dudley: Thank you, Sheila. And thank you everybody for coming. So I'm going to give you a brief overview of the rationale for using physician pay for performance to improve care and of methods to do so. If we go to the next slide, this is slide eight, the outline for my talk is – the thing we're going to talk about is why are people considering doing pay for performance in the first place?

Then we'll address who should receive the payment, meaning an individual physician or perhaps if it's relevant, their medical group or their clinic. Then we're going to talk about what the Affordable Care Act calls for CMS to do in terms of measuring quality and measuring cost in creating composites from there.

And then we're going to get into the mechanics of how the payment goes in the next two topics. How much to adjust payment and whether to set it up as a tournament among providers or to promote providers to get over certain a threshold, but how should the money go out to have the best possible effect on clinical care? I would say overall that my understanding from CMS is that these topics are up for discussion.

And so now is the time, as you're listening, to begin thinking about what you think the world should look like and in terms of how we measure quality, how we measure cost and how it gets rewarded. And make those suggestions to CMS, and now's the time when they're looking for such suggestions. So if we go into slide nine, I'll also talk about why you pay for performance. And in slide ten is the first piece of fundamental evidence that's led policy makers in this direction.

And that is that unfortunately, even today, quality still varies and that variation is bad for patients. So CMS gave a contract to the Rand – to Rand to

look over the charts of thousands of patients in a national sample across hundreds of different quality measures. And unfortunately for any of the quality measures, and these were quality measures that we as physicians agree on so within asthma, they were using – I'm a pulmonologist and a member of the American Thoracic Society and they were using ATS quality indicators.

And ATS guidelines decide what the quality indicators were. They – so even though it's things that we as physicians accept we should be doing, they found that we just don't do them a lot of times. That regardless of what disease they picked, average performance was in the 55 to 75 percent range.

And that led to discussions in policy circles about trying to make the basis of payment not the just – I did not list visitor, I did a bronchoscopy but also you know how well were things were done. Let's go to next slide, slide 11. There's also evidence that cost and utilization vary. So around the nation, we see very large variations in the use of coronary stinting from one region to another.

We don't know why this happens. It's not – you know it might not be hurting patients. It could reflect variation of patient preferences. But it's the type of thing that policy makers see variation in their costs and we as clinicians can't explain to them why that has to happen, so that makes them want to start measuring things and take that into account when they're doing payment.

If we go to slide 12, so what are they doing? The pay for performance is one of the things that they're doing. There actually are some other things they're addressing payment or they're doing – but the idea about pay for performance and the approach that CMS and others are taking about it is work with specialties societies to get physicians to gather to agree on what constitutes high quality. Write those up those guidelines and agree on what care is necessary, write that up as appropriate use of criteria, and then pay for care that's needed and is done right.

And the thought is that this is better than continuing the current system of pay for service where you just pay for doing more. On slide 13, let's talk a little

bit about who should receive the pay going to slide 14. The options here are that individual physicians receive it or that where there is a practice site like some people practice in more than one clinic. You could send it to the practice site or if there's even above that, there's an overarching medical group that's coordinating things and making contracts to CMS or insurance companies, wherever, you could send it to a medical group.

This is an issue that is not written down in the law; the law doesn't help CMS to do it, one way or another. So CMS is asking physicians what they want, you know, what they would recommend. And I think the key issue here is that if you pay down at the individual physician level, to a large extent, you're rewarding the final decision maker for most of these things. You know, it's one of us who actually does it or does not write the prescription or does or does not say you need a flu vaccine, or whatever.

But in reality, especially when you start talking about outcomes, sometimes, that's a team sport. So for patients to get their blood pressure under control, many of us are having the follow-up about making sure the person knows what diet they should be on, done, you know, with help. So a nurse is sitting down with them or the nutritionist is just sitting down with them. And so, right now, this is an open question as to where the payment should be directed.

Next slide, slide 15, let's talk a little bit about what the Affordable Care Act tells CMS they should do. Slide 16, we'll talk about quality measures. The law said that the quality measures should include structural measures. This means characteristics of a practice, like does it have an electronic health rep.

It also says it could include process measures. So a process measure is something that you do, like checking the patient – checking the patient's blood pressure or checking the patient's cholesterol. It also says that outcomes measures are an option, and the distinction here is the outcome can be, is blood pressure actually in control versus the process measure that I've checked it. Or it can even go further down the outcomes passing and say what's the stroke rate or the MI rate among the patients who have hypertension. And exactly how they're supposed to create this – how CMS is

supposed to create this set of quality measures and the quality composite is not specified in the statute. So if you have anything to say about it, now is the time to speak up.

Next slide, same issue applies for resource utilization, so an option for CMS is to apply resource use measures. An example of that would be to look at episodes of acute bronchitis and ask what percent of the time are you prescribing antibiotics or, evaluating appropriateness. So the American College of Cardiology has come up recently with their appropriate use criteria for coronary revascularization. Those could be applied to actual events of putting in coronary stints or doing CABG and asking did this seem to be appropriate. And in terms of resource utilization, CMS is looking for feedback from clinicians.

Slide 18, the last thing is that they're also supposed to do this, not just with the resources we use, but actually add up all the dollars and come up with some sort of cost composite. And how to do that is not specified in the law and what makes sense is, both among academicians and among practicing physicians, is a matter of great debate. So I extend your clinicians can pose meaningful measures to CMS. It's my impression that they really do want to hear from you and that – it's probably, particularly effective to use your – the society to which you belong to try and get that message in, in a coordinated way if that's possible.

And on slide 19, I wanted to bring up that this is not just CMS. So this is pay for performance among commercial health plans and what you can see is its become very common and this approach of using an array of measures like patient satisfaction, outcomes processes that's written in the law is actually the same way that the private pay for performance programs are working.

And you see to the right that there has been an increasing trend of also take – trying to include some type of cost composite. So that's probably going to be viewed by most people as the hardest thing to do right, the hardest thing to make fair. But it isn't just CMS doing it; in fact it seems to be a trend industry-wide.

So next slide, slide 20, in these last two sections, we're going to talk about sort of how the dollars go out, on what basis do dollars go out, and how many dollars go out. And on slide 21, let's talk about how much to adjust payment overall and I just will point out that CMS has a program that they're about to start for hospitals. And where they took one percent of the payment, they were going to put out and put in their pay for performance pool. And then they – as their – Sheila mentioned they're going to do, they sent hospitals their performance measures a year ahead of time saying here's how you're doing and that the time is coming for them to pay. Based on prior performance, it looks like two-thirds of hospitals will have less than a one quarter percent change in their payment and almost 95 percent of them will have less than a half percent change.

