

Physician Feedback Program and Value-Based Payment Modifier

Fee-for-Service Medicare

Listening Session

September 24, 2010

Background on the Physician Feedback Program: From MIPPA to ACA

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Goal and Purpose

- Goal: Provide Physician Feedback Reports that are meaningful, actionable and fair to every applicable Medicare physician
- Purpose of today-- Solicit input on:
 - Methodological issues for constructing and reporting resource use and quality measures and their composites into a Value-Based Payment Modifier
 - Report design and dissemination

CMS' Value-Based Purchasing (VBP) Principles

- Transform Medicare from a passive payer of services to an active purchaser of higher quality, more efficient health care
- VBP Program goals:
 - Improve clinical quality of care rendered
 - Improve the health of beneficiaries
 - Reduce adverse events and improve patient safety
 - Encourage coordination of patient care
 - Avoid unnecessary costs in the delivery of care
 - Stimulate investments in effective structural systems
 - Make performance results transparent and comprehensible

Statutory Authority for Physician Feedback Program

- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, Sec. 131 (c)
 - The Secretary shall establish a Physician Feedback Program under which the Secretary shall use claims data (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care. The Secretary may include information on the quality of care furnished by the physician (or group of physicians) in such reports.
 - Called “Physician Resource Use Measurement and Reporting Program”

Physician Feedback Program

- Phase I (2009 Reports)
 - Focused on resource use measures
 - Distributed to a small sample of physicians
 - 310 reports distributed in Spring/Summer 2009
 - Active and passive feedback on reports solicited
- Phase II (2010)
 - Reporting to groups of physicians and the individual physicians affiliated with these groups in 12 markets
 - Distribute on a larger scale than in Phase I
 - 36 groups identified via Tax Identification Numbers (TINs);
 - ~1,600 physicians affiliated with those groups
 - Reports include per capita resource use measures and quality of care measures

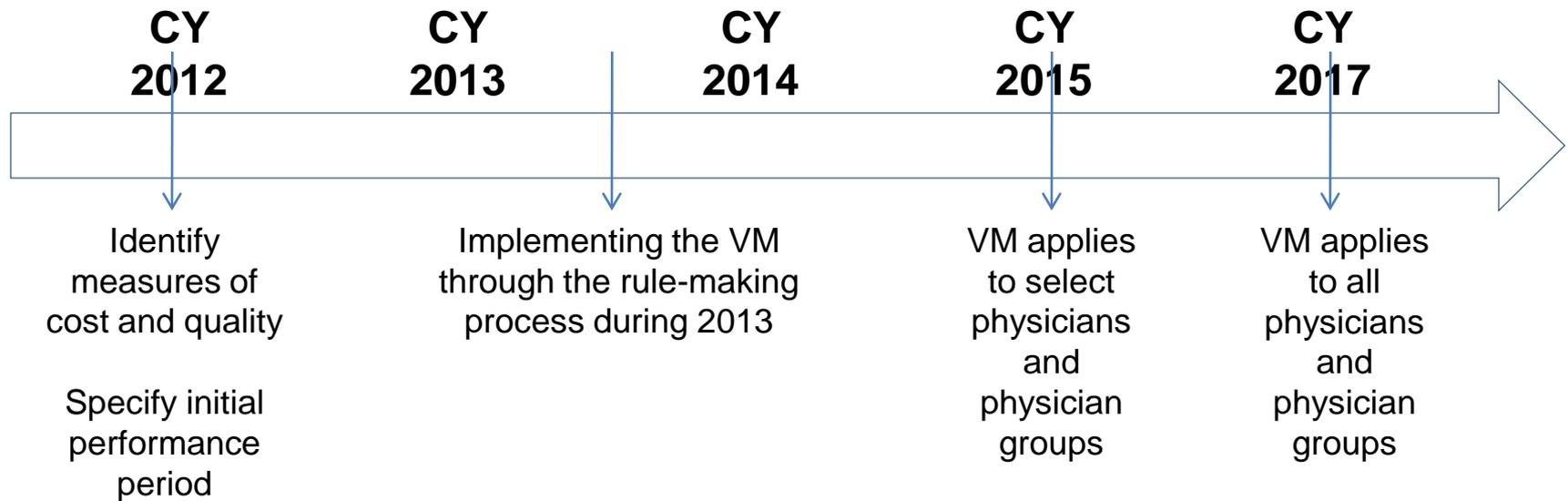
Impact of Health Care Reform on Physician Feedback Program

