Centers for Medicare & Medicaid Services
Listening Session Regarding: Physician Feedback Program and Implementation of the Value-Based Payment Modifier for Fee-for-Service Medicare
Moderator: Dr. Sheila Roman
September 24, 2010
10:00 a.m. ET

Welcome

Operator: Welcome to the Listening Session Regarding: Physician Feedback Program and Implementation of the Value-Based Payment Modifier for Fee-for-Service Medicare. There will be opportunities for comments at various points throughout the listening session. Priority for making comments will be given to people who are in person in the CMS auditorium. As time allows people participating by phone will be given opportunities to comment. An audio download and transcript of the listening session will be available through the CMS physician center website within two weeks after completion of the listening session at http://www.cms.hhs.gov/center/physician.asp.

We will now join Dr. Rick Gilfillan on site in the main auditorium of the Centers for Medicare & Medicaid Services in Baltimore, Maryland. Please go ahead.

Richard Gilfillan: Good morning. My name is Rick Gilfillan. On behalf of Jon Blum, the CMS Deputy Administrator and Director of the Center for Medicare, I'd like to welcome you to this listening session on the physician feedback program and implementation of the value-based modifier. Jon was scheduled to be here but got called back, as happens occasionally, to something in D.C. So I'm welcoming you on his behalf.

I'm the Director of the Performance-Based Payment Policy Staff here at CMS that was created earlier in 2010 to address the challenges in implementing a number of the value-based purchasing programs mandated in the Affordable Care Act. P3, as our staff is known within CMS, is responsible for a number of major physician and hospital oriented value-based purchasing programs as well as implementation of the ACO shared savings program.

Specifically with regard to physician payment, the physician feedback program and value-based payment modifier are the topics of today's listening session. We have had a number of listening sessions already on the ACO program.

By background just for your information, I'm a family physician, practiced for a number of years in Massachusetts and New Jersey and then got into

managed care in both the medical management side and the administrative general management side. And joined CMS, I guess about seven weeks ago now because of the opportunity that it presents I think for all of us to help create a new day in American healthcare and find ways to make the system work better for our patients.

This week marks the six month anniversary of the passage of the act. From the Medicare perspective, the Affordable Care Act provides CMS unique opportunities to improve the Medicare program and to transform we think over time the delivery of care in the United States. And you may have heard Don Berwick, the CMS Administrator talk in the past or more recently about the Triple Aim and I think it's useful to think about the Triple Aim as the framework for how we are thinking about a number of payment reform and reporting provisions in the Affordable Care Act.

And for those unfamiliar with that, I'll just point out: Triple Aim lays out an ambitious approach to defining success for all of us as healthcare professionals and healthcare providers and it says, we are to be in the business of building systems of care that can improve health, provide better health, provide better care and provide better cost than the systems that we have today. And you'll notice that the word better is in there three times, that comes from someone who's very interested in improvement. That is Don, from IHI.

So we think it's helpful to think about all of these provisions in that context. How will a particular aspect of the Affordable Care Act help us to learn how to support physicians, hospitals, healthcare professionals as they pursue new approaches to care aimed at driving success in delivering those Triple Aim outcomes.

There are several aspects of Medicare's payment policy that have been in place for years including increasing payment for value rather than for volume of services, improving performance through the healthcare delivery system by promoting evidence-based medicine, care coordination and shared responsibility. And preventing the onset and exacerbation of chronic conditions and also doing that in the context which honors and recognizes the diversity of patients and their individual preferences.

A couple of the notable provisions in the act that we're actively implementing, we're working obviously to speed up the adoption of the prescribing electronic medical records, clinical registries, we're exploring how to most effectively monitor and reduce preventable hospital admissions and readmissions, it will be an important focus for the engagements that we expect to have with the delivery system. We're working on the final design details for the hospital value-based purchasing program that will enhance the current paper reporting quality program.

And we're collaborating quite actively with other Federal agencies in the private sector to ensure that we've developed new measures of clinical quality including outcome patient experience, resource use and episode of care measures. We want to develop them, they need to be vetted and incorporated into the various Medicare payment systems.

Central to that and I think as a theme for the way we see CMS operating in the future is very active engagement with providers of care and other stakeholders in the delivery system. We expect to be out there talking to you, listening to you, talking with you, listening to you, working with you, thinking with you, identifying ways we can work together and collaboratively to improve Triple Aim outcomes.

The subject of today's meeting is the physician feedback reports now referred to as the Physician Quality and Resource Use Report. They're an essential precursor to the development and implementation of value-based payment modifiers for the physician schedule to be phased in beginning in 2015. Their development also closely ties to other reporting mechanisms such as PQRI, HITECH and we recognize the potential and opportunity to kind of leverage these different tools together to both simplify the environment for providers and physicians and have more impact by getting the synergy of these multiple programs working together. So we're conscious of that, we want to think with you actively about it and hear from you about creative ideas as to how we could do that.

I think we all recognize as healthcare professionals that our commitment is to delivering the best possible care for our patients. There may be times where the system hasn't been set up in the ways that facilitate the delivery of the care services that might be the most beneficial for patients. It is our goal to work with you, to find ways to create new supporting structures, new ways of interacting, new ways of paying that support you in the delivery of care and support you in the pursuit of what I think are the primary drivers for professionals that is getting best outcome for their patients.

So we're cognizant of the fact that there is a need to provide support and supporting infrastructure and that supporting infrastructure may be payment changes and may be reports that allow you to understand better what's happening with your population. And we are committed to working transparently and collaborative with you to that end. We need your input, feedback and experience.

I guess the question is that we'd like you to ask and think about is what will it take, what would help you from us? What would help you deliver improved or better health, better care, better cost for your patient population? We'd appreciate you thinking about that creatively, think about that context, think about the realities of day-to-day practice and give us active suggestions about how you think we could help you to that end. And I think it's fair to say that any ideas that you all have that are coming from that direction, we are very anxious to hear about it.

And I think as Don says to us constantly, if you don't know where to start, start with the patient. Think about the patient. Think about the patient experience. Think about the patient experience as they go through the care system. And think about what we all could do together working collaboratively to change that care experience in a way that delivers those three outcomes. And if you come to us with ideas based on that framework, I think it will be a great help in directing us to develop systems like the ones we're talking about today that then can come back and support you in that pursuit.

In fact I guess I'd offer a challenge and say I know that specialty societies have developed a lot of measures for your specific areas but I offer a challenge to you all to say, think about what are the key metrics, what are the key measures, what are the tools that would really most effectively help you, help that patient towards those outcomes and if you can give us ideas about what those measures, what those metrics are, what those approaches to measurement and what those approaches perhaps to payment might be, that would be very helpful.

So our listening session today is hopefully seen as an example of our intent to listen to your reactions. It's not all there is but there's a lot of time and there's a lot of information we're going to provide. I think the key to this meeting today and to all these sessions is for us to hear from you and we want to make sure that we structure it in a way that gives you ample opportunity to give us that feedback.

I think at the end of the day we are committed in CMS to helping you change the way care is delivered to accomplish and provide those Triple Aim outcomes. This is one step along the way towards learning from you and learning with you about ways that we can do that and over time, over these next three, I guess four years as we put in place, as you all put in place the infrastructure that will deliver more value. We'll put in place programs that will support you and reimburse you for delivering those outcomes.

All right at this point I turn the program over to Sheila Roman. Sheila is an internist and endocrinologist who continues to practice, so she's a real doctor, unlike me. She's been practicing for many years here in Johns Hopkins treating diabetics. A lot of Medicare patients obviously with very complex conditions and has been an expert and worked a long time in developing quality measures to improve patient care in hospital systems and is now working actively to do the same for physician services. So thank you again very much for being here. I know Jon appreciates it. We look forward to your input and thoughts and Sheila do you want to take it from here?

Dr. Sheila Roman: Yes. Thank you Rick for setting the stage and the tenor, I think for the day. That's very important. And thanks to everyone here at CMS and on the phone

for joining us today for this session. As Rick said, my name is Sheila Roman. I'm the team lead for CMS for the development of the physician feedback reports. To my right is Pamela Cheetham, who is the project officer for the physician feedback program and implementation of the value modifier. So over the years I think you'll come to get very familiar with us. I'll serve as - and our phones will be open and we'll be listening and we really are looking for those creative ideas.

I'll be serving as moderator throughout today's session. I'd like to take a moment just to review some logistics before we turn to the substance for today. First I'd like to remind everyone on the phone that the materials for this session are posted on the physician center spotlight section of the CMS website, that's www.cms.gov/center/physician.asp.

As you'll note from the agenda we really do want to hear from you today. This is to be a listening session. We have built in multiple sessions and provided opportunities throughout the day for public comments both comments in general and specific to the topics that are on the agenda. We are anxious to hear from people in the room and also people on the phone. And we'll devote time in each comment period to hear from both groups. The operator will provide directions on how to queue up to make a comment during the session.

We're trying to follow the times on the agenda. We are already a little bit behind, but have purposely provided time at the end of the listening session to continue comments from earlier sessions in the day or for concluding remarks that the audience here at CMS or on the phone may want to make. So that everyone has the opportunity to speak we ask that you limit your remarks to two minutes. We are also very interested in receiving your comments in writing. We've already received several to be sure that we capture the full details.

I will just briefly mention that as you probably know the comment period for the MPRM is closed. But these comments you know will not be reacted to in the final rule but we will be reviewing all of these comments and using their guidance as we move forward with the program. We will take only one

official break at 12:15 for lunch but for those in the room please feel free to step out whenever needed. You passed restrooms and many of you are probably familiar with the restrooms just off the hall that led you to the auditorium and coffee is available in the cafeteria on the lower level.

Background on the Physician Feedback Program

So without further ado, I'm going to start with the background on the physician feedback program and I think as you know this program has had a slow phase in and that we are really at the beginning. So this a very good time for us to hear comments about where we should be taking this program and how we should be moving it forward.

The goal of the program is to provide physician feedback reports that are meaningful, actionable and fair to every applicable Medicare physician. The purpose of today is to solicit input on the methodologic issues for constructing and reporting resource use and quality measures and their composites into a value-based payment modifier. And also we're looking to solicit input on reports design and dissemination and you'll see the next talk Pam will go over what our Phase II quality and resource use reports are projected to look like in the late fall of this year.

I think Rick touched on some of this but the guiding principles for value-based purchasing within the agency right now are to transform Medicare from a passive payer of services to an active purchaser of higher quality, more efficient healthcare. The specific goals really try to work around the Triple Aim of better health, better care, better cost and they include improving clinical quality of care, improving the health of beneficiaries, reducing adverse events and improving patient safety, encouraging coordination of patient care, avoiding unnecessary cost in the delivery of care, stimulating investments in effective structural systems, and making performance results transparent and comprehensible.

And I think as we move forward with this initiative, transparency as to what constitutes the measures that constitutes the quality score, the value score and how the composite is determined, transparency will be very important and we'll be really looking to work with you on those endeavors.