And that's so small, that – to my mind, as a practicing clinician, it's hard to get me to – it would be very hard to get me to focus on something where I was most likely to have a quarter percent change in what you paid me. And so I suggest that since we're going to have to be focused on these – because accreditations are going to require it, boards are asking us to do it and so forth – I would recommend that we ask CMS to put more money into it, more dollars behind it. So I personally suggest the 10–20 percent of payment be based on performance measures as long as we can agree that they're good performance measures, or at least the best that are available.

With these numbers, I don't know if they seem large to you, but if they do I still actually think they'll have a relatively small impact on our take home pay, up or down. So if our performance kind of varies about the same way that hospital performance varies. A number of 10–20 percent is a difference of about two and a half percent to 5 percent because our performance is going to climb, kind of clump in the middle. We all tend to do kind of the same. So the variation will be a lot smaller than 10–20 percent, only about two and a half to five percent. But it would be enough to get me to feel like, yeah, the payers actually do, care about quality. That would help. At least that's my personal opinion, that's not a CMS opinion or anyone else's.

And then there's the issue of how much to pay for each measure and in their hospital pay for performance program, CMS is planning to pay for all things equally, and I actually would like some recognition that some things are harder to do than others. Sometimes it's clinically harder to do. Like, it's easier to give somebody a flu shot than it is to get their blood pressure in control. And other times it's sort of clinically and socially easier to do. Like, I find it sometimes more difficult to get good outcomes with poor patients.

They've got more going on. Harder for them to follow the medical regimen I try to give them or the exercise plan or whatever it is. And that you know, they could – CMS could pay more for achieving good outcomes in Medicaid patients than in regular patients to recognize that extra sort of degree of difficulty. I personally would prefer that.

Next slide is about when they're comparing us amongst each other and trying to figure out who to pay, how do they do it? So they could use a tournament or a threshold, and if you go to slide 24, I define those things. So a tournament is actually something they did in a demonstration project before, where they paid the top ten or 20 percent of hospitals that was in a hospital demonstration program.

A threshold is where they say well, we're only going to pay you if you get your performance on these measures about you know 50 percent, 75 percent or whatever the threshold is set at. The pros of a tournament are for CMS. They can budget. If they say have a tournament, then they know exactly how many people are going to get paid and they can put a set amount of money and they know that the most they'll spend is however much money is in that pool. And the pro – the benefit to them of a threshold is they don't pay at all for people who are below the thresholds so they don't pay any money to people for really bad performance.

But the cons of these two types – kind of approaches fall on us, the providers. In a tournament, it's hard to know what – if you're the provider, you're the doc. It's hard to know what the docs around you are going to do so it's hard to know if you're going to get paid. So, if you're trying to figure out is it worth it for me to chase this and you don't know, you know how much other

people are doing it. It makes – it just makes the decision making harder for the doc or a group of docs in practice.

And with threshold thing, wherever the threshold is set, there are bound to be some people who are just barely off from that threshold and you know if the threshold is Y and you're paying at Y + 1 and you're not paying at Y – 1, then really, probably clinically insignificant differences in performance might lead to financial differences and I would think a lot of people would be uncomfortable with that.

On the next slide, slide 25, I suggest that they just pay us. They say whatever these quality things are; they just pay us each time we do it right as an alternative, so, you know if it's blood pressure control, pay us each time that the patient's blood pressure is in control. If it's flu shots, or each time the flu shot is done. And the advantage of these are that from a provider's perspective, you get paid whenever you do well and you know the thing about thresholds or how anyone else is doing and there's always a reason to do better with the next patient. You know, if you do it right, there's more payment coming down.

The con of this is for CMS, it's harder for them to know exactly how we'll perform so it's harder for them to set a fixed exact budget. Economists in general agree that this approach is sort of freed people's minds up to focus on doing better rather than having them focus on things like who's doing how well in the tournament and what the threshold is.

Slide 26, I'll just summarize here and wrap up. So, our performance hasn't always been the best, it could be in terms of quality and/or cost, and so the Affordable Care Act requires CMS to start making payment on that. The details are not to be – are still to be worked out, so this is your opportunity to have a voice and have a say. If you haven't gotten involved, I can tell you that most of the medical societies are already trying to figure this out and it's an opportunity for you to get in there and be a part of it.

On slide 27, with respect to the focus on costs, this is only going to be one of the things that CMS and other payers are going to offer in terms of ways of

getting at costs. Also be bundled payments coming at you where accountable care organizations you could consider joining. And medical societies are also beginning to get the ideas that they have to focus on this cost thing and they're doing more appropriateness in research utilization guidelines and criteria and that would be another way for you to get involved and say something back to CMS about it.

And last slide, slide 28. In general, pay for performance is likely to work better if we, the physicians, get out there and say, "Here's the stuff that matters. I'm an endocrinologist," or whatever you are, say, "These are the key things in my specialty that ought to be measured." And then if CMS puts enough money behind that and says, OK, well, it's a significant percentage of money – is based on doing what you say is the important stuff.

So I'll stop there, Sheila.

Dr. Sheila Roman: And I'd like to move straight into the second speaker's talk and that talk is entitled Quality Measurement, Physician In-Practice Performance and the speaker is Ted von Glahn. He is the Director of Performance Information in Consumer Engagement at the Pacific Business Group on Health. Ted?

Ted von Glahn: Thank you, Sheila. I'll start us off on slide 30. Our hope is that the learning that we've had here in California over the past few years will help all of us crystallize some of the key elements of the methods that Adams was just parsing out for you. And just by way of background at PBGH, we've been managing several performance initiatives and collaboratives here in California over the years that have involved, I think, all those stakeholders that are represented on the phone today. Much of our work here is early deployment. So putting – a putting performance measures into the works and refining the methods as we go.

So what you'll see is some of the fruits of that early work and I particularly want to underscore that I stand on the shoulders of an awful lot of people that are doing terrific work here in California and elsewhere, and particularly call out the physician advisory group that has overseen a lot of our methods work and, believe me, we have plenty of back and forth and don't always agree, but

I think we've made some good headway together and that group formerly was shared by Dr. Jerry Penso down in San Diego and out by Dr. Mike Kern up here in the Bay area. And much of the methods work that you'll see here has been led by Bill Rogers, a statistician who was with the – the Institute for Clinical Research at Tufts. And I want to underscore that if any of the participants here have particular questions about the statistical techniques that I'll touch on today, we'll to follow up with Bill because he's the brain trust behind much of that.

