



Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs

CMS Special National Provider Call Series
Physician Feedback and Value-Based Modifier Program
Wednesday, February 29, 2012

Purpose of the Special National Provider Call

- To provide CMS with input on the best practices and lessons learned from physician Pay-for-Performance programs in the private sector.
- To gain information so that CMS will be complementary to physician Pay-for-Performance programs in the private sector as CMS develops a value-based payment modifier.
- To obtain stakeholder input on current private sector Pay-for-Performance programs.



Agenda

- Opening Comments and Background – Sheila Roman, MD, MPH
 - Background on the Value-Based Payment Modifier
 - Introduction of Speakers
- Using Physician Pay-for-Performance to Improve Care – R. Adams Dudley, MD, MBA
- Quality Measurement: Physician & Practice Performance – Ted von Glahn, MPH
- Physician Pay-for-Performance and Other Incentive Programs: Lessons From The Field – Francois de Brantes, MS, MBA
- CMS Questions and Comment
- General Question and Answer Session
- Closing – Sheila Roman, MD





Background

Sheila Roman, MD, MPH
Senior Medical Officer
Performance-Based Payment Policy Group
Center for Medicare

What is the Value-Based Payment Modifier?

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 cost.

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.



What is the Implementation Timeline for the Value-Based Payment Modifier?

2013

- The initial performance period is slated to begin in 2013, meaning services provided during calendar year 2013 will be used in calculating the 2015 modifier.

2015

- Beginning in 2015, the Value-Based Payment Modifier will be phased-in over a two-year period
- In 2015 the HHS Secretary has discretion to apply the Value-Based Payment Modifier to specific physicians and/or groups of physicians that he/she deems appropriate.

2016

- In 2016 the HHS Secretary will continue his/her efforts to apply the Value-Based Payment Modifier to specific physicians and/or groups of physicians that he/she deems appropriate.

2017

- Beginning in 2017, the Value-Based Payment Modifier will apply to most or all physicians who submit claims under the Medicare physician fee schedule.



Using Physician Pay-for-Performance to Improve Physician Care

R. Adams Dudley, M.D., M.B.A.
Professor of Medicine and Health Policy
Associate Director, Research
Philip R. Lee Institute for Health Policy Studies
Principal Investigator, Bioinformatics Lab
University of California, San Francisco

The views expressed in this presentation are those of the speaker and do not represent the views of CMS.

Outline

- Why do Pay-for-Performance?
- Who should receive the payment adjustment?
- Affordable Care Act calls for quality, cost composites
- How much to adjust payment (overall and per measure)?
- Tournaments, thresholds, and other approaches to adjusting payment



Why do Pay-for-Performance?



Why Pay to Increase Quality, Lower Cost?

- Strong evidence that quality varies in ways that are bad for patients
 - From asthma to Urinary Tract Infection (UTI), for adherence to guidelines, we tend to perform in the 55-75% range*



*Source: McGlynn, et al., *NEJM* 2003, 348:2635-45

Why Pay to Increase Quality, Lower Cost?

- Strong evidence that cost and utilization vary
 - For instance, rates of coronary stenting vary several-fold from one region of the country to another
 - Less clear whether this hurts patients...it could reflect variation in patient preferences



Why Pay to Increase Quality, Lower Cost?

- Policymakers are adopting Pay-for-Performance to get physicians to work with their specialty societies to:
 - achieve consensus about what constitutes high quality care (guidelines), and
 - achieve better agreement about what care is necessary, then
 - pay for care that is needed and is done right.
- Viewed as preferable to fee-for-service that includes no value component (pay solely for doing more).



Who Should Receive the Pay?



Who Should Receive the Pay?

Options:

- Individual physicians
- The practice site (if applicable)
- The medical group (if applicable)

Issue:

- Reward the final decision-maker or
- Focus on the idea that much of modern health care is a team sport



Affordable Care Act Calls for Quality, Cost Composites



How Should Quality be Measured?