As many of you probably know the resource use measurement and reporting program was initially mandated in the Medicare Improvements for Patients and Providers Act of 2008 and that program initiated us to have the mandate to measure the resources involved in furnishing care and to extend it to include information on quality of care by the physician or groups of physicians in such reports.

In what we term Phase I of the program, which was in 2009, there was a focus on resource use measures. Reports were distributed to a very small sample of physicians, 310 reports were distributed in spring and summer of 2009. There was active and passive feedback on the reports solicited. But obviously a very small number of reports.

Phase II, which will debut in late fall of 2010, will be reporting to groups of physicians as well as the individuals physicians affiliated with these groups in 12 markets across the nation. The reports will be distributed on a larger scale than in Phase I but certainly will not have huge penetration into the physician community. We've identified 36 groups via tax identification numbers that will receive reports and approximately 1,600 physicians affiliated with those groups.

Reports for Phase II will include per-capita resource use measures and will also include quality of care measures. I'd like to move on to talk about the impact of healthcare reform on the Physician Feedback Program. It's sort of like, you know, a ball player getting a shot of testosterone. I'm an endocrinologist so I couldn't help it.

The Affordable Care Act has two sections that are relevant to the program: Sections 3003 and 3007 and I'll say a few words about both of them. Section 3003 continues and expands the physician feedback program to reach increasing numbers of physicians until every applicable Medicare physician receives a report. Section 3003 requires development of a Medicare-specific episode grouper and it requires us to provide Physician Feedback Reports that quantify and compare patterns of resource use of individual physicians to other physicians.

The statutory authority under Section 3007 requires CMS to apply a separate budget neutral payment modifier to the physician fee schedule payment formula. The value modifier payment adjustments are separate from the PFS existing geographic adjustment factors. Section 3007 also requires us to publish measures of resource use and quality and the analytic methods to be used for calculating the value modifiers through rule making. The payment modifier is mandated to be implemented beginning in 1/1/2015 for the services of specific physicians and groups of physicians and not later than 1/1/2017 for all physicians and groups of physicians.

I think this timeline, you know just reading through those dates, you know looks very much in the future but I think when we lay them out on a timeline and play them back a bit, I think you can see they're really just around the corner and both CMS and the physician community has work cut out for them in order to be ready for this brave new world if you will. In calendar year 2012, CMS will be identifying and publishing the measures of cost and quality that will go into the cost composite, quality composite and ultimately the value modifier.

We will also be specifying the initial performance period. In rule making in 2013 and 2014, we'll be laying out the specifications for the value modifier through the rule making process. And then as I've just said in CY2015 through CY2017, we'll be applying the value modifier to the physician fee schedule to select physician and physician groups and to all physicians projected by calendar year 2017.

So I think that we have a lot of work to do under the new mandates in the Accountable Care Act and I would urge you, I see most of you are associations, your affiliated physicians to begin thinking how they're going to do the frame shift into the Triple Aim of better health, better care, better cost. And help us to support you in picking measures that strive for the Triple Aim and will lead us down the path to keep on this timeline.

We view these two provisions as complimentary. The approach used for Section 3003 in expanding the physician feedback reports will serve as the foundation for implementing the value modifier so we'll be looking to you for

help, particular early on with the quality metrics and clearly prior to implementation of the value modifier we'll be enhancing the measures and methods that you'll hear about from Pam shortly. We'll be conducting data analysis and research to determine the best methods and measures and we'll be transparent with that and looking for input and ideas from you. We'll be refining the content of the reports and obtaining extensive dialogue input from you.

The remainder of the listening session, Pam, as I've mentioned several times now will overview the Phase II reports and then we'll move on in the morning to resource use and quality measure issues for the program and then in the afternoon to methodologic issues for constructing and reporting on resource use and quality measures. I'd like to open up the floor now for some general comments and then we'll move to the phones. We started a little bit late so we'll hold this for just a few but if there are some general comments, I'd like to take them now. Please come to the mic and identify yourself and affiliation.

General Public Comments

Steve Schmitt: Hi Steve Schmitt. I am an infectious disease physician in Cleveland, Ohio and I'm representing infectious disease (inaudible). I'd like to preface my comments by saying if my voice sounds hoarse it's because ID docs get them. I want to thank CMS for the drive toward quality and value which really does put patients first and I think it's a very key part of what we're talking about today.

But I'd like to make the comment that there are a number of groups of physicians, many infectious disease physicians included, that practice predominantly in an inpatient setting and so we think that a lot of our value is there in our quality inpatient care in a role in transitions of care for instance to home infusion therapy and making those key transitions to the outpatient setting. And in some of the quality non-clinical activities such as infection control, antibiotic stewardship, et cetera and we hope to work with you to develop some inpatient measures of quality and value as well.

And I also like to ask a question or ask for clarification as this goes forward with the value-based measures, how will that intersect with PQRI which is coming, there are negative payments coming on line in 2015 as well. Will success or failure in one or the other preclude success or failure, will you get two negative payments, will you get hit on both or feed on both and I thank you.

Dr. Sheila Roman: We're very aware that we have a lot of programs right now that have potential metrics in common that are running down separate tracks that need to merge together and I think we have to clearly think through the different incentives and disincentives and how they're going to merge but we're aware of that and have that on our agenda.

Bruce Kelly: Morning, I'm Bruce Kelly, I'm with the Mayo Clinic and I'm here representing the Healthcare Quality Coalition. We submitted a written statement to you signed by 22 groups and because our ideas we laid out there are kind of on a broader, I wanted to get this in the beginning so you can think about this as we talk about measures et cetera through the day.

We've looked very carefully at all the different permutations you could use and our over arching goal here was not to let the perfect be the enemy of the good and we feel you've got to really start somewhere. And we think a good place to start, out of the box is to look at the state and then eventually work from there down to smaller units in measuring both quality based on outcomes primarily and cost. And that will be total cost and utilization.

Over time as you get accountable care organizations, you could move down to that level or to group practices, hospital service areas, there's a lot of ways you can drill down. But our feeling was we start with states because we have some good data on states on both quality and we can measure utilization at the state level very easily. Also by having it focused on an area, you align the incentives for the physicians and the hospitals and all the providers to try to coordinate care better. That's how they're going to achieve better value scores is to work together. And at the state level you have state medical societies, hospital associations, et cetera who can really help to make that happen.

Also I noticed in your slide on the goals of the value-based purchasing and the alignment and I think if you look at using states to start, the alignment of that with the incentives being to work together, better care coordination, lower cost, improve quality, they lined up I think with everyone on the goals on your slide.

So, I guess that's our little overview, I want to make sure you keep that in mind as we talk now about much more specific types of measures, et cetera. Thanks.

Dr. Sheila Roman: Thank you.

Hugh Hill: Good morning, I'm Hugh Hill. I'm an emergency physician at Hopkins and while I appreciate the comments about needing to move towards the goal of working together, in a general way, I want to argue on behalf of being as granular as possible initially. In my 12 hour shift yesterday, I saw patients brought to the emergency room who'd been brought by the police as part of their processing, who'd been sent in by their primary care doctors for tests that were specifically for admission or sometimes for second opinions.

I saw patients who were frustrated by the pace of care or workup of their chronic conditions. I saw people who had complications of surgery within the global period of that surgery. We ordered tests to facilitate admission and to facilitate consultation which we may not have done otherwise. I saw well elderly and I saw young including a couple of beneficiaries who were near death. It is horribly complicated.

I'm grateful for the commitment to listen and to interact with us. I'm looking forward to seeing how that plays out. As emergency physicians we participated, I think fair to say eagerly, with the PQRI initiative and we want to help with this as well, but how? We're concerned with what we've seen so far and worried that we don't see ourselves included. We don't see these specific parameters of the practice of emergency medicine included and we hope to hear today how that's going to happen. But rather than just express worries, I want to say that we also see opportunities here. And we're eager to work with you to take advantage of those.

This is an opportunity to collect data, to look at some possibilities and we've appreciated how there's been some interest expressed in incorporating our practice costs involved in uncompensated and (inaudible) mandated care. And if there's a way to start collecting information about how much that would cost to do, this may be the opportunity to do it.

And finally as you talk about the transparency we're very glad to hear that we hope there'll be transparency in the process both here and with any contractors you engage in this effort. Thank you for holding this session.

Dr. Sheila Roman: Thank you. Any other comments from the floor? If not Simon are there comments from the phone?

Operator: We will now open the lines for comments. To state your comments, please press star followed by the number one on your touch tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity. Please note, your line will remain open during the time you are speaking so anything you say or any background noise will be heard in the conference. One moment please for your first comment.

Your first comment comes from the line of William Castler, your line is open.

Doris Lotz: Hi this is actually Doris Lotz. I'm the New Hampshire Medicaid Medical Director and I would just remind most folks, I'm sure they've all heard, that wherever Medicare goes other payers follow, including Medicaid. So keep Medicaid in mind when you develop these metrics and these reports particularly as we share a population in the duals. Thank you.

Dr. Sheila Roman: Thank you.

Operator: And there are no other comments on the phone at this time.

Overview: Phase II Physician Feedback Reports

Pam Cheetham: OK and let's move on then to the overview of the Phase II Physician Feedback Reports that we are expecting to have out late fall. And we

apparently have lost the slide. I'm sorry? OK. I'm told the projector needs to warm up after it becomes inactive for a moment somewhat like our computers, at least here at CMS. My name is Pam Cheetham and I am working closely with our contractor Mathematica Policy Research in developing what are still really prototypes for our physician feedback reports.

We're in Phase II and we are, I'm actually going to describe to you the approach that we're looking at in terms of collecting data, the data that these reports will be based on and we've posted on our website a prototype of the report for individual physicians. We actually are creating two reports. Oh, apparently people are having trouble hearing me, sorry, perhaps closer. We began with 12 geographic sites in order to target what was a beginning effort here and realizing that it was going to be still fairly small in Phase II.

We looked at Community Tracking Study sites that have, someone is assisting me with slides, sorry. We looked at 12 community tracking study sites spread across the country. These sites have actually been studied, their healthcare systems have been studied since 1996 and it's a fairly diverse group of metropolitan areas pending somewhat more toward urban than rural: Boston; Cleveland; Greenville, South Carolina; Indianapolis; Lansing, Michigan; Little Rock, Arkansas; Miami; Northern New Jersey; Orange County, California; Phoenix, Arizona; Seattle, Washington; and Syracuse, New York.

Those sites actually were the beginning impetus for our look at data and we looked at Medicare Part A and Part B data for 2007 for each of these sites. The Phase II report began by taking those, all of those data and organizing them by Tax ID numbers or TINs as we call them, to see if we could figure out logical groups. Those TINs consisted of at least one primary care physician, one medical specialist or surgeon who billed for evaluation and management services to Medicare under a shared TIN.