Let me slip past 30 and 31, we're just giving you flavor for our membership, and I'll turn to slide 32. My purpose, we do want to touch on the challenges that we've grappled with and physician and group of quality measurement. Let me underscore, my conversation is about the quality measurement work. François will pick up on cost and some other aspects of this, but just to anchor you, this work is about – quality measurement that I'll speak to. So we've got some challenges there that I want to describe to you, a couple of solutions that we're proposing for consideration, and then stepping into some of the start-up years for the value-based modifier program and what we suggest we turn our eye to, and then finally we close with – trying to be grounded and a couple of accountability principles that we think will help shape the debate.

I'm going to turn now to slide 33, and here you see, just sketching out, the challenges that we've been grappling with over the last number of years now but we're going to zero-in really on the first three. This notion of sample size and reliability, the case mix – and by case mix, I'm going to use that more broadly. I'm speaking both about the patient mix and about the measures mix. So, I think there are two different elements there that we have to have our eye on. The reporting – the notion of trying to keep this simple and very complex world; and data completeness actually in areas where we've done quite a bit of work including having experiences with physicians engaging in corrections processes and removing patients from denominators and correcting enumerators and so forth, and that's not in our scope for discussion today but just to know that's another – certainly another challenge in all of this work.

Let me step over to slide 34. I want to illustrate here one of the challenges with some results of actually work we did with CMS. The so called EQI Project in 2007 where we blended the Medicare fee for service patient experience with the commercial experience here in California, and here we're expressing the adequacy of the result at a physician level using this reliability technique and what we mean by reliability in this context is this notion of explaining the variability and scores among physicians.

And if you see this at a set of .70 reliability, imagine on that spectrum of zero to one. Zero is essentially saying, we've got a random effect, we got a lot of noise and no signal, and one would be a pretty strong signal where all of that variability is identified as due to true performance differences. So, we're looking at trying to understand as much of the real difference in performance as we can.

And part of the message in this display and I think these various measures although truncated descriptions are familiar to everybody. I think this is some of the measures that we reported on in 2007 and you see that different patient sample sizes per physician that yields that 0.7 reliability or higher. And what we learned, and some of that experience was, that there were a good number of physicians in California when you combined the fee for service Medicare world with three of the largest commercial plants here in the state, so a fairly good aggregation of information. There were a good number of physicians depending upon the measure that did not have a reliable result at the individual physician level.

And you can see just by these results, some of that was landed in the cardiovascular care world where the reliability required higher sample sizes. And of course in some other areas, particularly in some of the preventive care screening, large proportions of physicians had reliable results because of the nature of those denominators and the prevalence or incidence rate that we were dealing with.

Over on page 35, just wanted to provide a little bit of a back drop on attribution, which you're seeing here is the attribution rule, that we adopted in

the physician specific work and also aggregating results up to a practice site. So, a group of physicians practicing together at one physical address and so forth. I think we landed in a pretty good place on attribution, but people can disagree on some of the particulars about attributing to a single physician, multiple physicians, and so forth, and part of this is just to say this is where we landed.

That first element describing in a primary care world – and, of course, although this is measure-specific – so, you're going through a filter of measure X and its attribution rule for specialty types and then even practice setting. So, as an example, you might have had a group of physicians who are eligible at a specialty-type level because they were family practice or internal medicine but actually removed from the measure attribution because their setting was the urgent care clinic and so forth.

We thought it would be helpful just to explain and at the lower frame of the slide, the validation steps we took. So again, as I think people debate various attribution methods, here's some evidence about validation steps that may prove useful and in vetting those methods.

Over on 36, slide 36, these are in addressing the challenges; we looked at two ways to overcome some of the things I just highlighted, whether it's the sample size, the case mix, the measure mix, and the complexity versus simplicity of reporting. So we took an approach of looking at combining like measures into composites and also a blending approach. So blending of physician practice and medical group level results – and I think this, Adams was explaining – you can kind of hang the team support notion on the second one as part of the rationale.

Its first – its first topic of creating composite scores, you see three methods that we evaluated, and I will say this audience will be blessed, but I can't explain the computational differences here so I won't weave through that. But I think it's as simple as when you think of an adjusted opportunities model, you're really thinking about the number of successes, the number of positive quality events over the number of opportunities, and the other techniques you

moved more into full statistical models, and an item response theory, and sort of this combination, it would have credit where you're looking at an opportunity score but converting it to percentile rankings.
Those are the three – three that have been used in healthcare and in other contexts. So we chose those as our three to assess. On slide 37, we're looking at the rationale for why go there. Why create composites? And you really see four pretty distinct objectives, this notion of simplicity, ease of communication, opportunity to reduce error, of fairness and also feasibility. So each of those, sort of, are pretty discrete legs to build the composite rationale, and then as we go over to slide 38.

In the notion of blending and the underlying rationale there, I think we have both. What we've seen is the empirical evidence around shared influence. Again this is back to the team sport notion. That – that empirically, we see evidence for a blending of physician and practice performance and of course then, the underpinnings of, again, a high performing care system looks to a common set of care processes; looks to an infrastructure that a practice or a group creates in a management system and the culture and leadership that are all ingredients in a recipe for good care.

So I think we've got again both some technical evidence about why blend and also some beliefs and proven processes that get us to better care. We're also trying to be sharp about the extent of – the considerable extent of heterogeneity within – among physicians within a group. And that if you're only operating at the group level, you're masking an awful lot of performance variation--that has been a clear learning in our world I think, that of others. And that last bullet is really speaking to a very practical issue of giving the mix of performance information sources that CMS Medicare program is working with, got an opportunity to work with data sets that come in at the physician level versus at the group level.

And moving on to slide 39, the approach in the blending world. Think of this concept of a borrowing technique. So, you've got a physician with a, perhaps, a sample size of X for a given measure. And X may stand alone. It may be a perfectly ample sample size to report on the result. By the way, the word

"reliability" dropped off this first sentence so it's not about improving physician's scores but rather improving its score reliability.

And then this – the notion of instances where that sample is inadequate to stand alone, a borrowing of the results at the practice and or the group level, depending upon the organizational structure to produce a reliable result of that blend. Another aspect of evidence over on slide 40 that I wanted to note is the shared influence. Here we're pulling from some recent work that we did in testing a patient-centered medical home survey, so this is about patients' experience of care and service, and here we're actually sampling only among the chronically ill and what you see are results from 17 practices, for expanding the state here in California. And, of course, those domains are pretty familiar to folks on the left hand side.