- Quality measures could include:
 - structural measures, like adopting an Electronic Health Record (EHR)
 - process measures, such as checking blood pressure
 - outcomes, such as whether blood pressure is in control or even stroke rate
- Methods not specified in the statute, so clinicians have time now to propose meaningful measures that capture the essence of the medical care they provide



Affordable Care Act Also Requires CMS to Consider Resource Use Measures

- Such measures could include:
 - Assessing resource use for certain conditions, such as antibiotics in acute bronchitis
 - Evaluating appropriateness, as with the American College of Cardiology’s “Appropriate Use Criteria” for coronary revascularization
- Clinicians can propose meaningful measures to CMS

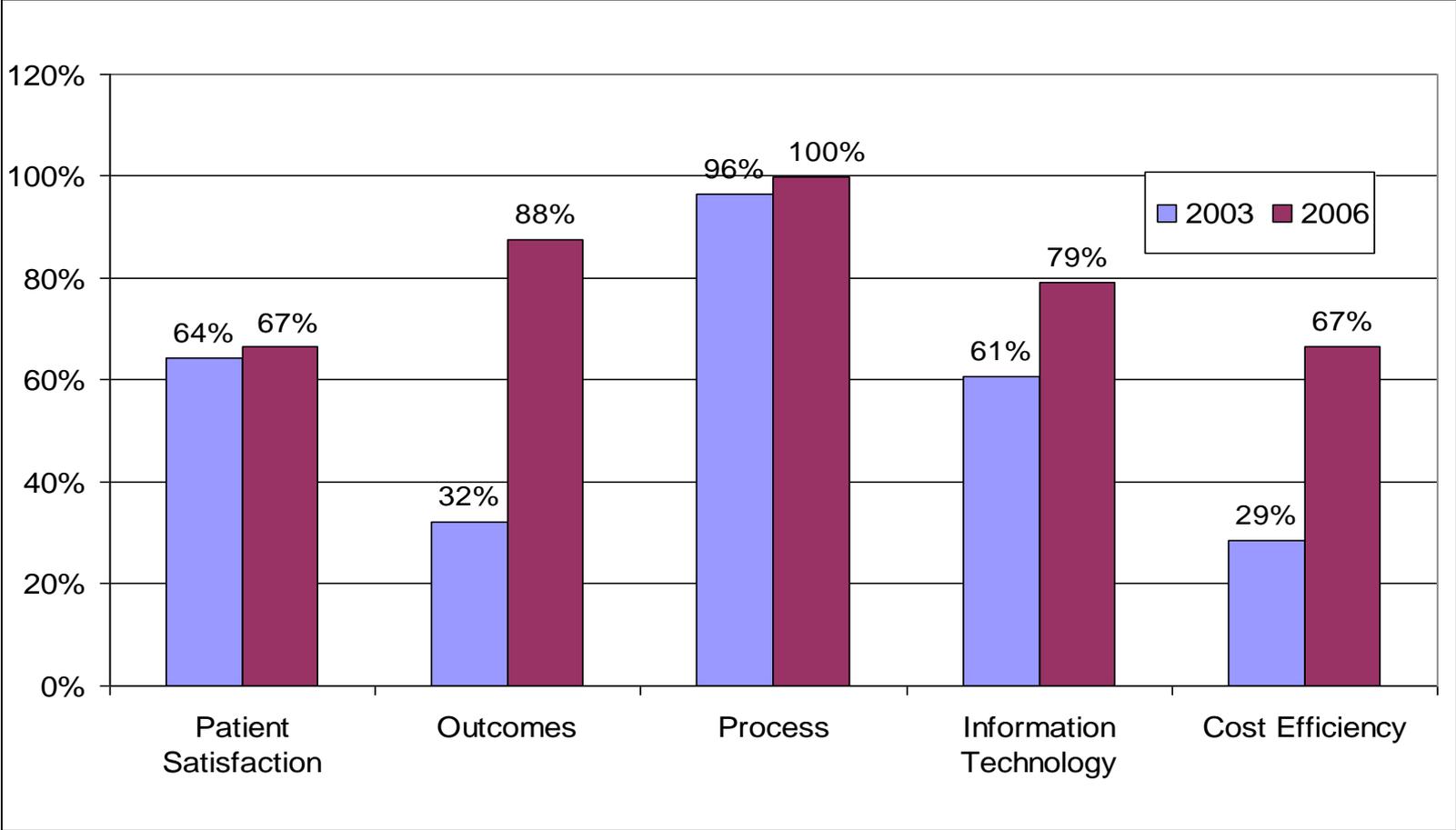


How Should Cost be Measured?