Each of those sites had to have at least 5,000 Medicare beneficiaries who were attributed to the group in 2007, and one physician practicing within the geographic area ofinterest. We also were interested in trying to start to tie PQRI programs together with the physician feedback effort so we included in

the TINs only those groups who had also participated in PQRI program in either the first year of the program 2007, or 2008, 2009 or 2010.

That's a fair amount of criteria for a group to meet and we ended up with 36 medical practice groups which we thought was a reasonable start for looking at groups. We also then drilled down into the groups to look at individual physicians who practiced in those groups and when I say physicians I am also including and I hope it is understood we're including nurse practitioners and physician assistants who are affiliated with a defined Medical Practice Group.

The criteria for those individual physicians was that they practiced in the CTS metro area or someone in their group practiced in the CTS metro area in 2007 and the practical application of this, although it was open to more than just primary care physicians, because of the numbers and the interface with HEDIS clinical data, a fair portion of the physicians that we looked at individually are in fact primary care, internal medicine, geriatric or family practice practitioners.

In order to be included in our group of individual physicians, it was important to have large enough case loads to actually make comparison so that was a important and also limiting factor in our selection of physicians. And I hope that although I'm referring to this in past tense, I'm describing a study layout and because the data are 2007 data, we kind of go back and forth between past, current and future tense. But my description is of the program concept and our approach; these are not obviously in stone.

Let me talk a little bit about a clinical quality piece. We use a subset of HEDIS measures. And there were 12 measures that we referred to as GEM measures. GEM is just an acronym for the study that they were initially looked at under. The HEDIS measures if you're familiar with them look at the percent of patients who received recommended, preventive and clinical services. There is a fair amount of focus on monitoring of chronic conditions and we thought that this was particularly pertinent for the Medicare population.

It's a small group of clinical measures but it covers a range of conditions that are both costly and quite impactful on people's quality of life. For the clinical quality measures, we compared individual physicians and a practice to their peers in the local metropolitan area and we also compared them to physicians in the 12 CTS sites. For medical practice groups we compared the groups to all 36 groups across all 12 CTS sites.

We also looked at hospitals and the portion of patients who had been admitted to a hospital and referenced our Hospital Compare website to follow up with greater detail on the clinical, and in the future, also resource reports for those hospitals. We referred people to the--I'm sorry for medical practice groups not individual physicians--we also looked at six ambulatory care sensitive conditions. The prospects of being able to defer hospitalization are increasingly important and of great interest to us and we thought that medical practice groups would benefit from being able to compare how they fare with their counterparts in the region and across the country.

For resource uses, we looked at per-capita cost for the medical groups and for physicians. Total per-capita cost, the average annual cost per patient and also per-capita cost by types of service, for instance inpatient, ambulatory care, ancillary services and we allow a comparison between counterparts in the region and across the country. There are six specific chronic conditions of great interest to us and those are included in the report. We also looked at total per-capita cost for congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes and prostate cancer. The relative cost for treating a patient with one of these conditions is an important piece of information and we're allowing physicians to compare their performance with those of their peers.

We also looked at hospital and ambulatory, I'm sorry emergency department admission, the rate of admission for patients were then attributed to either an individual physician or a group.

This slide is interesting and included in our proposed individual physician reports as well as the prototype report that we're working on for a group. It gives physicians an opportunity to see where the per-capita cost of their

patients fall in the range of a comparison with their peers. You see both the high and low end and where the individual physician falls in that comparison. And you'll see in the caption below which we've enlarged for the next slide that per-capita costs are risk adjusted and they're also price standardized and they're based on Medicare Part A & B claims from 2007 for all providers including professionals, the performing provider, hospitals, and post-acute care facilities.

The beneficiary is attributed to the medical professional. Obviously only those people are shown in the per-capita cost for an individual physician. Thirty is the minimum number of cases or attributed beneficiaries that we've looked at and we'll talk more about that in future presentations today.

The report dissemination process for 2010 is planned for late in the fall probably sometime in November. As I've said it's a small group of reports that we're still viewing as part of a process going forward. The individual reports are going to be made available through the Medicare Administrative Contractors or the MACs. So physicians will receive an advance letter telling them that the report is there, giving them some context for what this is and what they might expect to see, and then being urged to contact their administrative carrier.

The carrier will verify that they in fact are the physician they're claiming to be and our reports will be e-mailed to the physicians. We'll also have a help desk that will answer questions about how to receive a report and what kinds of data are included at that report, if people have questions about the underlying data.

For medical practice groups, we're going to follow the same dissemination approach as is used for PQRI, which require that groups have registered with the IACS portal system. We will send an advance letter to those groups announcing when it will be available and by the time they receive the letter the reports in fact will be there so there'll be no lag. We'll have a help desk for those people too and we're expecting to garner feedback as the result of this relatively small group of providers and groups receiving the reports.

I'm happy to answer questions.

Public Comments on Physician Feedback Reports

Pam Cheetham: Can you came to the mic please and please identify yourself?

Ashley Thompson: Ashley Thompson at the American Hospital Association and I'm so glad that you are going to take some questions because I just had a question about how you're going to deal with patients with multiple chronic conditions. So you have the six specific conditions but what are you going to do with the congestive heart failure patient that also has diabetes? Kind of where do they get, disseminate it or divide it and what are you doing with you know those complications that you'll run into?

Pam Cheetham: Actually one of the things that is going to be very helpful for people is that we're planning to post on our portal a detailed methodology of how we're creating these reports. It's quite complicated as you might imagine. I'm not certain how we deal with patients with multiple conditions. I believe, well I'm not even going to speculate. I'm happy to get back with you and try and give you more information but everyone please be aware that the methodology document is going to be extremely helpful and each of the reports also has both a glossary and a more condensed version of the methodology which we think is going to be very helpful.

These have been worked on for a long time. We obviously are very interested in additional input on all of this but we think we've laid at least the beginning ground work for many of the methodological issues that are involved. And the only thing I would add is that, and I think this may be your question, that we'll be looking at total per-capita cost for these conditions that for our patients we would consider for an episode a year from now. But we would be including in their total per-capita cost their cost for their other co-morbidities if that is more related to the question you were asking?

Ashley Thompson: They wouldn't be categorized as one thing or another. It would be total cost, if that's helpful?

Female: (inaud ible).

Ashley Thompson: I think that they do.

Pam Cheetham: Again I'd like to shift over to comment mode if we could and Brian?

Brian Witham: Brian Witham with the American Oncology and Cardiology. I may sneak a question in while I'm commenting. But you can feel free not to answer this if you want. I guess I'll start with the question. I wasn't clear entirely on sort of in the process for evaluation. When you did the first phase of these reports, you did kind of an active evaluation where people were calling the physicians and asking them what did you think of the report, you know with the clear. Will you be doing a similar process for the second phase?

Dr. Sheila Roman: We probably won't be talking to physician individually because it's phenomenally costly and time consuming and you get a very small number. We think that we're going to be doing focus groups of some type and talking to specialties about aggregate opinions.

Brian Witham: Yes I guess that leads into my comment which is I would really encourage you to talk advantage of those organizations specifically, those who have the conditions that are being targeted. We've been fortunate to work with some of the staff in CMS who've been working on this process, some who have moved on to some other things on those kinds of really specific issues and we've spent several hours with the staff with a number of our physicians who are involved in our performance measurement and value based purchasing areas.

And I think that it's really hard to kind of talk about these things in general in a meeting like this until you sit down with the reports and have it in front of you. So I would encourage that. I'd also encourage a sample report, actually a series of sample reports to be put up on a public website so that anyone in the public could view what the report looks like so you don't have to obviously identify what physician is out there but hopefully it will be from a real person and be identified in some fashion so that anyone could comment on it. That will be very helpful as well.

Dr. Sheila Roman: Let me reiterate again that there is a draft of the templates that we're planning to use for fall on the CMS website. It hasn't been released publicly but it is there and we are certainly interested in people's comments.

Pam Cheetham: And I can give you that website during the break if you'd like. Further comments from the floor?

Tanya Alteras: Hi I'm Tanya Alteras from the Consumer-Purchaser Disclosure Project. I just have a few comments and these probably apply to other presentations that are going to be given but I thought I'd share them now. One is in terms of developing the peer groupings; we just want to express some opposition to comparing physicians, to only comparing physicians in the same specialties. Within the primary care physicians and other specialties may practice more efficiently for patients with certain conditions of the six that you mentioned here.

And this should always be assessed just to get the correct peer groupings. So we think that CMS should really include primary care physicians and relevant specialists in any reference groups. And then my other comments on your presentations, in terms of attribution, we think that different attribution methods should be used for cost versus quality measures. And this probably applied to some of the other presentations that are going to be given. We do support CMS proposal to plurality minimum for cost metrics but for attribution of quality we recommend plurality of E&M visits for single primary care practice attribution and a minimum of one E&M visit for eligible specialist. So I think this gets beyond what you were talking about but we want to make that comment here.

Pam Cheetham: And you know we'll be addressing attribution and peer groups so you may want to actually get up again and bring up those issues.

Dr. Sheila Roman: And of course you're always welcome to send written comments with specific recommendations. We are interested. Thank you.

Tanya Alteras: Great thank you.

Dr. Sheila Roman: Any other comments from the floor?

Camille Bonta: Hello, Camille Bonta with the American Society of Gastrointestinal Endoscopy. We still continue to hear from our members with respect with obtaining the PQRI reports from the contractors that it's not as straightforward process as it should be. I'm sorry I don't have any solutions to offer you here today but if it's going to be used as a model for getting the resource use reports, I do voice that the process for PQRI isn't as easy as basically that should be there. They think it should be as easy as retrieving your information from your bank account online and it's just not that straightforward.

Also with respect to group reports, medical practice groups, we ask for consideration and we've commented on this in the fee schedule proposed rule with respect to the GPRO for the PQRI and the E-prescribing and that is that groups, whether in their individual positions have their own TIN and they're not practicing under one TIN, that they'd be recognized as a group practice even though they're not reporting under one TIN. So we'd ask for that consideration.

Dr. Sheila Roman: If I could just ask a question of you: how would we know that they were practicing together?

Camille Bonta: Yes. You know and that's a good question for me to, you know, we can think about it some more but I think that there's just there want to be some (inaudible) efficiencies. There's obviously care coordination within the practice that there be some recognition even though they're not structured from a billing process that way. But from a care coordination and team approach to care they are, they function as a group practice.

Dr. Sheila Roman: And I would say from our perspective we would love some input on how we can identify groups who really function as groups.

Camille Bonta: OK, thank you.

Iran Naqvi: Iran Naqvi from the Office of Rural Health Policy. And I'm sure you can anticipate what I might be about to say. So regarding your approach, although I know that this is now closed, I just wanted to really heavily emphasize that

with the approach, the original approach looked at the metropolitan areas and I know you're looking at comparison groups but we strongly, strongly recommend your looking also at the rural health areas. Medicare is the majority population at Critical Access Hospitals and so going forward with the continuation of your approach, the continuation of the looking at the various measures, if you could be very inclusive of measures that are very pertinent and relevant to rural health America, our office would very much appreciate that.