You're seeing a practice side effect and a physician effect. And you're really looking at the performance variation that's being explained. Whether we're at the site level or at the physician level, and zero-in on any of this – you can – I think the overarching takeaway is, there's a contribution in both areas to explaining performance differences. Whether we're talking about the site or the physician and, I think, intuitively these numbers, the relationship would make sense to – in most instances we see the office staff, for example, having a much larger – the practice site having a much larger affect than the individual physician.

And in the self care arena, the physician, and patient engagement about barriers to managing their condition. And the affect of, and that's really largely anchored in communication experiences, between patients and physicians, so again part of the empirical evidence for sharing an influence that's being felt from both the practice and the physician.

We highlight some of the findings from the two methods that we evaluated, so stepping into the composite world. Here you see that comparison across the three composite techniques, and I would say they were comparable on several of the key dimensions as you can see in this chart but with a couple of important differences that sort of cast the weight of the argument for us to recommend the adjusted opportunities model particularly because of its

transparency and we thought it better – it achieves some elements of fairness that are fairly important to, I think, all of us. Which is this notion of getting the mix of measures, the difficulty in the mix of measures and in the mix of patients, this model, the adjusted opportunities model, more readily handles those elements of creating a comparison score among physicians.

This next slide, moving on to slide 42, here we have the results for the blending of physician and practice results. What you see in that first pairing there is that individual measure level. So we've got in this example, four diabetes screening measures and across a large number of physicians in California. The reliability levels were quite low. So we see seven, depending upon the measures. So that's where you see the range, the seven percent to 21 percent. So across those four measures at the low end for one of the four, only seven percent of the physicians had reliable results. And at the high end, only 21 percent had reliable results.

You see a huge gain with the blending. So when we blend the physician results with their practice results, the numbers sort of leap up into that 80 percent range in terms of reliable results. The second pair of items here is talking about the composite level. So when we composite those four measures, we see 30 percent of the physicians being reliably scored. So again you can compare that 30 percent to the 7 to 21 percent range and you know, modest but important gain, I think importantly, this is illustrating – the reliability is not just about aggregating up, not just about total sample size. But it's about that the element and the variation within the unit where there's the doctor, the group and the variation among units again is – is the variation greater within as opposed to across doctors or across practice sites. So I think that's part of what's influencing the modest gain there.

Again, if we take the composite and we use a blending approach, a pretty significant improvement in the proportion of doctors who reliably reported up to the 65 percent level.

I want to switch gears a bit now and just turn to the value-based modifier implementation and a couple of elements of the implementation that from our experience, we believe, that part of the thrust here is broad participation. How

do you create a program that includes all physicians, and how do you advance the measures that matter the most? That's really the underpinnings of this recommendation.

What you're seeing with those domains, they're sort of simple examples of a handful of domains in the left hand side, running from effective care outcomes and so forth. And then again, just examples of measure topics that could be included in those domains whether we're in the cardiovascular diabetes or preventive care world. In the early years, we're recommending that the program be organized, organize these domains around the measurement's system or source the information source as a way to include more physicians.

If you don't do that and if you're blending outcomes and process and patient experience and clinical any which way you go when you start blending, you'll see attrition. Right, some number of physicians won't have reportable results because of the information systems that are available to them today. So again this is more of an early years recommendation to help include a fair – larger number of physicians at the get-go.

Over on slide 44, this is a simple example of measures that matter most. And we're actually working with some folks here in California for physicians of hospitals in the area of a dashboard for total joint replacement and, it would be our hope that, as Adams was expressing, that a number of the professional societies and others step forward with measures that matter in – particularly in the specialty care area. Where we know we've got some pretty significant gaps today, and we would encourage a parsimonious set of measures for this example and ones that, of course, are most meaningful, given the patient outcomes.

Just to note that most of the methods that I touched on here, we have applied in the real world that there have been consequences whether it's been for improvement recognition purposes, for payment, for public transparency, or consumer choice. And you're just seeing some of the programs where these methods have been applied, whether it's the IHAP for P program and the scoring of medical groups and the clinical patient experience world. A lot of our composite and reliability techniques have been used there, more than a

decade of work with the California office of patient advocate and, again, applying those methods for consumer reporting. We lead a group here in the physician performance initiative world where those attribution and reliability rules have been applied, and the exception here is the blending.

So just to be clear, the blending is a new – a technique that we've just finished some methods research work on, so that has not been applied out in our market place as of yet. And then we just close with slide 46. Just to note that I think the accountability principles that we would advocate be considered in the mix here are highlighted in those four final bullets. I think I'm at my time, so I'll close there. Sheila, I'll turn it back to you.

Dr. Sheila Roman: Thanks, Ted. That's a very comprehensive look at quality and how we'll be bringing quality into the quality composites part of the value-based modifier. I'd like to move now to our final expert who'll be speaking with the focus on cost. The title of his presentation is Physician Pay For Performance and Other Incentive Programs Lessons From the Field, and our expert speaker is François de Brantes, who is Executive Director of the Healthcare Incentives Improvement Institute. François?

François de Brantes: Thank you, Sheila. So if you go to slide 48, what is the health care incentives improvement institute, or HCI3 for short? It's a not-for-profit company that resulted from the combination of Bridges to Excellence and from PROMETHEUS Payment, and I'll get into a little bit on each one of those. And our work is really to do, to implement – to design and implement using different payment models and then observe their effects and report on those effects as much as possible.

Our zone of focus has been mostly between what you could call or think about as basic non-enhanced fee for service and basic non-enhanced capitation because we believe that, as Adams mentioned, the general volume of payment is moving beyond those two poles or in between those two poles. That's where the experimentation is going and no one really knows what the ultimate mix is going to be and for what that mix ought to be used, so that's really the focus of our work in the field.

On slide 49, just a little history on Bridges to Excellence, which was founded in the early part of the 2000s, mostly sponsored by large self-insured companies around the country. Many of the same companies were on a – Ted's slide, and our focus there was relatively simple. Let's see if we can recognize physicians who are delivering quality of care in a community, and let's then financially reward them by giving them recognition, a bonus, some kind of a financial recognition. And in addition to that, we will highlight those physicians to employees so that they could preferentially go and seek out those physicians to manage one or more chronic condition for which those physicians are recognized.

The scope of Bridges to Excellence recognized physicians, including those who are recognized by the National Committee for Quality Assurance, the NCQA, as well as other performance-based organizations around the country. It's a very small, relatively parsimonious group of organizations, but they – their job is to independently measure the performance of physicians, and here we are talking about individual physicians. Although measurement can happen also at the practice level, even if it does happen at the practice level, underneath that, this measurement of individual physicians. So to Ted's point, you know there's a blend here of both individual and group with a preference towards getting down to that individual physician measurement.