- Statute requires CMS to use:
 - Composite of cost measures
- Again, clinicians can propose meaningful measures to CMS



Commercial Health Plan P4P: Increasing Emphasis on Outcomes, IT, Cost-Efficiency



Source: Rosenthal et al., Climbing Up the Pay-for-Performance Learning Curve..., *Health Affairs*, 2007. 26(6): 1674.

How Much to Adjust Payment (Overall and Per Measure)



How Much to Adjust Payment Overall?

- Hospitals tend to have similar performance. By putting only 1% in the hospital Pay-for-Performance pool, CMS ended up with only small differences in pay:
 - Two-thirds of hospitals have less than 0.25% change, almost 95% have less than 0.5%
- To make it worthwhile to physicians to track their performance, I suggest 10-20% of pay be performance-based under a fully implemented system:
 - If physician performance clusters like hospitals do, this would have most physicians seeing only 2.5-5% difference in take home, but would send a signal that quality matters



How Much Payment Adjustment For Each Measure?

- In CMS' hospital Pay-for-Performance, all things are weighted equally
- However, it would be possible to adjust pay according to how difficult something is to achieve
 - For instance, it is harder to get good outcomes with poorer patients, so high quality with Medicaid patients could be more highly rewarded than for other patients



Tournaments, Thresholds, and Other Approaches to Adjusting Payment



Pros and Cons of Tournaments and Thresholds

- Definitions
 - Tournament = Only top X% get paid
 - Threshold = You only get bonus if your performance is above Y%
- Pros
 - Tournament = Can budget exactly how much you will pay
 - Threshold = Don't pay at all for really bad performance
- Cons
 - Tournament = It's hard to know what others will do, so it's hard to know if you'll get paid.
 - Threshold = Is Y-1% really that different from Y+1%?



An Alternative to Tournaments or Thresholds

- Pros
 - You get paid whenever you do well, without regard to thresholds or anyone else's performance
 - There's always a reason to do better with the next patient
- Cons
 - It's hard to know how we will perform, and hence how much to budget for bonus payments
- Economists generally agree pros outweigh cons.
 - Werner, RM, Dudley, RA. Making the "Pay" Matter in Pay-for-Performance: Implications for Payment Strategies. Health Affairs, 2009; 28(5):1498



Summary

- Our performance is not always optimal, and the Affordable Care Act requires that CMS begin to adjust payments based on quality and cost to drive us to improve
- However, the details are still to be worked out, including what to measure and how much to pay
- Many medical societies are starting to offer ways to measure the most important aspects of quality, for quality improvement, transparency, and payment purposes



Summary

- If the focus is on cost, this is likely to require other payment reforms and the impact on quality is uncertain
- However, medical societies are increasingly offering guidelines about appropriateness or resource utilization in very specific situations, which might be ways of increasing quality while also lowering cost



Summary

- In general, Pay-for-Performance is likely to work better if physicians push for measurement of things that really matter, and for a payment reform that has at least 10-20% of payment based on quality





Quality Measurement: Physician & Practice Performance

Ted von Glahn
Director Performance Information and
Consumer Engagement

The views expressed in this presentation are those of the speaker and do not represent the views of CMS.

PBGH: Our Members Our Mission

- The Pacific Business Group on Health helps employers improve the quality of health care and limit health care cost increases for their employees.
- Our 50 members spend 12 billion dollars annually to provide health care coverage to more than three million employees, retirees and dependents in California alone.

PBGH Vision

A health care system transparent about the quality, cost and outcomes of care, where consumers are motivated to seek the right care at the right price and providers are incentivized to offer better quality, more affordable care.