- Affordable Care Act (ACA) of 2010-Sec. 3003
 - Continues and expands the Physician Feedback Program to reach increasing numbers of physicians until every applicable Medicare physician receives a report
 - Requires development of a Medicare-specific episode grouper
 - Will provide Physician Feedback Reports that quantify and compare patterns of resource use of individual physicians to other physicians

Value-Based Payment Modifier (VM)

- Statutory authority under ACA Section 3007
 - Requires CMS to apply a separate, budget neutral payment modifier to the physician fee schedule (PFS) payment formula
 - VM payment adjustments are separate from PFS existing geographic adjustment factors
 - Publish measures of resource use and quality and the analytic methods to be used for calculating the VM through rule-making
 - Payment modifier implemented beginning 1/1/2015 for the services of specific physicians and groups of physicians
 - Not later than 1/1/2017 for all physicians and groups of physicians

VM Implementation Timeline



Physician Feedback Reports and the VM Program

- Two provisions are complementary
- Approach used for Sec. 3003 will serve as foundation for implementing the VM
- Prior to implementation of the VM
 - Enhance measures and methods
 - Conduct data analysis and research to determine best methods and measures
 - Refine content of the reports
 - Obtain extensive stakeholder dialogue and input

Remainder of Listening Session

- Following an overview of design and dissemination plans for current Phase II Physician Feedback Reports, we'll discuss:
 - Resource use and quality measure issues for the Physician Feedback and VM program
 - Methodological issues for constructing and reporting on resource use and quality measures

Overview:
Phase II Physician Feedback
Reports

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Approach

- CMS examined Medicare claims from 12 representative metro areas whose health systems have been studied since 1996. These areas, called Community Tracking Study (CTS) sites, include:

Boston, MA

Miami, FL

Cleveland, OH

Northern NJ

Greenville, SC

Orange County, CA

Indianapolis, IN

Phoenix, AZ

Lansing, MI

Seattle, WA

Little Rock, AR

Syracuse, NY

- All Medicare Part A and Part B claims for 2007
- Phase II reports compared physicians in the same metro areas and across all CTS sites

Medical Practice Groups

- Shared TIN used on 2007 claims and met all the following criteria:
 - At least one primary care physician and one medical specialist or surgeon who billed for evaluation and management (E&M) Medicare services under the TIN
 - At least one physician practiced in a CTS site
 - At least 5,000 Medicare beneficiaries attributed to the group
- Medical Practice Group (TIN) participated in the PQRI program in 2007, 2008, 2009, or 2010

Individual Professionals

- Physicians, nurse practitioners, and physician assistants affiliated with a defined Medical Practice Group who:
 - Practiced in a CTS metro area in 2007
 - Practiced in a medical specialty or group that provides primary care, e.g., General, Internal, Geriatric, or Family Medicine
 - Had enough patients to allow comparisons for quality and resource use measures