It has been primarily a threshold based performance, although as Adams suggested, we know that that has some issues associated to it that we've been trying to compensate for and I'll talk a little bit about that. Today most of the large national health plans, as well as many regional Blue Cross plans are using the Bridges to Excellence programs as a mechanism to financially reward physicians and/or highlight them into their – what they referred to most generally as the high performance networks.

What are some of the principal findings that we have published on Bridges to Excellence over the past decade? You'll find those on slide 50; they basically fall into these three relatively intuitive categories.

Number one, what you measure matters, and Ted talked a lot about that and I'll show you an example of some recent research. Our focus, of course, has

been mostly on clinical data. So the recognition programs, the performance measurement is done entirely from clinical records, not from claims data. That has been a challenge. That is becoming less and less challenging as the adoption of health information technology and electronic medical records, in particular, continues to progress.

Higher incentives lead to greater response. Again, this is sometimes – I look at this list and I think it's the – the list of the obvious, but, you know, in health care, you often have to publish the obvious for people to believe it and this has been not very different, so higher incentives lead to greater response. We've shown relatively clearly that as the amount of incentive increases, the response to that incentive also increases, and, as Adams mentioned earlier, if what you do is create an incentive program where there's essentially half of one percent fee schedules or income at risk for provider, they're not going to pay a whole heck a lot of attention nor should they.

So that amount needs to really be significantly higher if we want behaviors to shift. And, finally, and I think this is important because it goes to the core of what all the – all of us, the three speakers on this phone, have been spending a great majority of their professional careers towards, is a notion that better quality costs less. And we know that from our work and we've published that. We've seen very clearly the physicians who are recognized, so we therefore have better results in the quality of the management of the patients with chronic conditions; also end up by having lower overall episode cost of care relative to match non-recognized physicians.

So next slide 51, why measuring matters. And I think this is instructive at a couple of levels, this chart. First of all, it's comparing physicians who are recognized by the NCQA as with a patient-centered medical home recognitions. So as you'd know, that's a survey, the physicians fill out, attesting that they have certain systems in place.

In this particular community, there was an additional performance of measurement being done and that was a clinical performance measurement done three domains, diabetes, CAD, asthma. And what we ended up doing is looking at the comparative episode cost of care for these six chronic

conditions, and what we noticed is that physicians were doing much better. The PCMH physicians were doing much better in the domains that they were also reporting – for which they were also reporting clinical measures.

So the mere fact of filling out a survey that designates you as a PCMH or non-PCMH doesn't seem to have much of a statistical effect on cost of care. But the act of looking at a specific quality measures associated to specific domain actually does have an effect. And again this is consistent with what Adams talked about, consistent with Ted – what Ted talked about, and I think it's instructive for CMS as it thinks about the quality component of its value modifier. Structure is important, but it's not that important. What really matters is ultimately these – either intermediate outcomes or other measures of quality of care tied to a specific domain.

So let's move from, you know, the measurement of quality to talking a little bit about the cost side of the equation. Because really, ultimately what we're talking about are reward mechanisms, and so, in slide 52, what I'm highlighting here are a couple of things.

One is, the private sector has very much evolved from what was the model in 2002, which was essentially a straight bonus. Once a physician was recognized, it's a threshold based program, as Adams mentioned. You reach a certain threshold, you get a certain reward. That still is occurring in some levels although the slight modification to that, to introduce more of this concept of continuing performance and rewarding continuing performance has been to establish tiers of recognitions.

So that as you go from a base tier to a higher tier, your general quality performance improves. You reach your new threshold and you get an additional reward. And that's a step function we know that, again has some issues but at least it starts introducing this notion of your performance matters, you need to be judged against your own performance. We're going to encourage you to improve that performance over time as you do better for the next patient, you will get something else.

So that has moved from this fixed bonus idea to more of a variable bonus. And as you do that and as we've done that, we've also shifted from some actuarially defined bonus to more of an episode cost construct where we're looking at the cost of care associated to the management of the patient with a specific chronic condition or a group of chronic conditions, and, here, the formula is again today, relatively simple. There's no downside, it's mostly upside.

You calculate whether or not this is surplus, i.e., the actual costs of care are lower than the budgeted cost of care and if so then you could start creating – you can start thinking about ways of distributing that surplus. Physicians again were migrating to this notion where physicians are being measured against their own performance. So if you set a budget at the patient level for a patient managed by a physician, you're really looking and saying to that physician, what matters is your performance. That budget is set to that patient based on your management, not some artificial construct of comparison between you and someone else.

So, this kind of leads us to this notion again of how do you calculate cost of care? And in our world what we really focused on, again, are episode costs of care. And our foundation has been the work around the Prometheus Payment model and so summarized on page 53. That effort started in the middle of the last decade, funded by both the Commonwealth Fund and Robert Wood Johnson Foundation. And the purpose, initially, was to define these Evidence-informed Case Rates, or ECRs, which are severity-adjusted at the individual patient level.

So, you try to get away from the small sample size issue that Ted talked about by really creating your statistical models on a population of patients and then creating an expected budget, severity adjusted for that individual patient. You include co-morbidities. So then, you take into account not just the management of a diabetes but, as both Adams and Ted mentioned, we believe that managing patients especially those with chronic conditions is a team sport, has to be a team sport. So therefore you want to include co-morbid conditions and you want to look not just as what tightly what an individual

physician does but also what happens to that patient as that patient encounters other physicians. And you can – through some level of clinical prioritization , you can slide a patient into one kind of these lumpy chronic care episodes as opposed to another.

What's important here in this concept of value-based payment as opposed to looking separately at cost and separately at quality, is that you want to include a quality scorecard component that matches the cost component. So, if you're looking at a cost of care for patients who have a chronic condition, of course you want to create a scorecard that's going to look again not just tightly at one chronic condition but also at other chronic conditions. So that you're trying as best you can of matching the domain of measurement on cost with the domain of measurement on quality.

So let me give you an example of how you can start blending these concepts together and you have that on slide 54. And assume a physician with a mix of about 500 patients that have different chronic conditions. Some of them might have just diabetes; some of them might have diabetes and CAD. Some of them might have diabetes, CAD, and COPD, and so on and so forth. But you know altogether, there's about 500 of these. The episodes we refer to again as ECRs, are going to be perspectively budgeted for each one of those 500 patients excluding care not associated to the chronic condition.