Dr. Sheila Roman: We thank you for that, and with our scale–up, I think we will be including rural areas. If no further comments from the floor, Simon on the phone?

Operator: We will now open the line for comments. To state your comment, please press star followed by the number one on your touch tone phone. To remove yourself from the queue please press the pound key. Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity. Please note your line will remain open during the time you are speaking so anything you say or any background noise will be heard in the conference. One moment please for your first comment. Your first comment comes from the line of Jerome Connolly, your line is open.

Jerome Connolly: Good morning this is Jerome Connolly and thank you for the opportunity to ask a question and make a comment. I represent a large number of rehabilitation providers, physical, occupational, speech, language pathologists and I have a couple of questions about the way this program moves forward.

First of all if you were to repeat the website, URL, for the report template and any other website information that you give out, if you give that out at the break, would you please give that out over the phone as well. Secondly, I understand that you were talking about physicians and nurse practitioners and PA's at this point and that's certainly understandable.

I understand the methodology that you're using going forward particularly with respect to metropolitan area analysis. And I understand the particular conditions that you're targeting. However I do believe that the authorization

includes to roll out to all providers who are physician providers, which would include the rehabilitation therapies. And I'd like to know what the methodology has in mind to include those kinds of conditions and those kinds of providers and perhaps sound an alert that there is some better and more beneficial data available within the rehabilitation therapies with respect to cost and outcomes, that is not available say in certain other medical specialty or other conditions and I would encourage you to be open to that. In other words I would be saying that may be reason to use a different kind of methodology for those kinds of patients and where beneficial data is available. And not to expect that we just use the same methodology that you're rolling out for physician and PA and then PEU's and apply that to the non-physician providers down the road. So I would encourage and as a response to that and then encourage you to be open to an expanded methodology where different outcomes and other data are available. Thank you.

Dr. Sheila Roman: Could you give an example of the types of methodologies you are referring to?

Jerome Connolly: Oh absolutely I'd be happy to. There are a number of very detailed patient assessment instruments that are used commonly in the rehabilitation sectors and these instruments have been published in refereed journals, have a high degree of responsiveness, reliability and validity and they measure functional outcomes. Whether that be in speech language communication or in functional outcome and functional status of the various patients who are undergoing therapy. Be that a hip replacement or a shoulder adhesive capsulitis or a stroke.

And there is a wealth of data. One of the organizations that has a wealth of data in speech language pathology is the American Speech Language and Hearing Association and there are also a number of other organizations that have a robust database, functional outcome data that has all been collected in the neighborhood of 3.1 million episodes of care, that have all been collected using valid, reliable and responsive measures.

Dr. Sheila Roman: Thank you very much. You know I would say that we are aware that the law says we will be extending beyond physician and physician extenders, you

know after 2017 and we're hoping that we learn enough along the way to be able to utilize these types of measures and metrics that you're referring to. Thank you.

As far as the website, right now, we're on the physician center spotlight section of the CMS website, but we do expect to have a website specific to this project--the physician feedback program and implementation of value modifier--up sometime prior to the report dissemination in late fall this year.

Jerome Connolly: Could you give the exact URL one more time please?

Dr. Sheila Roman: It's www.cms.gov/center/physician.asp.

Jerome Connolly: Thank you.

Dr. Sheila Roman: Any other comments from the phone Simon?

Operator: There are no other comments on the phone at this time.

Resource Use Measures: An Overview

Dr. Sheila Roman: Thank you. We'd like to move on now to the measures section of the morning. I think we look forward to a dialogue with all of you here in the room and on the phone. We'll have two speakers which will follow one another.

The first is Niall Brennan, who's Deputy Director of our Office of Policy in the Center for Strategic Planning here at CMS, and he'll be focusing on the resource use measures, and Shari Ling, Medical Officer in the Quality Measurement and Health Assessment Group in the Office of Clinical Standards of Quality. We'll follow with a discussion of some of the current use and challenges of where we are with physician performance quality measures. If I could ask Niall and Shari to join us up here.

Niall Brennan: OK, thank you Sheila. Good morning everybody. Thank you for joining us in person and on the phone. Get right to it. So why resource use measures. Well in case any of you haven't been paying attention, we spend an awful lot of money on healthcare in this country. And despite documented research

into the variation in resource uses, we really don't have a good sense of why healthcare spending varies in different areas or among different providers. So this is an effort that you know has been embodied in the Affordable Care Act that we are now embracing at CMS and have embraced over the past few years to move towards more of a value-based purchasing concept.

OK. Our key goals over the next few years are to slow growth and help lower system cost while maintaining our improvement in quality. Resource use reports and the value modifier are just one portion of that overall goal. We believe the greater transparency around resources use can lead to practice innovation and quality improvements. We believe that resource use reports are one of the tools that can do that.

Looking at resource use alone can also improve quality if you think about duplicative imaging studies that has both resource use and quality of care implications. Although as Pam and Sheila have noted we also intend looking at a range of quality measures as well. And finally we've been mandated to look at resource use under MIPPA and the Affordable Care Act.

So there are a variety of different types of resource use measures. As Pam outlined in her presentation for Phase II of the resource use reports, we're looking primarily at per-capita based measures, or population measures; however they are not the only type of resource use measures out there. So I'm going to mention a few others. In addition to a per-capita based measures, you have service-specific measures such as readmissions and imaging efficiency measures and they are two areas in which CMS is currently very active in.

We have hospital readmission measures for congestive heart failure, AMI and pneumonia and there are several imaging efficiency measures either getting close to NQF endorsement or that already received NQF endorsement. And finally there are episode-based measures. Most of you may be familiar with episode-based measures but for those of you who are not, episodes of care are measures that organize claims that are relevant to an underlying condition into a single measurable unit.

You can have acute or chronic episodes of care; chronic episodes are generally defined as being a year in length. And acute episodes can be variable in length. So you could have an acute episode of 30 or 60 days around a hospitalization for example.

So these different measures achieve different things and have different uses. Population-based measures are slightly more straightforward to calculate than episode-based measures. You're essentially counting all the dollars and counting all the people and coming up with a broad metric of resource use. So a clear advantage is that you know they're fairly straightforward, they're easy to understand, et cetera.

A disadvantage may be is that some people may view them as less actionable because it's difficult to look at all of the care the provider provides and figure out where you should zero in to focus on practice improvement. Episodes on the other hand, people argue that they're significantly more actionable because instead of looking at all the care, you're looking at all the care related to a certain condition. However that increases the complexity involved in constructing these measures and the clinical logic involved in creating episode-based cost measures can occasionally get a little bit complicated and especially in a population with multiple co-morbid conditions like the Medicare population. It can sometimes be difficult to determine with exact precision if a particular service or drug should group to one episode over another.

I'm sure many of you are aware that resource use measurement is a necessarily active field and has been for the last number of years even though CMS is only starting to embrace it now. There are a lot of commercial products out there that are widely used by private health plans such as the Episode Treatment Grouper, the Medical Episode Grouper and the Cave grouper. And in additions to these efforts, there have been a lot of other efforts to create, use and implement variations on resource use measures.

The National Committee for Quality Assurance has developed a series of per-capita based resource measures for people with certain conditions. The folks at Prometheus have developed some episode-based measures as have the

American Board for Medical Specialties in conjunction with the Brookings Institution.

There is a process underway at the National Quality Form to endorse resource use measures. The NQF has been very active and has played a very important role over the last number of years in endorsing a large number of quality measures in a way that brings all key stakeholders around the table to rigorously assess the measures for scientific acceptability, importance, validity and feasibility.

To date there have not been many resource use measures that have been a part of this process and so they have convened a steering committee to develop criteria for endorsing resource use measures. If you're not aware, the NQF has a white paper addressing these issues available on their website and it's available for public comment until October 5th I believe and it lays out some of the criteria they are thinking about for endorsing resource use measures.

And finally Section 3003 of the Affordable Care Act requires CMS to develop an episode grouper. We have followed a fair and open process throughout in this procurement. An RFP went out over the summer and we will be coming to a final decision regarding those proposals very shortly.

So later this afternoon, we're going to go into all these issues in significantly more detail but I just wanted to flag for you ahead of time some of the key methodological issues in resource use measurement. They are risk adjustment, attribution, benchmarking--attribution and benchmarking have both been already mentioned in public comments. And composite scoring, risk adjustment, you know it's essential to make sure that we're taking into account the fact that patients can have different disease and illness burdens and that we need to fairly calibrate the measures to ensure that physicians and other providers are not being unfairly penalized for dealing with a sicker than average population.

Attribution from my previous work in this field, it's definitely one of the issues that the provider community cares the most passionately about. There are both philosophical and technical issues relating to attribution and who is

accountable for care. Philosophical ones are who should be responsible for how much care that a patient receives, whether that be at a per-capita level or even at a disease specific per episode level.

And then the technical issue is once we've decided upon an appropriate attribution approach, how do we manipulate claims data in order to ensure that we're doing it accurately and translating it into practice. Benchmarking in peer groups are also key. Ultimately this is about looking at resource use and comparing it to norms and so we have to establish what those norms are and ensure that they're also as fair as possible.

And then Sheila later today will talk to you all about composite scoring. And that's really, really important because there are lots and lots of measures out there and we don't want measure overload or to overwhelm the recipient of these resource use reports. You know just give them a list of 120 measures and say here, go figure it out. And I think that's it.

Shari Ling: Good morning, all. So Sheila introduced me earlier. My name is Shari Ling. I'm a Medical Officer in the Quality Measurement and Health Assessment Group. I'm an internist and Geriatrician and therefore a generalist but I'm also a rheumatologist and therefore a specialist and I'm also hoarse. So our infectious disease colleague here may be my new best friend.

So let me begin with the purpose of quality measurement and the physician feedback program. The intent here is to provide monitoring of quality data along with resource use to drive quality improvement, to convey performance compared to one's peers however we define it. We heard some comments about being general as well as being specific and to push for system transformation. That is as laid out by Rick earlier to achieve the Triple Aim.

Niall has reviewed with you some of the resource use types of measures and here are the different types of quality measures at our disposal. There are process measures that you probably are all most familiar with. There are outcome measures and also composite measures which you'll hear more from Sheila about later. So the process measures touch on care processes that are known to deliver high quality care. That is, these include screening and

diagnosis measures such as mammography as an example, treatment and rehab, acute and appropriate treatment and management of hip fracture as an example, education and prevention screening for smoking as an example, and the proportion of the population receiving the indicated care. Now process measures by tradition have not been risk adjusted and we try to level the playing field by acknowledging some exclusion of confounding conditions or by stratifying population.

And in contrast, outcome measures which are what we traditionally think of as our hard targets including mortality and hospitalization, but also broadly achieving desired targets of therapy such as achieving an LDL score or level of less than 130, or a blood pressure target,or avoidance of a hospital admission. These do require traditionally risk adjustment and we'll hear more about that from Curt Mueller this afternoon. Now the last category is that of composite measures and that's where we can combine several either process measures, process with outcome measures. Perhaps even combining clinical and resource use measures and these are in process as we move forward.