PBGH Members



Purpose

1. Challenges to Physician & Group Quality Measurement

- Small Samples
- Case Mix
- Reporting
- Data Completeness

2. Candidate Solutions to Overcome Challenges

- Composite Scoring
- Blending Physician, Practice, & Group Results

3. Implementing Value-Based Payment: Incremental Steps

- Organize Quality Domains by Measurement System
- Adopt Specialty Care Composites

4. Physician Value Modifier Accountability Principles

- Shared Physician & Group Accountability
- Advance to Outcomes
- Feasible
- Fair



Measuring Physician Quality: Challenges

Quality performance scoring at the physician level is challenged by:

- Smaller sample sizes/lower reliability – proportion of variability in performance that can be explained by real performance differences
- Case mix – differences in measure achievement difficulty and patient mix
- Reporting – peer comparisons; simplify information when multiple measures
- Data completeness
 - Measures gaps across specialties
 - Missing data – coding, error, etc.
 - Data fragmented across insurers



Reliable Results: Patient Sample Sizes Per MD

Measure	Number of Patients Yield 0.70 Reliability
Arthritis Anti-Rheumatic Med	18
Breast Cancer Screening	47
Cervical Cancer Screening	22
Colorectal Cancer Screening	18
Diabetes A1c Screening	25
Diabetes Nephropathy Screen	20
CAD LDL Lowering Med	41
Heart Failure Pts Warfarin Med	62
Cardiac Pts Had LDL Screen	29
Monitor Persistent Meds	26

Blend of California Medicare and commercial insured patients

Attribute Patient to Physician & to Practice

Attribute patient to single Primary Care Physician (PCP) with whom patient had most ambulatory E&M visits in measurement year and year prior.*

Attribute patient to all measure-relevant specialists with whom patient had at least one Evaluation and Management (E&M) visit.

For medical practice attribution assign patient to practice with whom patient had most ambulatory E&M visits (patients attributed to MDs and then to practice).

Validation

- 68% of HMO patients were attributed to assigned PCP
- 74% of patients attributed to PCP for chronic care had 2 or more visits
- 89% of patients attributed to PCP for preventive care had 2 or more visits
- No difference in physician average scores between 2 attribution rules tested



*tiebreaker: assign patient per most recent visit

Measuring Physician Quality: Resolving the Challenges

We assessed two ways to overcome sample size, case mix and reporting challenges:

1. Combining like-measures into composite scores, three methods tested
 - Adjusted Opportunities
 - IRT (Item Response Theory)
 - PRIDIT (Principal Component Analysis of RIDITs)
2. Blending physician and practice and/or group-level results



Create Composites to Produce Quality Scores

Rationale

- Simplify and communicate multiple, important domains of health
- Reduce measurement error by combining samples across measures to produce reliable scores
- Incorporate methods to address differences in measure achievement difficulty and patient case mix
- Organize measures by data sources/measurement system and produce performance results for more physicians and groups across spectrum of information capabilities



Blending Physician, Practice & Group Results to Produce Quality Scores

Rationale

- Physician, practice & group each contribute strongly to performance
 - Roughly one-third of diabetes performance variance explained by physician, practice, & group respectively
- Physicians in a practice/group increasingly sharing care processes, business systems, and leadership/culture to achieve patient care excellence, but...
- Considerable performance heterogeneity among physicians within group
- Blending physician and practice/group more efficient use of information
- CMS performance information programs mix of group and physician reporting



Blending Physician, Practice & Group Results to Produce Quality Scores

Approach

- Borrow information from practice and group performance results to improve physician scores
- Weight applied to physician-only results varies depending upon physician's patient sample size
- Variance component analyses produced factors to weight the physician, practice and/or group influence on performance



Shared Influence of Practice and Doctor

(Scores Variation per Patient-reported Experiences)

Patient Experience Domain	Practice Site Effect	Physician Effect
Communications	1.95	2.88
Care Coordination	6.99	3.58
Access	6.82	4.21
Office Staff	5.11	2.10
Self-care: Set Goals	5.92	6.39
Self-care: Talk Barriers	2.81	6.72
Self-care: Skills Instruct	5.32	5.26