So we're not going to include the random rash that the patient might have, the flu the patient might have, maybe a small accident or fever break, or any other procedure or issue that's not related to the management of those chronic conditions. And then we're going – we're going to – once we've established these budgets that's done perspectively, so in the beginning of 2012, we can create a prospective budget for 2012. That will establish the guide post for the physicians about what the expected budget for the managed patients are.

And then at the end of the year, you compare the actual budget. So, you don't wait to the end of the year to say what would have been the budget if I have calculated the budget in the beginning of the year which seems to be a completely artificial process. Instead, you set the budget in the beginning of the year and then you look at what happens once the year has been completed.

And the extent, again, to which the actual is lower than the budget, there is a surplus to be distributed and that's where you start tying the scorecard's score.

So the way we're implementing some of these new programs is that – let's assume that on these 500 patients, there's a distributable bonus of a million dollars. But the scorecard score, the physician is 85 percent, then the physician is going to get $850,000. So back to the concept that Adams talked about relative to rewarding the incremental performance, if the physician gets an 86 percent as opposed to an 85 percent, then they're going to get a higher bonus. So there is a continuous incentive to do better and better for the next patient that comes in.

On slide 55, some, again, important principles and design elements around these types of programs. One is that we've, again – because we feel that especially for the management of the patients with chronic conditions, it ought to be a team support. We like the multi-attribution of the patients and it's a relatively easy process and it allows you to understand what is that natural referral network around which the patient receives their care. And whether the physicians are all understand what that natural referral network is or not, they are de facto joined around that individual patient.

So you can create a one-to-many attribution which allows the prospective budget to be split between, you know, from the whether a percentage formula between different practicing physicians who again are all managing or co-managing this patient, and you're going to hold them accountable for their portion of the budget if you will.

They are compared to themselves, I mentioned that before, and I think that's an important principle because it's an incredibly problematic pay for performance design issue when you have these tournament style effects where you actually don't know where you're going to end up at the end of the year or how your performance is going to be judged because you have no idea how everyone else is going to do. So if you have a budget, that's yours. You understand what you – what it is and that's what you're going to be held

Importantly, budgets are budgets, so they're not – it's not a prospectively paid mechanism. It's really a prospectively said budget and then on the back-end you can have fee for service reconciliations where you look again at actual cost against budgets and there might be a distribution. For those of you who think that this is a – it sounds familiar because that is the formula that the Centers for Medicare and Medicaid Innovation is using in its bundle of payment pilot. When they refer to us models two and three where the provider establishes the perspective budget and then CMS is going to continue to pay fee for service and there's a back-end reconciliation and a true up, if you will, up or down based on what the established budget was ahead of time.

So, if you think about that specific concept, it's one where you end up with surpluses and deficits. And you can convert that surplus or that deficit essentially into a value modifier. Because if you're doing well, you have a surplus, then that tied to a scorecard score can lead to an increase in fees schedules. If you have a consistent deficit, then that tied to a scorecard score can lead to a negative value modifying – modification of your fee schedules. And I put an example on slide 57 that you can turn to and then we'll turn it back to Sheila for questions and answers. But, again, think about this as a physician who realizes a $40,000.00, so not a huge amount, but a $40,000.00 surplus across attributed patients.

The average performance is – it appears as about 30,000, so you can calculate a score exposed of cost performance of that particular physician. You can tie that to a score on a scorecard and blend both together to get some kind of a value score. So this is just an example of how you can create a quality adjusted cost score which means you first start by calculating cost then you apply quality. Of course, you can do the opposite of creating first quality thresholds, as Ted talked about, and then potentially applying a cost factor to it. And there's no right or wrong answer here, and I think both have pros and cons that will be, I'm sure, debated over the next several months as CMS continues to listen to the field.

Some closing thoughts on slide 58, yes, there have been forms of value-based purchasing now around for a couple of decades. We've all learned a

tremendous amount from them. I think what does – from my experience what absolutely does seem to work is you need to set the bar above average. And so some threshold of performance should be set above average because you want to encourage performance to be better than average, you need to reward individual achievement against individual benchmarks. There's no question about that, but, you know, I think one – big policy question is, again, do you want to set at least the minimum threshold of performance, or is it OK for someone to start at the bottom and be rewarded for improvement that doesn't even get them to the average?

Or, do you reward that differentially for the person who's already way above average and whose incremental improvement is going to be relatively difficult? So these are really important policy questions that CMS is going to have to wrestle with. Another important point is this notion of the predictability of potential gain or loss. If you have no predictability in gain or loss then it's very difficult to ask commitment and resources and effort on the part of physicians towards any kind of quality or cost-based improvement and then the speed and action-ability of feedback. That's an essential component; you cannot wait a year and a half to give feedback on two years ago worth of performance because it's a long pass.

Somehow CMS is going to have to wrestle with giving somewhere close to every six months maybe – hopefully down to quarterly responses or reports back to physicians in the field because otherwise it's just incredibly difficult to get to continuous improvement. And then, I think, finally, our big lesson learned is you can't – you're never going to please everyone in designing these projects and so you shouldn't even try. Just figure out how to work in so that it accomplishes the policy goals, knowing full well that five percent of the recipients are going to hate it, 10 percent are going to be, you know, really against it, and tend to balance or find a way to make it work.

And so with that, Sheila, I'll pass it back to you.

Dr. Sheila Roman: OK, Thank you.

Nicole Cooney: And this is Nicole, I just want to jump in really quickly and thank our presenters. There's a wealth of information that's been presented today for us

to consider. I'd like to just acknowledge that we are running a little bit behind schedule, so we're going to zip through the next few items on the agenda to allow time for participant Q&A. Sheila, I'll turn it over to you.

Dr. Sheila Roman: Yes. And thank you very much. You know I think that you have put in a structure for us, some of the salient questions that we're trying to grapple with. I guess I would throw out just a couple of questions and then I do want to move on quickly to public comments since we are running late. But how much – given that the statute allows us to apply the value modifier both at the group and the individual level. I think we've heard from a number of speakers about different approaches to individual versus group reporting. I would ask the speakers if they would comment on how much emphasis they would place to performance measurement at the individual versus group level. It's something that comes up quite often in our discussions here.

Adams Dudley: Well, one option. So first of all, I think that the main thing you need is to hear from the physician community by how they think they would like it. So I have in my own mind, this is Adams Dudley, by the way. I have in my own mind how my practice goes. But other people are in different situations. But a possibility or a possible response for CMS is to tend or to err on the side of pain up to the group. And then allowing the group to decide amongst themselves on how much do we push that back down to the individual physician, or how do much do we think of this as a team activity?