So within physician measures, you're probably all familiar with the Physician Quality Reporting Initiative. The 2010 version has some 170 plus measures with multiple reporting options by individuals or as groups in a group practice using the GPRO tool. There's movement towards electronic health record reporting. And we also have the HITECH initiative that is the Health Information Technology for Economic and Clinical Health initiative that includes three core measures thought to be broad reaching and all encompassing relevant to generalists and specialists alike. But also clinical quality measures that touch on various specific conditions.

We have the HEDIS measures of which the GEM measures are a subset. GEM, representing Generating Medicare Physician Quality Performance Measurement Project of which are claims-based. Now the HEDIS also has, is by and large, I'm sorry - the HEDIS is generally claims-based but also represents measures that are a hybrid. Part of these measures are also survey-based and that is subject for future discussion and consideration for us as we move forward.

Now these are the subset of the HEDIS Quality measures. These are the GEM Measures. They are claims-based and general and broadly applicable. We have four categories including diabetes, cardiovascular disease, cancer screening and medication monitoring and below which you see the specific process measures. There are four diabetes measures, three cardiovascular disease relevant measures, and two cancer screening measures, and three medication monitoring process measures.

There are also outcome measures. There are clinical outcome measures. Intermediate outcomes including those which I've mentioned, achieving the blood pressure target or Hemoglobin A1c target. There is mortality, inhospital mortality, and there are attainment of successful avoidance of adverse events. One of our commentators also mentioned functional status. So perhaps attainment of a specific functional target would be another type of an outcome measure, as would be attaining quality of life as defined by standardized instruments that are currently available.

Now as you review the list of measures, the 12 HEDIS measures you recognize and we recognize that this is a limited set. These are reflecting core conditions that are high prevalence, chronic, and also expensive being diabetes, cardiovascular disease in particular. These quality measure sets will evolve over time. Our current measure sets are predominantly process measures and we recognize the need for outcome measures as we move forward. In specific we desire outcome measures that are meaningful to you as practitioners such as tying together the processes, the care processes we measure, that is, achieving perhaps an LDL outcome with an outcome of avoidance of MI or stroke.

We recognize that the relevance of the measures that are included does vary between populations and practices and really would seek your advice on these limitations and challenges. So our future direction: we intend to address other important chronic conditions such as osteoporosis and osteoarthritis. We recognize that the conditions and the measures that they're currently specifies deal with individual chronic conditions.

We have not tackled yet the challenge of those patients with multi-morbidities. It's very common for us and in my practice to see someone with hypertension, diabetes, heart failure and arthritis so that is a tough nut to crack and we would value your opinion on how to proceed to do so.

We also recognize that palliative and end of life care is another tough nut to crack. So we would welcome input on that line as well. We also know that the measure set, that the current measure set is really focused on physician's outpatient setting. We desire measures that are patient centered, that can march across settings that tie in physicians, hospitals, post-acute settings including the nursing home and the emergency department. And that we recognize that this initiative and our efforts to measure quality must align with existing programs and future programs including HITECH meaningful use.

We've heard that concern about PQRI as it marches forward. And all in all the measures that we select will provide building blocks for development of composite measures in the future. So I thank you for your attention.

Public Comments on Resource Use Measures

Dr. Sheila Roman: So the floor and the phone are now open for questions. You know I see people getting up, come right up and we have some questions that CMS would like to pose and get answers to as well. Please.

Chip Amoe: Hi my name is Chip Amoe. I'm with the American Society of Anesthesiologists and obviously up to this point all the feedback reports have been focused on primary care and you know the areas of greatest concern that you've identified already. My question is where are you in the process in terms of looking at how you're going to measure other specialties such as anesthesia. I don't want to speak on behalf of my other colleagues but things like radiology, pathology, eventually come, according to your timeline, come in 2017, all physicians are going to have to have some sort of resource use report that's mandated by Congress. And is that indeed the case and is that your view and where are you in terms of looking at that right now?

Dr. Sheila Roman: I think it's been certainly been pointed out to us in our comments and we realize that the measures that we'll be using in the Phase II reports are clinical preventive measures that don't address many specialties. The emergency room physician from Hopkins pointed out that hospital measures would better measure the work that he does. So I guess I would throw the question back to you and say what would be meaningful to your specialty and actionable for us to measure and report back to them to help you and us achieve the Triple Aim for the patients we care for.

Chip Amoe: Sure, first of all I mean certainly the PQRI measures that are applicable to anesthesia and those specialties the ones that we've identified are clearly important and things that we look to for measurement because they are self identified by us and put forth. I will say that I know that a lot of my specialty colleagues have concerns about the fact that our measures are having difficulty getting through the process and thus being able to be given to you to be looking at for our future measurement.

I will say that looking at the HITECH Act for example, I know you pointed out that. You looked at the core measures and you know clearly you all believe that they are going to be applicable to everyone. Anesthesiologists, believe it or not, are not going to be exempt under the HITECH Act. We're not going to be deemed hospital-based specialties, because a majority practice in the outpatient setting. A lot of those measures are going to be applicable to them even though they aren't applicable.

If you look at the core set there's a number of them that include follow-up care, we don't do that. That's not part of our general responsibility. So I think there really is for our types of specialties, like I said anesthesiology, pathology, maybe radiology, I don't want to speak on their behalf but for our specialty at least I think sitting down and working with you.

We have right now an Anesthesia Quality Institute. It's a data registry that we're collecting data information and we're having our anesthesiologists report directly to that institute and we're developing our own feedback reports for them and so we would encourage you when you get to this point, I'm not

sure if you're there yet and ready to wrap your head around that because I know there's a lot of these primary care issues first. But when you're there, we encourage you to please reach out to us and we will do the same and contact you. But please reach out to us and let us give you some of the preliminary data. I think it is preliminary and the feedback is ongoing between AQI and the physicians that we're giving those reports to right now. But we'd like to work with you so that we are properly measured and not consistently trying to put a square peg into round hole like we feel like we have been up to this point. So appreciate it, thank you.

Dr. Sheila Roman: Thank you. Further comments from the floor?

Ashley Thompson: Hi, Ashley Thompson again from the American Hospital Association. Two things, first of all thank you very much for having this listening session and for reaching out to the stakeholder community. Can't tell you how much we appreciate the opportunity to provide you with some feedback as you go forward.

Secondly you might wonder why the American Hospital Association is here given all the physician specialties. And just want to make sure that you're aware that hospitals employ--2007 data--over 188,000 physicians, so one in every five. That was in 2007. The trends have been increasing employment among doctors by hospitals such that most people say we're closer to every one in four doctors are actually employed by hospitals. So this is a big issue for us as well and one that we hope to get more engaged on and one that we hope that you'll listen to our voice as well as you did for our anesthesiology colleagues, our ID colleagues and all the others.

Regarding resource use, just one, I think what I heard is that you're going to be looking at per-capita resource use as well as perhaps episodes per resource use. And if you're not looking at episodic resource use we want to strongly encourage you to do so. We know that there have been problems in the past with the groupers but as we look at the Accountable Care Act, with all the demos and all the pilots and the Centers for Medicare & Medicaid Innovation, it really seems like you throw a thousand seeds and see what flowers bloom.

This seems like a great opportunity given all the complications of episode groupers to really explore different ones in use because right now the stakes in general are much lower. The data are confidential. It's not publicly reported. The data doesn't impact payments. This might be the opportunity to really explore what works and develop it over time because as we move towards bundling with ACOs, that information's really going to be critical so we just encourage you to do that. Thank you.

Dr. Sheila Roman: Thank you. I would also point out as you probably are aware that the total per-capita includes both Part A and Part B base, so hospitals do have a stake.

Brian Whitman: Hi Brian Whitman from the American College of Cardiology again. And this comment is related to the quality measurement. You know I think one thing that is not here that I think is sort of overarching in here is how to get to quality measurement without having clinical data and you know I think it's unfortunate that through the next version of these resource use reports are kind of going to the most kind of base area of claims-generated performance measures in the GEM project.

And it seems going forward especially if this becomes a payment program, we probably need to look to more sophisticated mechanisms for measuring quality. You know we know people are going to be reporting on quality through electronic health records, we have a number of registries that people are using on an outpatient basis and recognizing that many physicians out there outside the specialty of cardiology, after other specialties, have access to that.

I don't think we should necessarily hold everyone to the lowest standard. I think we need to make a program that brings you up to a standard that they are able to report clinical data as much as possible. And potentially put people in a position to say how are you going to be able to tell us what your clinical performance is. We can generate that based on claims but if you don't think that's good enough, you can participate in a registry, you can submit data through an EHR, something like that. I know that's operationally difficult but this is important and something that really needs to be considered.

Dr. Sheila Roman: Thank you.

Thank you. I guess would sort of pause here and ask one of the questions that CMS is interested in, is how prepared are care providers to submit data electronically. I think Brian has mentioned that some of the specialty associations had registries and that's one way but in general we'd like to hear from the audience about how prepared providers are to submit electronically data to us.

Tanya Alteras: This is Tanya Alteras from the Consumer-Purchaser Disclosure Project again. I want to echo everything that the last commenter said, I agree with everything he said. And I would suggest that in terms of just generally looking at more robust measures beyond the GEM program. Looking at the private sector and what's being used and that would include registry data which is not now being publicly reported. It's this sort of black box.

And then working with a consensus based entity. I know CMS needs to do in terms of the measures to their employees so working with NQF to get those types of measures fast tracked so they could be used in this program before 2017. In terms of specific measure areas, I think that we need to look toward care coordination and care transition measures as well as outcome measures to really start looking at resources use beyond process use. And looking at how physicians are doing in terms of coordinating care and lowering cost, improving quality for their patients.

Steve Schmidt: Hi, Steve Schmitt, Infectious Disease Society of America. And I would echo what the last two folks have said. I think, you know again getting towards some of the clinical measures that really do dramatically affect resource use, you might think about infection prevention databases such as NHSM database where you've got infection rates and how various physician groups affect those rates and that contributes to that.

And then you know I think in terms of talking about transition with care, registries, and moving from the inpatient to the outpatient. I think we need to consider how for instance registries of outpatient antibiotic therapy and time to first follow-up visit, complications of those kinds of therapies, you know,

line infections, clots, that sort of thing are the things that we look at in our databases and registries and would be interested in going forward.

Dr. Sheila Roman: Thank you.

Chip Amoe: Hi there Chip Amoe with the American Society of Anesthesiology again. I just wanted to respond directly to your question about how prepared our folks are to submit data electronically. Right now anesthesiologist utilize what's known as AIMS which are Anesthesia Information Management Systems. That's the electronic device or software that basically take what you know the electronic information that we write down on paper and submit those as claims. That's then captured electronically.