Clinical Quality

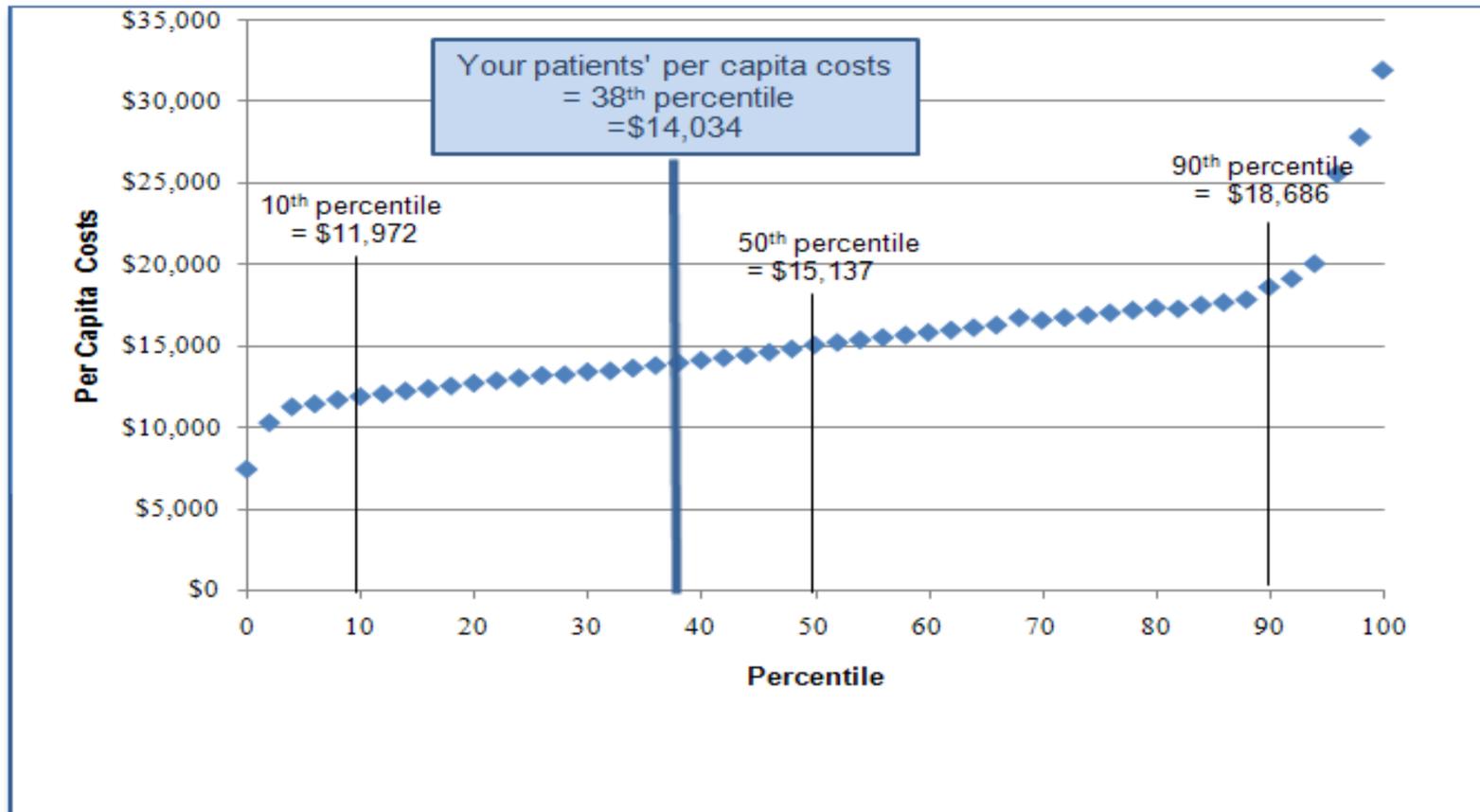
- Quality of Clinical Care Measures: For 12 claims-based measures (a subset of HEDIS® measures), % of patients who received recommended preventive and clinical services.
 - Individual professionals: compared with peers in local metro area and with peers (same specialty) across 12 CTS areas
 - Medical Practice Groups: compared with all 36 groups across 12 CTS sites
- Listing of hospitals in the CTS site used by your Medicare patients
- Medical Practice Groups only: 6 ambulatory care sensitive conditions (ACSC) measures

Resource Use

- For all Medicare patients attributed to the individual physician (or Medical Group), total Part A and Part B costs
 - Total per capita costs (average annual costs per patient)
 - Per capita costs by type of service (e.g. in-patient)
 - Total per capita costs for patients stratified by specific chronic conditions:
 - Congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, and prostate cancer
- Hospital and ED admissions

Per Capita Costs, Percentile Distribution

Exhibit 4. Medicare Patients' Per Capita Costs* for Medical Professionals in Your Specialty in the Indianapolis Metropolitan Area (n=#), by Percentile, 2007



*Per capita costs shown here are risk adjusted and price standardized, and are based on all Medicare Part A and Part B claims submitted in 2007 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical professional. Costs are calculated only for medical professionals with at least 30 attributed beneficiaries.

Per Capita Costs

- * Per capita costs shown here are risk adjusted and price standardized, and are based on all Medicare Part A and Part B claims submitted in 2007 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical professional. Costs are calculated only for medical professionals with at least 30 attributed beneficiaries.*

Report Dissemination 2010

- Individual Affiliated Professionals
 - Advance letter (early Nov. 2010) with instructions on how to obtain report
 - Same process as requesting a PQRI report:
 - Request report by contacting physician's Medicare Administrative Contractor (MAC)
 - To ensure confidentiality, MAC verifies physician's identity
 - Reports e-mailed to physician by MAC
 - Help Desk: QualityNet & Mathematica

Report Dissemination 2010

- Medical Practice Groups:
 - Advance letter to medical group administrator (early Nov. 2010) with detailed instructions on how to obtain the group's report
 - Same process as obtaining a PQRI report:
 - Available in PDF format via the PQRI portal (can also access PQRI reports) at <http://www.qualitynet.org/pqri>,
 - An active IACS account is required to access the portal