Larger numbers show stronger influence
(variance component analysis; chronically ill patients survey in 17 practices)

Composite Methods Evaluation Criteria

Criteria	Adjusted Opportunities	IRT	PRIDIT
Summarizes a higher-level quality of care construct	✓ +	✓ +	✓ +
Increases reliability at the individual physician-level	✓	✓	✓
Patient population case-mix adjustment	✓ +	✓ +	✓
Fairness: measures frequency & difficulty adjustment	✓ +	✓ -	-
Multi-level structure (group, practice, and physician)	✓ +	✓ +	✓ -
Transparency	✓	-	-
Computational simplicity	✓	-	-

3 methods yield equivalent results for large samples; results diverge with small samples/measures less congruent

Physician/Practice Blending & Composite Scoring (4 Diabetes Screening Measures)

Individual measures: 7%-21% MDs reliable scores

Blending: 77%-80% MDs reliable scores

Composite measure: 30% MDs reliable scores

Blending: 65% MDs reliable scores



Organize Composites by Measurement System/Capabilities

	Cardiovascular	Diabetes	Preventive
Effective Care	LDL Screen Heart Failure Med CAD Med	A1C Screen LDL Screen Nephropathy Screen	BCS, CCS, COL cancer screens Vaccinations Depression screen
Outcomes	BP Control LDL Control	BP Control LDL Control A1c Control	BP Control LDL Control BMI mgm't
Patient Engagement: Practice-level	Access Coordination Self-care Mgm't	Access Coordination Self-care Mgm't	Access Coordination Self-care Mgm't
Patient Engagement: MD-level	Communications Knowledge of Med History/Person Self-care Mgm't	Communications Knowledge of Med History/Person Self-care Mgm't	Communications Knowledge of Med History/Person Self-care Mgm't

Most physicians can participate as accountability advances toward outcomes.

Add Specialty Care Composites: Total Joint Replacement Example

Domain	Measure Topics
Outcomes	Functional/Social Role Status Condition-Specific Symptom and Function
Effective Care	Multi-site Registry Participation/Data Uses Hospital Readmissions
Cost & Efficiency	Episode Cost of Care
Patient Engagement	Shared Decision-Making Self-care Management
Patient Safety	Hospital Acquired Conditions Patient Safety Indicators

Putting Measures to Use: California Experience

Composite Scoring

Payment: IHA Pay for Performance

Reporting: CA Office of Patient Advocate

Attribution Rules and Reliability Thresholds

Physician Feedback: California Physician Performance Initiative

Reporting: California Physician Performance Initiative

Physician and Group Blending

Methods Under Development



Physician Value Modifier: Accountability Principles

1. Shared physician and medical group accountability

- Reward physician-specific results
- Blend physician & group results

2. Create structure & incentives to advance to outcomes

- Higher weights assigned to outcomes composites
- Add specialty/condition composites when ready

3. Feasibility

- Physicians participate via group & MD reporting systems
- Quality composites organized by measurement system capabilities (e.g., process, outcomes, patient-report)

4. Fairness

- Adjust for measure difficulty and patient mix
- Performance scored relative to peer group
- Reward performance and improvement





Physician Pay-for-Performance and Other Incentive Programs: Lessons From The Field

Francois de Brantes
MS, MBA

The views expressed in this presentation are those of the speaker and do not represent the views of CMS.

What is HCI³?

- Not-for-profit emanating from the combination of Bridges To Excellence, Inc. and PROMETHEUS Payment, Inc.
- Engaged in many Foundation-funded and private sector pilots and initiatives
- Focus of organization spans the spectrum of payment reform, excluding the two poles
 - Fee-for-Service (FFS) and capitation
 - We believe that the majority of new payment models will be located on the spectrum between FFS with no value based component, and capitation
 - FFS and capitation include well-researched negative incentives that can be avoided through other payment incentives



Bridges To Excellence (BTE)