Right now the market penetration for AIMS across the nations is about five percent. Academic centers are higher than that. We're getting much more, I think there's about 32 to 35 academic anesthesiology programs that are up online contributing electronic data at this point, so.

Dr. Sheila Roman: That's helpful

Flora Lum: Good morning, I'm Flora Lum. I'm with the American Academy of Ophthalmology. To get to your question for Ophthalmology, we did a survey that we concluded this year that shows that nearly 25 percent of our members are either already on EMRs, EHRs or moving towards using an EHR. Also ophthalmologists are very amenable to new technology and to participating in these quality programs. We're one of the leading participants in the PQRI program.

But I think to answer or to go beyond your question Dr. Roman, I also think CMS need to ask themselves that question. How are they going to be able to accept and utilize the EMR data. We're one of the first specialties to actually have a true outcome measure that went through PCPI but it was rejected by NQF and CMS because they don't have a way to utilize or to obtain the data that would be necessary for that functional measure. So I really think that it goes beyond just asking the physician groups, how is CMS going to be able to use, to obtain and utilize that data.

Jim Blakeman: Hi I'm Jim Blakeman from Emergency Groups Office, Senior Vice-president. We are a medical billing company serving emergency medicine and it occurs to me that the specialty of emergency medicine is probably capable of delivering a lot of electronic data in part because the way charts are coded, the way bills are prepared are through an extracting method.

Rather than the physicians in this specialty commonly choosing a level sort of from their own perception, the industry is built around the concept that clinical reviewers or non-clinical reviewers will look at the medical record and extract data from it in order to prepare claims. Now obviously they do that now relative to evaluation and management procedures and so forth but it's a whole industry of people looking at medical records all day long, extracting data, putting into billing systems that are very capable of delivering electronic data right now and with a change in focus from simply claim related you know what visit level was this but determining some clinical indicators.

Like this asthmatic, what medications are they on right now, they're in the emergency department today. What are the medications that they are taking today? You know so the primary care doctor can tell you what he prescribed. We can tell you what the patient actually told us today they were taking. So just thinking of the specialty itself having a sort of window into when the system didn't work for a patient, they showed up in the emergency department. Now they've got a problem. What contributed to that?

We may be sort of in a position to tell you that electronically that we're extracting data. You give us the clinical indicator. We can determine that together. But in ways of providing that data to you through clearinghouses and you know through billing systems that are capable of collecting that now. So it's just a suggestion.

There is a trade association, of course the American College of Emergency Physicians and the Emergency Department Practice Management Association also are eager to have that conversation if that's of interest.

Camille Bonta: Camille Bonta, American Society of Gastrointestinal and Endoscopy. There's been a lot of discussion about the challenges of measuring resource use for patients with chronic conditions who are also being treated for co-morbid conditions but also want to emphasize the need to weed out preventive services that may be provided during ongoing care of a chronic condition that aren't directly related. So obviously in gastroenterology, screening and surveillance and colonoscopy and you can see where it would be a problem. Two scenarios: one, we've got a physician who is managing that chronic condition that may be GI related and then the time for the patient to get their screening colonoscopy falls within that, that episode of care but also in a multi-group, a multi-specialty group, practice where you may have a patient who has congestive heart failure but also the time period presents itself for when they need a screening procedure.

So I just like to draw that to attention. We want physicians to be positively rewarded for following guidelines and making sure that the patients are getting their screening and follow up the appropriate intervals and we don't want them penalized on the back end from a cost perspective. Thank you.

Dr. Sheila Roman: Any other comments from the floor? All right. Simon would you queue up for comments from the phone please?

Operator: We will now open the lines for comments. To state your comment, please press star followed by the number one on your touch tone phone. To remove yourself from the queue please press the pound key. Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity. Please note your line will remain open during the time you are speaking so anything you say or any background noise will be heard in the conference. One moment please for your first comment. Your first comment comes from the line of Christi Sarasin, your line is open.

Christi Sarasin: Yes hi, this is Christi Sarasin in Maryland. I am just wondering in what you have done so far and as you go forward, what consideration is being given to incorporating patient compliance or non-compliance into the risk adjustment methodology?

Dr. Sheila Roman: I think that issue we can address this afternoon. I think you know it's a tough nut to crack. But I think we would appreciate receiving that comment again this afternoon and perhaps we can have more discussion on it as we talk about the risk methodologies that we are planning for Phase II.

Christi Sarasin: Thank you.

Dr. Sheila Roman: Any other comments from the phone?

Operator: Your next comment from the line of Jennifer Eames Huff, your line is open.

Jennifer Eames Huff: Hi, my name is Jennifer Eames Huff. I'm with the Pacific Business Group on Health which a business coalition of 50 purchasers, and PBGH also co-chairs the consumer-purchaser disclosure project. I'm underscoring some of the comments that my colleague has made already, but also making some additional comments as well. And actually the first one is to just appreciate you for having this listening session and hearing our feedback on how to move this program forward, for the value-based modifier is an integral component to healthcare reform and changing the way physician payment is to moving towards rewarding value.

And having the Affordable Care Act offers the opportunity to be innovative and forward thinking. I was really pleased to hear at the beginning of the session, the emphasis on seeking creative ideas and creative thoughts in trying to roll out this program. In terms of the measures being used in the program, I agree with the types of measures that you've listed as other ones to build upon in addition to the GEM measures that are included, and I think as you know other people have said as well, feel like you need to move beyond just the process measures to the clinical outcomes, to the functional status and the quality of life type measures.

I think one thing that I haven't heard in the discussion yet that I would like to put out there is also including measures related to patient experience. I think quality of life and functional status, some of those measures do get at patients' perception of their care, their functional status, whether it's pain or other such things. But I also think getting that patient experience in terms of their

interaction with the provider, in terms of the care coordination, would provide valuable information in terms of the quality of care that is being provided.

Additionally I'd also like to offer up something to think about in terms of the data that's being collected and capturing data that would be able to allow for analysis of disparities in care. So the measures that are going to be included in the program should also include basic demographic information about the patient, their race, ethnicity, language and gender. So that information can be used and this program can be used to also look at disparities that we know are all too present and care.

Although I am strongly in favor of moving beyond the process measures, I realize some of the value in them is that they are already electronically available. A set of measures that hasn't been discussed for physicians that is based on administrative data but is also clinically enhanced, so they would include either pharmacy data or lab values, is measures that were in the National Quality Forum project on clinically-enriched administrative data. So there may be a way to expand beyond the conditions that you have currently in the program. You've talked about moving beyond those and using some measures from that project to help with that expansion. Thank you.

Dr. Sheila Roman: Any other comments on the line?

Operator: Your next comment comes from the line of Ron Ramsdell, your line is open.

Dr. Ron Ramsdell: This is Dr. Ron Ramsdell, Executive Director of the Multi-Disciplinary Medical Academy. We're a little concerned over the electronic medical record systems with PTs and other entities that see the patient frequently during the week. The auditors are now already making some accusations about repetitive statements and saying the same thing over and over again.

The medical record on EMR needs to be where the doctor can state or the therapist can state what's accurate for that day. You know we don't believe it needs to be an exercise in creative writing but I can already see from what I'm getting from the field is that you're auditors are not going to accept this. There's only so many ways that a computer can say something. So are we going to address that in some way or another?

Dr. Sheila Roman: I'm not quite sure exactly what you're asking? You know it sounds like it's an auditing question?

Dr. Ron Ramsdell: Well it's an auditing question as far as the way the auditors interpret the records but there's nothing in the electronic medical records based where the doctor, if he uses the repetitive statement the auditors are going to call it as a canned note and that's the basis of electronic medical records is that they are consistent with canned notes. For them to use electronic medical records and then have them to be subject to the accusations of just repetitive notes day to day you know especially on subjective, objective finding if they're the same, you know they're going to be, basically they're going to be fighting recovery efforts unless that's addressed up front is the basis of electronic medical records is to document accurately every time regardless of the repetitive of the statement.

Dr. Sheila Roman: Your comments certainly are duly noted and I guess I would extend from that that electronic medical records need to have the operational ability to download the types of information that would be useful to us in constructing resource use measures and quality measures.

Dr. Ron Ramsdell: OK, thank you.

Dr. Sheila Roman: Next comment from the phone please?

Operator: Your next comment comes from the line of Phil Bongiorno, your line is open.

Phil Bongiorno: Thank you. Hi, this is Phil Bongiorno with the Society of Thoracic Surgeons. I'm the director of government relations. I too want to thank CMS for holding this listening session. One of the things I want to address was the question about being able to share information electronically and I think one comment that I wanted to make was that STS believes that every effort needs to be made to encourage the development and expansion, accurate, incredible clinical database for the use in any quality improvement and in any quality or any public reporting system. Claims data are not just sufficient for measures of outcomes and are incapable of allowing adequate risk adjustment.

And I guess the question I had was very briefly was, what I think I raised in a meeting with the AMA the other day, of what CMS is doing to encourage the development of clinical databases, in particular medical specialty societies.

And secondly the other question I had was too, we made a lot of these comments in the past particularly at a December 8, 2009, listening session on physician value-based purchasing and I'm wondering if a report was ever issued by CMS. I think that was due May 1, 2010 under MIPPA.

Niall Brennan I can take that: in fulfillment of the MIPAA-based requirement, we provided a letter report to Congress mainly because so many aspects of the Affordable Care Act updated and expanded our value-based purchasing mandate and activities. So Congress was okay with the letter report because it had sort of become almost an interim phase and now we're moving it onwards with the rest of the program expansion.

Phil Bongiorno: Is that letter available to us on the CMS website or some other forum?

Niall Brennan: It's still in clearance.

Phil Bongiorno: Oh it's not been issued?

Niall Brennan: Correct.

Phil Bongiorno: Thank you.

And to the other question about the development of clinical databases, is there an effort by CMS to, I think it promise is the fact that you're looking for ways to develop formats to allow for entities like Medical Societies to be able to and has the capability this type of data, I think our question has been, and we've made this point in previous comments, is what will CMS do to encourage this development, I think in the form of funding or other mechanisms.

Dr. Sheila Roman: I don't think there's really anybody in the room who can address you specifically on that question. I guess I would turn the question around a little bit and ask you from your perspective at STS how you could best interact with

CMS understanding that you guys have had you know a registry that serves a very large majority of your practicing physicians nationally. How you would see that capability best being utilized with CMS. I'd appreciate your comments.

Phil Bongiorno: Sure, well I think we had a good start with the PQRI program and the recognition of registry-based reporting and I guess my question is or our concerns are is that we would like, and I think reflecting some of my colleagues comments, is the fact that we'd like to raise the standard when it comes to this type of reporting and have CMS, encourage CMS to do whatever they can to raise those standards. I guess, to answer your question about what we've done, you know we've worked for the last 20 years as you mentioned with our members. This was not an easy process for us. I think it was done with the intention of improving quality and it's going to take time but and that's why you know I think in partnership with CMS, I think we all want to work together to encourage the development of this type of format. I think it works well and we're trying to look at this from the perspective of improving this for all medicine and I guess that's the basis of our concern and comment.