And, in general, where there are groups, there have been a variety of responses to that. Some groups have kept all the money and said, "We're going to use this to improve our systems overall." And presumably, their physicians are OK with that or they can (inaudible) and leave the group. And others have pushed it down to the individual physician a lot.

Ted von Glahn: This is Ted von Glahn. I would promote the notion of – the amount should be material with both so that I do think, again, the evidence shows us that both the individual physician and the practice have an important influence on value. And so I wouldn't – there's no argument in this empirical evidence that it should be de-minimize for either party.

Dr. Sheila Roman: OK. And François, you seemed to invoke pushing to the – pushing as hard as you can to get to the individual level. Do you have any further comment?

François de Brantes: No. the challenge here is going to be – and it's less of a challenge honestly for CMS than it has been on the private sector. We struggle continuously with sample sizes. In our work, we use mitigated for that by taking full sample of patients within an individual patient practice. So we've essentially said, it doesn't matter whether the patient is Medicare, Medicaid, commercial. Let's look at the outcomes in the quality of care for all those patients. That's a concerning a point, by the way, for me in the more recent PQRS, I think in the more recent PQRS direction of wanting exclusively the practice to report on Medicare patients.

One of the – I think the important principle is, we don't want physicians to practice differently on any class of patients. And so asking them to do a reporting that focuses their entire attention on one class of patient as opposed to another is actually detrimental for one class over another. So we – I think you get half sample sizes in particular is your measuring quality. If you don't focus on an individual class of patients but you really look at what's happening in the practice overall, and at that point, you can get down to the individual physician for the most part, not for everything but for the most part.

Dr. Sheila Roman: OK. Thank you. And given that getting down to the individual level is so hard from a reliability measure as Ted von Glahn showed so clearly, I think in his discussion. How do you approach the quality measures that you choose? Do you have physicians choose their own measures – as has been the practice in the physician's quality reporting system? Do you have a core set of measures that you have asked your physicians to be responsible for? And finally, how do you then deal with the reliability of the measures themselves?

Ted von Glahn: This is Ted von Glahn. One thought is, if the physicians were to have the flexibility to choose their own measures, which I would not advocate. But if that was the case then, I think sort of competing that would be a requirement that they have sufficient patient sample sizes to be reliably reported, that they're participating in reporting mechanisms so that they can stand alone on their performance.

Adams Dudley: And this Adams Dudley. I would add to that. Not only that they have to have sufficient sample size on the measures in which they choose to report but also some way of checking that that's the core of what they do. That there aren't large opportunities to measure in other areas because they see a lot of patients for which there would be some other set of quality measures and those things are being left alone.

What you want is a system that says definition, "hey, for the essential of what you do, we will reward you if you do better." And that means that you want them to have enough patients of that type and you also wanted to cover all the key things that you do not just say, "Oh well, wait for me to manage this, just to focus on one thing that I know I can do well in."

Dr. Sheila Roman: And just very quickly, one last question from me and then we'll open it up for the audience. How can the CMS value modifier program complement private pay for performance programs?

François de Brantes: Well, look, I think it's by continuing these kinds of dialogues and trying as much as possible to ensure that there's some level of harmonization in particular, around the cost component of the value modifier.

How you measure cost, how you assess that and attribute it, I think it's still a field that most of us on the private sector are continuing to experiment or grapple with. Ultimately, there's going to be some convergence when CMS makes a number of decisions. And the more the dialogue stays open between CMS and the private sector on methodologies, not forgetting that we deal with populations that are different. And so – and that's OK. But that might mean CMS in some instances giving way a little bit to the demands of the private sector because some of our needs might be slightly different and I think to me, that's probably the most important issue.

Adams Dudley: And so – this is Adams Dudley again. I would highlight, so that the most important are of alignment is on the definition of and standards for the measurement. So if the private sector pays a different way or has a different kind of formula for, say, diabetes then CMS does. That won't be nearly as

bothersome as just the private sector wants to measure one thing and Medicare wants to measure another thing.

Ted von Glahn: I think those are the right priorities, and this is Ted von Glahn. I would add as on the next rung is the measurement system alignment. Everyone grapples with the burden issue here around measurement reporting and we should have an eye to whether our opportunities to further align between the private and public sectors around the actual information processes– that's to everybody's benefit.

Dr. Sheila Roman: OK. Thank you very much. I think it's been a great discussion. I'm going to hand the mic, if you will, back over to Nicole and then, we'll open up the call to questions from the public.

Polling

Nicole Cooney: Thanks, Sheila. At this time, we'll pause for just a few brief 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 that there may be moments of silence while we tabulate the results. Holley, we're ready to start the polling.

Operator: CMS greatly appreciates that many of you minimized 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 and attendants 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 in the room, 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 listening in, enter the corresponding number between two eight. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

That does conclude the polling session for today's call. We will now move in to the Q and A session.

To ask a question, press star, followed by the number 1 on your touch tone 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 hand set before asking your question to assure clarity.

Please note, your line will remain open during the time you are asking your question. So anything you say or any background noise will be heard in the conference.

Question and Answer Session

And your first question does come from the line of Judy Burleson.

Judy Burleson: Hi. This is Judy Burleson at the American College of Radiology. And so my question is, recognizing that the physician value-based purchasing statute mandates the payment modifier be eventually applied to all physicians, it would be very interesting to hear from the three of you, the experts in private practice, how you would see the principles and designs that you've discussed applied towards individual physicians or practices that provide ancillary services such as imaging.

For example, the current CMS model in the resource news reports contributes imaging cost to trading physicians. How would you, or do you measure, the radiologist or imaging provider cost performance? Imaging has such a big impact on the cost. And then with the idea of pairing quality and cost measures by condition or topic, that makes it even more complex as the –

quality measures that are used may not be attributed to the ancillary service physician.

Dr. Sheila Roman: François, do you want to take the first stab at that?

François de Brantes: Sure. All right, that's a good question. And I'm going to maybe give you some more general answers than you'd like because I'm not sure we have time to get into huge specifics.

Number one, and you bring up an important point that I didn't make that I should have. This notion of pairing one-for-one for one quality measures and cost measures is a fool's errand. So in other words, cost and calculating cost, for example, for an episode of a patient with diabetes is going to include, likely, most all patients with diabetes. And when you look on the – for example, at performance classic quality measures for diabetes, there's a whole list of exclusions that applied for very legitimate reasons when you're measuring quality. You would not want to apply those same exclusions when measuring cost. And there are lots of reasons that I'm not going to get into. So I want to first lay out and set straight the fact that I would not – never recommend that CMS try a one-for-one match between quality measures and cost measures.