- Founded in 2002 by large employers
- Recognize physicians for the quality of care they deliver and:
 1. Give them a per patient financial reward
 2. Highlight their performance to plan members
- BTE-recognized physicians include all physicians recognized by the National Committee for Quality Assurance (NCQA) and other Performance Assessment Organizations – threshold-based performance
- Aetna, United HealthCare, Anthem and many regional BCBS plans use BTE Recognitions as part of their P4P efforts



Principal Findings on Bridges to Excellence

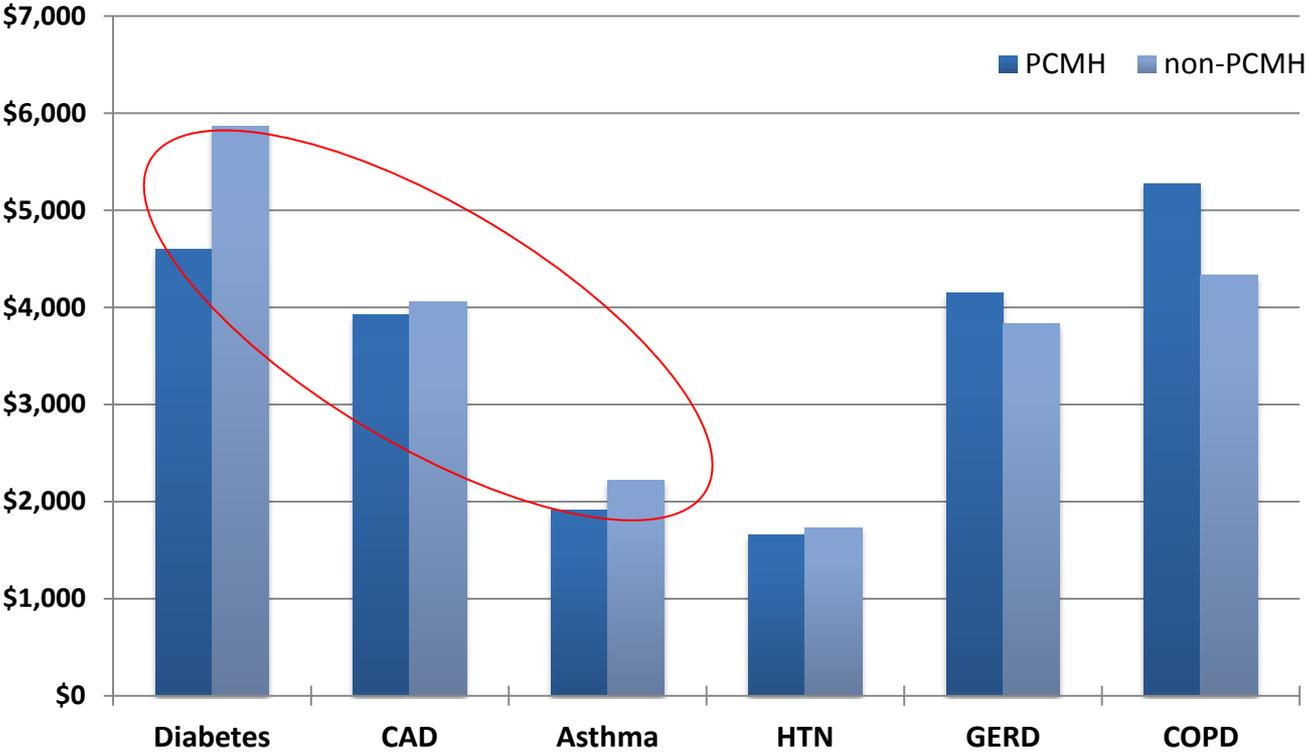
- What you measure matters¹ – our focus has been on clinical measures associated to lower costs, e.g. blood pressure control in patients with diabetes
- Higher incentives lead to greater response² – physicians with more upside at stake are more likely to become recognized, and the higher the effort required of the physician, the greater the incentive has to be
- BTE-recognized physicians have lower episode costs of care than matched non-recognized physicians³