Dr. Sheila Roman: And I guess I would ask you to be very specific for this program, how could we work with you specifically on using your database to develop metrics that would be applicable for your practicing community so that we would, you know, your feeling on how that would help us produce actionable reports for your physicians.

Phil Bongiorno: Well I think, I can't get into all the specifics over the phone and I'm not prepared to do that this moment but I think we've demonstrated in the past of how we've applied the data and the feedback to our members over the last 20 years in some of the specific procedures that we report on. We've reduced the risk adjusted mortality in coronary artery by-pass surgery by 50 percent over the last 20 years and so by providing this feedback.

So I think we have data to show how the outcomes have improved and just to make sure that CMS takes that into consideration. We can get into some of the other and we're certainly going to comment to CMS specifically on what

you're requesting, but that's just one example of how we've used the database over the last 20 years.

Dr. Sheila Roman: Thank you. I think it would be great to see a response in writing from you and perhaps a visit to CMS.

Phil Bongiorno: Terrific, thank you very much.

Dr. Sheila Roman: Any other questions from the phone or comments from the phone?

Operator: There are no other comments on the phone at this time.

Dr. Sheila Roman: OK, I think we're running really just about on time so I think rather than pose further questions to you, we'll save that for later in the day. I'd like to really thank everybody. I think it's been a very good back and forth discussion this morning. We'll reconvene at 1:15 and really spend the afternoon focusing in or methodological issues. Again we really view ourselves at the beginning here. We want to hear what you have to say and with the understanding that things will get better as we get more experience and move forward.

For those of you on the phone, I believe you'll be getting instructions from Simon as to signing off now and dialing in at 1:15. Thank you all once again and I look forward to us re-gathering at 1:15.

Methodological Issues

Dr. Sheila Roman: OK, welcome back to the afternoon session on physician feedback reports and implementation of the value modifier. As I said earlier, we will be focusing on methodologic issues.

I just want to make sure that the people from the phone are connected in. Simon, are people from the phone connected in?

Operator: Yes, all participants on the phone are connected, and we are live.

Dr. Sheila Roman: Thank you.

OK. The topics that we'll be covering this afternoon include risk adjustment, so I'd like to invite the audience member who had the point that you wanted to make about risk adjustment, if it's not addressed during our presentation to please bring it up again.

I think that risk adjustment is something that is very important as we progress with these measures. So I'd like to get down and really understand where people are and where people think the agency should be.

The next thing we'll be covering is performance measurement, and there's a lot of nitty-gritty topics that fall under that, including attribution, benchmarking, peer group comparisons and sample size. We've also heard, already, a couple of comments about attribution and peer group comparison. So please, to that person, bring those up again if we're not addressing them adequately.

And finally, we'll talk about composite measures and how they apply to the value modifier. That will be followed by really a – by a full hour we've allotted for public comments on methodologic issues. Then we'll talk about key milestones.

You know, it looks like it's far away, 2017, but really a lot of the important underpinnings have to be put in place, and the performance period will happen really in the not-too-distant future.

So we'll just review some of that, leave some time for some remaining comments from you in the audience, and then I'll just close up with some final thoughts, and hopefully we'll be out of here before 4:00 pm.

So without any further ado, three of us will be covering these topics. And the first topic on methodologic issues, risk adjustment, will be covered by Dr. Curt Mueller, Director of the Division of Research on Traditional Medicine, Research and Evaluation Group here at CMS in the Center for Strategic Planning.

Curt?

Dr. Curt Mueller: Thank you, Sheila.

My goal is to summarize how CMS is thinking about research adjustment methods, which, as Sheila has noted, are important ingredients in both its resource use reports and ongoing work on the value modifier.

Risk adjustment is used to address the provider's concern that my patients are sicker than yours, or I don't want to be penalized because my practice's patients are sicker and therefore more expensive to treat.

Risk adjustment methods facilitate a fair and accurate comparison of outcomes of care across providers and health care organizations. Risk adjustment is a statistical process utilizing information on Medicare beneficiaries to adjust for differences in beneficiary characteristics before comparing costs and outcomes.

When we risk-adjust expenditures, we calculate a dollar measure of resources used by the physician that reflects the practice's case mix. CMS has used the hierarchical condition categories, or HCC, model since 2003 under its Medicare Advantage program.

This model is used to calculate a risk score for each beneficiary. The model is based on 70 condition categories or flags – the beneficiary's age and sex and other factors, including both disability status and Medicaid status.

The HCC model can be used to calculate expected costs associated with a beneficiary's diagnostic history. If you calculate average expected cost for all patients in the practice, and compare this to the – this average to the average actual cost, you have a measure of whether the provider's resource use exceeds or is less than resource use for the average practice with a comparable diagnostic profile.

While this process adjusts for differences in diagnostic history of the practice's beneficiaries, it doesn't adjust for differences in severity, because severity levels are generally not well-measured under the ICD-9 coding system, which is the foundation for the HCC model.

Earlier this morning, the question was raised about whether we risk-adjust for patients' non-compliance. To date, we haven't. But this is a very interesting and important issue. We are aware of its importance, and we're certainly interested in it. And we're very much open to suggestions as to how we might get at the issue, in particular how we might measure it in a way that's potentially valid.

We used a variant of this generic risk adjustment approach in estimating risk-adjusted per-capita costs during Phase II of the resource use project, as described in this slide. The contractor did some trimming of outliers and calculated the ratio of actual to expected cost for the provider's practice. This ratio was multiplied by the comparison group's average cost to get a risk-adjusted cost as reported to providers in their resource use report and will be provided in subsequent reports.

In the future, we will continue to study methods of risk-adjusting costs at both the per-capita level and for specific episodes of care as part of our work on the episode grouper. These estimates will ultimately feed into calculations of the value modifier.

Just as we plan to risk-adjust cost measures, CMS will be planning and implementing risk-adjustment strategies for quality measures that will be incorporated into the value modifier. Our jumping-off point will be prior work on risk-adjusting hospital mortality and readmission rate measures.

In general, risk adjustment of these measures has been a modified version of what I've described for per-capita measures. Factors used to risk-adjust these particular measures have included primary and secondary diagnoses from the index hospitalization and condition categories that account for co-morbidities derived from prior year inpatient, outpatient and physician claims. Adjustment has been by condition, and models have been validated.

And I think at this point, I'll turn it over to Niall.

Niall Brennan: Thank you, Curt.

OK, I gave a little preview of this earlier this morning. I will walk you through some issues and questions related to attribution, benchmarks, peer groups and sample size.

So, as I mentioned in my earlier presentation, attribution is certainly an issue that is of great interest to anybody engaged in these types of measurement efforts. And on the first slide, I've listed some key issues that get at both what I described earlier as both the – sort of the philosophical underpinnings towards attribution and the technical underpinnings.

So some of the key issues are 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; and somebody had commented on this earlier, should the same providers be held accountable for cost and quality measures or, maybe expressed a little bit differently, should the same attribution methods be used for resource use and quality measures?

So let's talk first about to whom to attribute before we talk about how. Essentially, there are two main approaches. You can attribute to one provider at a time or multiple providers at a time. For single provider attribution, you could attribute using some type of gatekeeper, or PCP, model, which may not work particularly well in Medicare Fee-for-Service. Or you can employ algorithms that assign episodes or per-capita measures to a provider based on the plurality of patient visits or costs.

With multiple provider attribution, you could attribute to multiple physicians, say a PCP plus one or multiple specialties. You could attribute to physicians and hospitals or physicians and other institutions.

And then there are questions as to whether, under multiple attribution scenarios, should accountability be equal or should accountability be proportional to the care provided by those physicians or providers.

And finally, there's an issue regarding the threshold you pick when – with which to formally assign responsibility for a measure. Generally speaking,

the higher a threshold you pick, for example, 30 percent of E&M visits, the higher you – if you go to 50 percent, by definition – you will attribute the measure to fewer providers. If you go lower, you may have less specificity and less of a clear signal that a single provider is responsible for the majority of care.

From a technical point of view, generally speaking, attribution methods have tended to focus on either using contacts or visits or dollars-paid claims. You could look at total visits in assigning attribution or evaluation and management visits. This is often – or, this has been used in the past by other measurement efforts, because they feel that evaluation and management visits are a signal of provider interaction with a patient.

Or you could also use paid claims, and again, the same issue applies there. Should you use the dollars associated with E&M claims or the dollars associated with other types of claims, such as surgical claims? If you do use non-E&M claims or dollars, particularly dollars, there is a feeling or a concern that this will unduly weight attribution decisions towards proceduralists or providers who perform expensive procedures.

So the attribution approach, under Phase II, we employ a minimum plurality approach. And, in English, that means that a beneficiary is attributed to a physician group if the plurality of E&M visits to the group with the plurality – I apologize – of E&M visits, but only if that group bills at least 30 percent of the E&M dollars for that beneficiary.

Further, a beneficiary is attributed to an individual physician in that group based on the percent of claims billed within the group TIN if a physician has a greater than or equal to 20 percent of the beneficiary E&M dollars.

And following this attribution approach, the total value of the beneficiary's Part A and B claims are attributed to that provider group and that individual physician within the provider group.

Moving on to benchmarking, again, lay out some key issues. There are arguments for and against them all, obviously. Another important thing to

bear in mind is that we don't necessarily have to choose one. We can employ multiple strategies here.

In terms of how benchmarks should be calculated, should we use national benchmarks, local benchmarks or multiple benchmarks? Could a report contain several metrics showing your performance relative to providers in your area and then also benchmarking the area to more national norms?

How should performance be evaluated relative to a benchmark? This has been an issue with quality measurement in the past, too. Should we benchmark people to the best performers, to average performers? Should we reward attainment? Should we reward improvement, et cetera?

And finally, what should the statistical basis for benchmarks be – exceeding some dollar average or norm, being above some specified percentile or deviations from a mean?

Again, with regard to peer groups, we really have both philosophical and technical issues. The issue of peer group comparisons has already been raised by several commenters. And again, we don't necessarily have to choose one. We could employ multiple methodologies.

Should comparisons be performed within a specialty or across specialties? Or should we do both to provide information on your performance relative to the clinicians who practice you know in a style most closely to you but also to other clinicians who treat similar patients.

One of the technical issues here is accurately identifying provider specialty from claims data. There have been some issues in the past with inaccurate specialty data and perhaps – and also providers who do designate their specialty accurately but practice in a way that does not reflect their specialty. So there can be lots of specialists who are essentially acting as de facto PCPs for certain patients.

So for Phase II of the resource use reports, our current benchmarking approach for individual physicians is that their peer groups are other physicians in the same specialty in the same metro area and across metro

areas. So again, we see that this is a mix of some of the options that we – that I just outlined. And I think when data is presented in this way, it has the potential to be most helpful and actionable to physicians.