The two streams will be measured separately but, as I mentioned and it's in my slides, you can bring these elements together in a value index simply by having separate scores for each. As it pertains specifically to radiology and, I think I'm going to kind of again echo what Adams and Ted had talked about. We all believe this is a team sport. And I know that all the physicians and all the medical specialty societies are all worried about "my little place in the world," and, "I'm just an anesthesiologist," "I'm just a radiologist and I'm doing a specific image study and how can I possibly be responsible for the massive amounts or tests that are being ordered by my colleagues."
And I would say in our world, too bad, you're part of the team whether you like it or not. And we're going to judge your performance based on what happens to the patient as a whole. And it's not what some people want to hear, but I think it is a reality that measuring cost in a meaningful fashion is going to be measuring the team around the patient.

It's not going to be measuring the individual actions of an individual physician or client's physician that precepts my – that's my opinion, it's not CMS'.

Adams Dudley: And Sheila, this is Adams, can I join in?

Dr. Sheila Roman: OK.

Adams Dudley: So, I would – and I do it to hopefully be reassuring on this topic. So I think what you want if you're the – from American College of Radiology, you want to help people think what's appropriate thing for radiologists to be held accountable for, and how would that work out? So, and it will depend on which payment model we're talking about. So, in an accountable care organization that might be a great set up for you to say, "Oh well, we the radiologists will work with the ordering physicians to figure out appropriateness of this or in any situation in which the ordering physician is being held responsible for things."

The radiologist could work out with the ordering physicians some sort of method of sharing the benefits, of figuring out the most efficient way to do that. But it might be, and there are going to be some areas in the country where it's too hard to organize that, where the practice at the primary care level is very fragmented. In those situations, with the radiologist should do is respond with things that nonetheless do make sense for them to be measured on. So, for instance, what is the radiation dose for a chest CT? It can be higher or lower, and historically we've just gone with high and make sure we've had good image quality. And these days, people are saying, "Well, that may not actually be safe for the patient."

And so, finding those things, the world is trying to hear from you and finding those areas where, you know, you feel like you can take responsibility or what the conditions are under which you could take responsibility is the key thing for you to do next. At the American College of Radiology, you are in an unusual position compared to some other types of providers that certainly are types of providers that people are thinking about. But as long as you don't go

around saying, “Well, this is stupid and it shouldn’t apply to us,” which people – it doesn’t seem like people are going to accept. Then I think there’s definitely interest in hearing what you think would be a salient measure to your practice and a meaningful way to measure what you’re doing going forward and to pay for what you’re doing going forward. I think you should view it as an opportunity, not a scary thing.

Dr. Sheila Roman: Can we move on the next question, please?

Nicole Cooney: Thank you, Judy, for your question.

Operator: The next question comes from the line of (Kent Moore).

Bruce Bradley: Hi, this is Bruce Bradley from the American Academy of Family Physicians, and I wanted to weigh in on the group reporting versus individual. I think that for all the reasons you mentioned, the group reporting option is proper for payment and judgment. But with that report really should go all the NPI data if it makes up that group so that people trying to manage that group’s performance can combine it with internal data that you may not have to make meaningful changes within their own systems.

So, if you’re going to set up a reporting system, make sure that you can give back individual data even though that data might not have adequate statistical power for the purpose of payment or judgment.

Dr. Sheila Roman: Any comment from any of our experts?

Ted von Glahn: Bruce is always right.

Adams Dudley: Yes, this is Adams. I agree with Bruce, but it may seem like it will not be the same. But the reality is that in many instances in the past, payers have not done that. And so CMS needs to be able to make sure that a) they can give the data back and b) that it can be done in a timely fashion. So, during the way of competition in the 1990s, one of the most destructive patterns was that insurance companies wanted to negotiate drug capitation with providers and hold them responsible for drug costs. And that seemed initially to make sense

to – or at least to be possible or plausible – because we do write the prescriptions. But then we the providers discovered, well the insurance companies aren't able to get the pharmacy data back to us without an 18-month lag.

So we're held responsible for something where we can't actually manage it because we just don't get the information. And that was – that was very damaging to the ability of providers to function well under a drug capitation.

Bruce Bradley: That's still a problem with this system.

Adams Dudley: CMS – sorry.

Bruce Bradley: Reports…

Adams Dudley: CMS does seem to have a great history of getting claims data processed real fast.

Bruce Bradley: Big problem.

Nicole Cooney: Hi everyone, this is Nicole Cooney. And Bruce, thank you very much for your comment. I'm very sorry that we – our speaker – two of our speakers actually do have a conflict at 4 o'clock. So we will not be able to take any more questions at this time. We do have a way for those of you who have questions and comments to submit them to us. You can e-mail them to qrur@cms.hhs.gov. I'll repeat that again, I'd like to turn over to Sheila for just a few closing thoughts, I'll repeat that address after that.

Dr. Sheila Roman: I would – first of all, like to thank our speakers today for their excellent presentations. I think that, you know, CMS has heard from the private sector a number of things that we've been grappling with. And some ways that the private sector has come up with solutions and we'll be – thinking about that and probably coming back for some conversation to follow with you.

So, I think this has been very productive for us as a listening session. Today, I would encourage the folks on the phone if you may have had questions to

send to us and we'll do our best to respond to you. And I think I'll turn the program over now to Nicole Cooney.

Nicole Cooney: I just wanted to point out that on slide 60, you'll find information and a URL to evaluate your experience with today's National Provider Call. Evaluations are anonymous and strictly confidential. I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls Resource box within two business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you've already completed the evaluation. We appreciate your feedback.

I'm very sorry that we ran out of time during our Q and A session today. If we did not get to your question or comment, you can e-mail it again to qrur@cms.hhs.gov, again that's qrur@cms.hhs.gov. Please note that while we will not be able to address every question, we will review them all to help us develop frequently asked questions, educational products, and future messaging on this program.

We'd like to thank everyone for participating in today's call, and audio recording and written transcript will be posted to the physician feedback program page on the CMS Web site. You can see the final slide in our presentation for the URL. And this should be available in approximately two to four weeks. Also in our final slide is the date for the next call in this series, Wednesday, March 14. We will announce registration as soon as – as it is available.

Again, my name is Nicole Cooney and it has been a pleasure serving as your moderator today. I would like to thank Dr. Sheila Roman, Dr. Adams Dudley, Ted von Glahn, and François de Brantes for their presentation. Have a great day everyone.

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

END