-
1. de Brantes F, Wickland P, Williams J - "The Value of Ambulatory Care Measures: A Payer's/Purchaser's Perspective" American Journal of Managed Care, June 2008
 2. de Brantes F, D'Andrea G, "Physicians respond to Pay-for-Performance incentives: Large incentives yield greater participation", American Journal of Managed Care, May 2009
 3. Rosenthal et al, "Bridges To Excellence: Recognizing High Quality Care", American Journal of Managed Care, October 2008

Why Measuring Matters – What You Don't Measure Doesn't Change

Average Relevant Costs after Severity-Adjusting Typical Costs: PCMH vs. non-PCMH



The Patient Centered Medical Home (PCMH) practices involved in a pilot have been reporting clinical measures on patients with Diabetes, CAD and Asthma. Not on hypertension, GERD or COPD.

HCI³ Analysis of a regional health plan using the PROMETHEUS ECR Analytics, 2012

Evolution of Reward Mechanisms in Private Sector to Reduce Costs

- Straight bonus per patient once the physician is recognized
 - Many health plans still use this model
 - BTE Recognitions include tiers to reward more at higher levels
- Fixed and variable bonus based on reductions in episode costs
 - Still no downside
 - Any calculated surplus ($\text{Actual} < \text{Budget}$) is first applied to offset fixed bonus
 - Physicians measured against themselves
 - Budget is 0% inflation based



PROMETHEUS Payment – Bundled Payment

- Started in 2005 by large employers and funded by Commonwealth Fund and Robert Wood Johnson Foundation (RWJF)
- Defined episodes are termed Evidence-informed Case Rates (ECRs). Some characteristics:
 - Severity-adjusted for every patient
 - Include co-morbidities: “lumpy” bundles
 - A patient only has one chronic care ECR – the “anchor” chronic condition
- Physicians are also judged on an overall quality scorecard that includes all chronic care domains, not just a single condition



Example

- A physician with a mix of 500 patients with different chronic conditions. ECRs are prospectively budgeted for each patient's chronic care (not other care)
- Any upside distribution (when actual < budget) is contingent on the physician's total scorecard score
 - A physician earning a 85% on the quality scorecard would get 85% of the upside



Some Important Principles and Design Elements

- Patients can be multi-attributed, in which case the prospective budget is split, and each practice has a specific budget
- Physicians are compared to themselves, and the undistributed upside of each goes to all physicians in top deciles
- Budgets are just that – it's not prospectively paid – and FFS-paid claims are retrospectively reconciled against budgets (identical to Center for Medicare & Medicaid Innovation (CMMI) Bundled Payment Pilot Models 2 and 3)



Expanding Beyond a Chronic Care Per Member Per Month (PMPM)

- Prospective budgets can be calculated for specific conditions, clusters of conditions, procedures, and acute medical events
- Actual costs can be compared to those prospective budgets, and physicians held accountable for the surplus or deficit
- Surpluses and deficits are then mitigated by the quality score of the physician's scorecard



Example of a Quality-Adjusted Cost Score

- A physician realizes a surplus of \$40,000 across attributed patients. The average performance of peers is a \$30,000 surplus, leading to a 1.33 cost performance
- The physician achieves a 65% score on a 100 point quality scorecard, and the average performance is 75%, which leads to a quality score of 0.87
- The “value score” = $1.33 * 0.87 = 1.16$



Closing Thoughts

- Forms of Value-Based Purchasing (VBP) have been around for two decades
 - What seems to work:
 - Setting the bar at above average
 - Rewarding individual achievement against individual benchmark as well as improvement from prior achievement
 - Predictability in the potential gain or loss
 - Speed and action ability of feedback
- You can't please everyone, nor should you try.





Closing

Sheila Roman, MD, MPH
Senior Medical Officer
Performance-Based Payment Policy
Group
Center for Medicare

Evaluate Your Experience with Today's National Provider Call

To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.

To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call from the menu.

All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

We appreciate your feedback!





Bookmark Our Website and Visit Often

<http://www.CMS.Gov/PhysicianFeedbackProgram>

Thank you for your participation in today's call and please join us on March 14th for the second call in this series.

Evaluate Your Experience with Today's National Provider Call

To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.

To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call from the menu.

All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

We appreciate your feedback!