Resource Use Measures: An Overview

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Purpose of Resource Use Measures

- Documented variation in resource use, even after adjusting for patient characteristics
- Need to slow growth in health system costs while maintaining or improving quality
- Transparency around resource use can lead to practice innovation and quality improvements
- Mandated in MIPPA/ACA

Types of Resource Use Measures

- Population-based measures
 - Per-capita resource use
 - Utilization rates per 1,000 population
- Service-specific measures
 - E.g., readmissions, imaging efficiency measures
- Episode-based measures
 - An episode organizes all claims clinically relevant to a particular condition (e.g., asthma) into a single analytic construct
 - Can have acute or chronic episodes
 - Chronic episodes typically defined as 1 year

Attributes of Different Types of Resource Use Measures

- Population-based measures
 - Straightforward to specify and calculate
 - May be less “actionable” because they encompass all care for beneficiaries (although can be stratified for beneficiary characteristics)
- Episode-based measures
 - More complex to specify and calculate than per capita or service-specific measures
 - May be more “actionable” because of condition-specific focus

Current State of Resource Use Measurement Efforts

- Many existing resource measurement approaches (ETG, MEG, Cave, NCQA, Prometheus, ABMS/Brookings)
- NQF process to endorse resource use measures underway
- Section 3003 of ACA requires CMS to develop episode grouper

Key Methodological Issues of Resource Use Measurement

- Risk Adjustment
 - Taking into account past resource use and geographic differences prior to making comparisons
- Attribution
 - Issues of responsibility and control
- Benchmarking/Peer Groups
 - Identifying peers and targets
- Composite Scoring
 - Assigning weights to quality and resource use metrics

Quality Measures, Current Challenges & Future Directions

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Purpose of Quality Measurement in Physician Feedback Program

- Provide/monitor quality data along with resource use
- Drive quality improvement
- Convey performance compared to peers
- Push for system transformation

Types of Measures

Process

- Screening and diagnosis
- Treatment and rehabilitation
- Education and prevention
- Proportion of population receiving indicated care
- Do not require risk adjustment

Outcome

- Mortality, morbidity, and functional status
- Knowledge, attitudes, and behaviors
- Patient experience, satisfaction
- Impact on patients
- Require risk adjustment

Composite

- **Two or more components:** can be any types
- **All-or-none:** multiple process measures, must meet all
- **Weighting of components:** various methods
- PQRI measure groups
- Clinical quality and resource use

Physician Measures

- PQRI
 - Claims – using quality data codes (QDC), Registry, Electronic Health Record, Group Reporting Option tool
- HITECH
 - Electronic Health Records
- HEDIS
 - Claims, Hybrid, Survey
- Generating Medicare Physician Quality Performance Measurement (GEM) Project
 - Claims
- Other Physician Measures

GEM Measures

- Subset of HEDIS quality measures
- Claims-based
- General and broadly applicable

Diabetes ≤ 75 yrs	Cardiovascular Disease ≤ 75 yrs	Cancer screening	Medication Monitoring
LDL screening	LDL screening	Breast ≤ 69 yrs	Antidepressant management (acute phase)
Hgb A1c testing	B-blockers post-MI	Colorectal ≤ 80 yrs	Annual for persistent meds
Eye (retinal) exam	B-blocker persistence post-MI		DMARDS for rheumatoid arthritis
Attention for nephropathy			

Types of Outcome Measures

- **Clinical Outcomes**
 - Intermediate outcome
 - BP < 140/90, A1c < 9.0
 - Mortality:
 - 30-day Mortality, In hospital mortality
 - Avoidable indicators
 - Adverse Events;
 - Catheter related UTI, surgical complications
- **Functional Status**
 - Improvement in Ambulation
- **Quality of Life**
 - SF-36, Minnesota Living with Heart Failure Questionnaire

Current Limitations & Challenges

- Diabetes mellitus
- Heart failure
- Coronary artery disease
- COPD
- Prostate cancer

- Quality measures will evolve
 - Current measures predominantly process measures
 - Need for outcome measures
- Relationship to meaningful outcomes
 - e.g. LDL screening & CV events
- Relevance
 - Varies between patient populations and practices

Future Directions

- Immediate challenges
 - Other chronic conditions (osteoporosis, arthritis)
 - Multiple co-morbidities
 - Palliative and end of life care
- Patient-centered measurement across settings
 - Physicians, hospitals, post-acute, nursing home
- Alignment of measures with other CMS programs
 - HITECH meaningful use
 - PQRI
 - ACOs
- Building blocks for quality composite

Methodological Issues: An Overview

Topics Addressed

- Risk Adjustment
- Performance Measurement
 - Attribution
 - Benchmarking
 - Peer Group Comparisons
 - Sample Size
- Composite Measures

Methodological Issues: Risk Adjustment

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*Research and Evaluation Group
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Purpose of Risk Adjustment

- Address concerns that “My patients are sicker than yours...”
- Facilitate a fair and accurate comparison of outcomes of care across health care organizations and providers
- A statistical process to identify and adjust for differences in patient characteristics before comparing outcomes of care

How We Risk Adjust Resource Use

- If we risk-adjust patient expenditures, we can calculate a measure of resources used by the physician reflecting practice case-mix
- We have used the HCC model since 2003 (under the Medicare Advantage Program)
- Model was devised by RTI International, under contract to CMS
- Risk Score is based on 70 HCCs, age, sex, Medicaid and disability status)

Risk Adjusting Resource Use

- Adjustment is for diagnostic history, not severity (because diagnosis does not distinguish severity levels under the ICD-9 system)
- Cost is risk-adjusted by dividing the beneficiary's Actual (observed) cost by Expected cost associated with the beneficiary's diagnostic history

Risk Adjusting for Phase II Physician Resource Use Reports

- Trimmed beneficiaries' outlier costs and standardized costs for geographic variation
- Estimated Expected cost of the physician's beneficiaries using the model:
$$\$ = F(\text{Risk Score}, \text{Risk Score Squared}, \text{ESRD Flag})$$
- Calculated risk-adjusted per capita cost of the physician's beneficiaries from actual and expected costs

Risk Adjusting Quality Measures

- Outcome measures of quality also need risk adjustment
- CMS' risk adjustment for hospital mortality and readmission accounts for index admission secondary diagnoses and co-morbidities from the prior year from inpatient, outpatient, and physician claims
- Separate clinical models for each condition estimated on administrative data, validated by models based on chart data, can be applied to other providers and settings

Methodological Issues: Measuring and Comparing Performance

Niall Brennan, MPP

Attribution

- Key Issues
 - Who should be accountable for patient care expenditures?
 - Should attribution be to individual physicians/clinicians or teams of providers (including institutions)?
 - What services should count in attribution decisions?
 - How much of patient care expenditures should providers be accountable for?
 - Should the same provider(s) be held accountable for cost and quality measures?

Attribution Options

- Single provider attribution
 - First contact/visit
 - Plurality of patient visits or costs
- Multiple provider attribution
 - Physicians only; Physicians + other providers
 - Equal accountability regardless of proportion of care provided
 - Accountability proportional to care provided
- Minimum attribution thresholds
 - Higher – less attribution
 - Lower – less specificity

Attribution Options

- Based on number/proportion of patient visits
 - Total visits
 - Evaluation and management (E&M) visits
 - What about procedure-based services?
 - First visit
 - What if Emergency Department visit?
- Based on paid claims
 - Total professional claims
 - Proceduralists may most often be attributed patient/episode because service fees higher than for PCPs
 - E&M claims
 - Surgical claims

Current Phase II Attribution Approach

- Minimum plurality approach
- Physician group and individual (Group) Physician attribution
- Beneficiary attributed to *group* with plurality (greatest #) of E&M visits, but only if TIN billed at least 30% of E&M “dollars” for beneficiary
- Beneficiary attributed to *physician/EP* based on plurality of claims billed with group TIN, $\geq 20\%$ of beneficiary E&M “dollars”
- Total value of beneficiary’s annual Part A & B claims attributed to TIN/EP

Benchmarking

- Key Issues
 - How should benchmarks be calculated?
 - National benchmarks
 - Local benchmarks
 - Multiple benchmarks?
 - How should performance be evaluated relative to a benchmark?
 - Benchmark to best performers
 - Benchmark to average performers
 - Attainment versus improvement?
 - What should be the statistical basis for benchmarks?
 - Average/norms
 - Percentile rankings
 - Deviations from mean?

Peer Groups

- Key Issues
 - How should appropriate peer groups be identified?
 - Should comparison be performed within specialty or across specialties?
 - Can provider specialty be accurately identified from claims data?
 - Inaccurate specialty data
 - Providers practicing outside their designated specialty

Current Phase II Benchmarking Approach

- For Individual Physicians/Professionals
 - Peer groups are other physicians in same specialty in the same metro area and across 12 metro areas
 - Data are displayed only if peer groups ≥ 30 physicians
- For Medical Groups
 - Peer groups are all groups across 12 metro areas
 - Data are displayed only if peer groups ≥ 30 medical groups

Sample Size

- Key Issues
 - What is an appropriate minimum sample size for quality and resource use measures?
 - Would it differ for confidential feedback reporting vs. public reporting vs. incentive payments?
 - How many physicians will generate sufficient sample sizes for quality or resource use measures?
 - Should physician results be subjected to reliability testing, e.g., examining consistency across time?

Current Phase II Sample Size Requirements

- At least 30 cases required for total per capita determination
- At least 11 cases required for clinical process measures
- At least 30 “peers” required to compare physicians and medical groups

Methodological Issues: Composites of Quality & Cost Measures

Sheila Roman, MD, MPH

Definition of Composite

- A composite is a single summary of provider performance that
 - Combines a number of individual measures of the provider's performance
 - Within a single dimension or across different dimensions of health care
- Examples of composites:
 - Within a given dimension of health care (e.g., a patient satisfaction composite)
 - Across several dimensions of health care (e.g., process of care quality measures, resource use measures, patient safety measures, health outcome measures)
 - Across a single type of provider (e.g., the performance of all physicians affiliated with a medical group practice)
 - Across different types of providers (e.g., the performance of both hospitals and physicians affiliated with an accountable care organization treating a given patient population)

CMS Uses of Composites

- Section 3007 of ACA requires CMS to propose measures of quality and cost:
 - To be incorporated into the VM
 - VM is to be constructed, to the extent practicable, on the basis of composite quality and cost measures
- Composites of quality and cost would also be included in confidential Physician Feedback Program along with individual measures
 - Present the provider with information on the many factors that make up their VM

Ways to Construct Composite Measures

- “Opportunity” composite for process of care measures:
 - Denominator is number of Medicare patients who are candidates for any of the process measures
 - Numerator calculated by summing the number of patients who were both candidates for and received any, or all, of the care
- Weighted composite:
 - Weighted average across all performance/scores for individual measures
- Variant of weighted composite:
 - First combine domains based on specific conditions or beneficiary cohorts

Ways to Determine Weights for Composites

- Expert or provider consensus
- Statistical analysis:
 - Regression, factor analysis, principal components analysis, structural equation modeling
 - Weights for composite determined by contribution to relative variation in composite score

Options for Determining Weights

- Equal weighting
- All-or-none weighting
- Compensatory weighting
- Variable weighting

Next Steps:

Key Milestones for Physician
Feedback Reports and VM Program

Sheila Roman, MD, MPH

Implementation Timeline Milestones: 2008 - 2010

- 2008-2010: Conduct dialog with stakeholders regarding report design, content, methodology
 - Physicians, groups and specialty societies; comments on PFS rulemaking process; public listening sessions; technical expert panels
- 2009: Initial dissemination of Phase I reports to ~300 individual physicians
- 2010: Dissemination of Phase II reports to ~1,600 individual physicians and ~36 medical groups

Implementation Timeline Milestones: 2011

- Scale up of reports to 10,000-20,000 physicians (with possible enhancements)
- Begin dialog with stakeholders in choosing VM measures and creating composite scores
 - Physicians, groups and specialty societies; comments on PFS rulemaking process; public listening sessions; national provider calls; technical expert panels; collaboration with CMS' provider outreach teams
- Continuation of research and stakeholder input on methodology considerations in constructing measures
 - Price standardization; attribution, risk adjustment, peer groups/benchmarking, minimum case size; cost and quality composite scores

Implementation Timeline Milestones: 2012

- Specify initial performance period for 1/1/15 VM through rule-making
- Publish VM measures of quality and resource use
- Further enhancement and scale-up of feedback reports that quantify & compare patterns of quality and cost

Implementation Timeline Milestones: 2013 - 2017

- 2013: Begin implementing the VM through rule-making (analytic methods to convert measures to a modifier)
- 2013: Scale-up distribution of feedback reports with VM measures of cost and quality with goal of sending a report to all applicable Medicare physicians
- 2014: Complete implementing the VM through rule-making
- 1/1/2015: Begin applying VM to physician fee schedule (PFS) for services of “specific” physicians and medical groups
- 1/1/2017: Begin applying VM to PFS for services of all physicians and medical groups