And data are displayed only if the peer group is comprised of more than 30 physicians. For medical groups, the comparisons are all groups across 12 metro areas, and the data are displayed only if the peer groups consist of more than 30 groups.

So the final issue that I want to talk about today is sample size. Again, for anybody who's been engaged in quality or resource use measurement, this is not a new issue. So the key issue is, what is an appropriate minimum sample size for quality and resource use measures? And does that threshold change depending on whether we're providing confidential feedback to physicians and providers versus publicly reporting the results versus tying those results to payment incentives of some type?

How many physicians will generate sufficient sample sizes for quality or resource use measures, and should physician results be subjected to reliability testing to examine consistency in results over time?

Currently, for Phase II of the resource use report project, our minimum sample requirements are as follows. We will require at least 30 cases for total – for total per-capita determinations, and at least 11 cases are required for the clinical process measures.

And, as I mentioned on my previous two slides, in order to compare either individual physicians to other individual physicians or medical groups to other medical groups, there needs to be at least 30 comparison groups against which to compare.

So that's it for my presentation.

Sheila?

Dr. Sheila Roman: OK, thanks, Niall.

Basically, we'll end the discussion on the methodologic issues with a discussion of composites of quality and cost measures. And I guess it's my bias that the rubber really hits the road at the measures level in underpinnings for calculation of the measures, but that the measures need to be reined in in some fashion so that a value modifier, as called for in the legislation, can be applied to the physician fee schedule.

So with that said, just a few words on composites and some different approaches as to how CMS may choose to develop composites, both for quality and costs and then combining those composites into a value modifier.

Just quickly, definition of 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.

Some examples might include, within a given dimension of health care, a patient's – for instance, a patient satisfaction composite. Across several dimensions of health care, a composite of process of care measures, resource use measures, patient safety measures and health outcome measures.

Now, some would say that one can get into treacherous territory combining measures that may have very different ranges, because they're very different types of measures. Another example across a single type of provider, the performance of all physicians affiliated with a medical group practice or across different types of providers, for instance the performance of both hospitals and physicians affiliated with an accountable care organization treating a given and defined patient population.

The current speculated use of composites by CMS is as mandated in Section 3007 of the Accountable Care Act, which requires CMS to propose measures of cost and quality to be incorporated into the value modifier, which 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 the confidential physician feedback program where there would be the ability to see what

actually comprises the cost score, the value score and what goes into the value modifier and to present the provider with information on the many factors that support their value modifier.

There are a number of ways to construct composites. CMS has previously used an opportunity composite for process of care measures and that's one in which the denominator is the number of Medicare patients who are candidates for any of the process measures and the numerator is calculated by summing the number of patients who were both candidates for and received any or all of the care.

Another possible, another way to construct the composite is by a weighted composite, which is a weighted average across all performance scores for individual measures or a variant of weighted composites where first domains are decided upon and combined based on either specific conditions, types of measures or for instance beneficiary cohorts before weights are assigned for constructing the composite.

Ways to determine what weights will be assigned include expert or provider consensus and I think to date you know there's not a lot of experience and we certainly understand that the development of composites is a complex activity and there are statistical analytic ways to approach determining weights for composites including regression analysis, factor analysis, principal components analysis and structural equation modeling.

And weights can, for composites, can be determined by the contribution to the relative variation in the composite score itself. Some options, potential options for determining weights include equal weighting which is obviously the simplest way to go and it tends to be the recommended option for determining weights, at least I think that that's been the one recommended by the National Quality Forum.

Where there is summing across all measures using equal weights or applying predetermined weights to the raw item scores. All or none weighting where the provider needs to achieve specific specified targets for measures in order to be awarded points for, toward that composite.

Compensatory weighting where the provider can achieve any of the specific targets for the measures in order to be awarded points. And obviously there are pros and cons to both of those – all three of these where measures that are low performers can hide within a composite score.

And obviously there are pros and cons when we think about all these methodologies and finally variable weighting which can be based on any number of things including the precision or reliability of the measures. One might down weight certain measures because of their lack of precision or reliability or one might weight based on empirical evidence of relationship of a particular measure to an improved outcome.

Or one might weight resource scores, for instance, within quality score bands so that there was a minimum quality score before giving any weight to a resource score. So any – a lot of possibilities and variations on how CMS might proceed forward with determining a composite and we'd be very interested in hearing your responses to all of the presentations that you just heard on risk adjustment, on performance measurement and all that goes into performance measurement, risk adjustment, attribution assignment, peer group, small N problems and finally how we should be thinking about deriving a composite for quality and resource and combining that into a value modifier.

So I'll open the floor for comments now, we have a fair amount of time allotted and I'd really appreciate a robust conversation.

Public Comments on Methodological Issues

Mary Patton: Hi, I'm Mary Patton from the Association of American Medical Colleges, and I just have two quick comments on the risk adjustment. We know that you're using the HCC model, but we just want to encourage that you include socioeconomic status of patients to the degree possible, potentially using patient zip code.

I know you did some work in Phase I using physician zip code but we think that you may want to look at patient level. We also – and this kind of goes back to a previous comment made in the morning session. We think that you

may want to consider either removing or stratifying patients who might have a potential compliance issues, in particular we are concerned about patients with mental disorders and substance abuse problems with whom you know trying to get patient compliance and managing is particularly difficult. So either look at those separately or potentially remove them from analysis.

Thank you.

Dr. Sheila Roman: Thank you. Would you have any other suggestions for ways to adjust for socioeconomic factors? Or whether we should adjust – we've heard arguments on both sides .

Mary Patton: We've heard both. Yes we've heard both situations, it can be stratified I don't think it necessarily needs to be risk adjusted but we have heard from anecdotally and we've seen a few like it seems to be an association we did an internal readmission analysis that we seem have to found an association with readmissions and income.

We don't want to remove, we don't want to remove this finding we want to look at, we're trying to understand it better. But we don't want people to be disincentivized when treating a difficult population. So again we're thinking maybe, potentially income from zip code, that's what we used in our internal analysis and we can provide you more information about that if you're interested.

Or I know it's hard to get that information but to the degree possible we think that there are, there could be issues particularly in inner city urban areas with some of those patients.

Dr. Sheila Roman: Yes. Thank you.

Steve Schmitt: Hi Steve Schmitt, Infectious Diseases Society of America. Several things, first of all quickly just – I completely agree with the comment about whether or not it's – we can accurately identify the specialties of practitioners who are sending in claims.

Unfortunately I think there's probably, there are probably big gaps in how that's reported and we're going to have to figure out ways to get around that because it's going to be critical in attribution strategies.

Question for – what do you do in this era of highly specialized medicines when there are folks who are in the same sub-specialty or specialty who are performing very, very different roles, some of them may be very high cost, some of them may be very low cost but they may be all contributing to the same sort of strategies.

And then in terms of risk attribution, the role of the patient in non-adherence is one thing, with meds is for instance a very important thing, HIV patients, diabetics who won't take their medicines appropriately. It's not always mental illness, they may just not want to do it or not tolerate the medicines.

What do you do about the patient who gets an infected prosthetic knee, has it – it's recommended to take it out, they refuse to have it out and then you have a whole series of complications and docs who end up taking care of those complications and to whom do those things get attributed?

And then finally, I liken--this is a baseball analogy and I hate to use these things in too many things--but you know you've got the pitcher who walks the bases full and then the next person comes in and has to deal with – the relief pitcher comes in and has to deal with that.

So what about how do you deal with complications of care and the physician who ends up doing the lion's share of dealing with complications that were primarily started under another physician's care? And then, and then lastly in the public reporting blew by, very quickly how is there a – I just want some clarification, ultimately here or elsewhere about how you see this data being publicly reported.

Thank you.

Chip Amoe: Hi there, Chip Amoe, American Society of Anesthesiologists, I have two comments. Number one, with regard to risk adjustment and just adjusting for various you know whether it be geographic locations or not, have you thought

about also adjusting based on type of setting, for example an academic teaching facility will have higher cost to treat a patient than a smaller community hospital?

You have more – the cases are longer and I'm speaking from you know an anesthesiology perspective if you're utilizing the drugs within, given surgery what might be a one hour case in a smaller community hospital might end up being a two to three hour case in an academic center because you have residents that are there that are teaching, you have medical students that are you know that are closing.

So the cost attributed to each you know level of care is going to be different in those various settings. So to do it based strictly on specialty across the board may not necessarily work. Certainly you want the quality aspects, I think to be there but I think when you get down to the point of measuring the actual cost of care I think you need to be comparing those comparably.

And then secondly on a – with respect to the public reporting, obviously when a patient walks into a facility to go get surgery they don't look at the board and say I want that anesthesiologist to give me anesthesia today. So there's really not a lot of opportunity in the same way you don't walk in and say I want that radiologist to read my x-ray or that pathologist to do my lab work.

It's just not the way we operate. So therefore from a public reporting standpoint, to be publicly reporting the data for each individual physician in a case where the public does not have the opportunity to choose is not necessarily helpful to the process. In those situations I think you'd want to give each of the individual physicians their own report so they can compare amongst themselves but from a public standpoint you may want to be looking at that in terms of the overall you know sort of a composite of care.

So a patient would then choose where they want to go get their knee surgery done based on you know less complications at XYZ Hospital versus another hospital or using that anesthesia group versus another anesthesia group or that radiology group, et cetera. But we really need to think about logically if you're going to give that information out in the public setting, how are the

patients going to be using it and if they can't make their decisions based on it why even put it out there and confuse the patients to begin with.

So just something for consideration.

Tanya Alteras: Tanya Alteras, the Consumer-Purchaser Disclosure Project. On the issue of risk adjustment we just want to express our support for the hierarchical condition categories, the HCC model for cost data. As you know NCQA found this method to perform as well or better than other models and I believe that is being considered.

On the topic of sample sizes, we would ask you consider using a point seven reliability threshold, either in lieu of or in conjunction with minimum sample size and that's for quality measures not for cost metrics. And you know I think I mentioned this before you know recognize the minimum case size for reliability would vary by measure.

So I'd be interested in hearing what you have to say about that. For – on the issue of peer groups I mentioned earlier this morning, I just want to reiterate our concern about comparing physicians in the same specialties and how particularly in light of Niall's presentation where you spoke about providers practicing outside their designated specialty and we think of you know primary care providers who are providing care to patients with multiple chronic conditions and sort of going outside the primary care framework.

We'd like to see peer groups – the way that that's dealt with reflect that. And again I mentioned earlier the issue of attribution, I just want to reiterate that we think attribution methods should be different for cost versus quality measures.

So as you mentioned before the plurality minimum would be appropriate for costs but for quality we would really support using a plurality of E&M per primary care providers with them using a minimum of one E&M per specialty.

And then finally on the issue of composites, whatever model is used whether it's the all or nothing or some other model, we really would like to see the

highest priority being given to patient experience measures, health outcomes measures. then total resource costs and finally cost growth, in that order and whatever the composite framework is.

Thank you.

Dr. Sheila Roman: Just as a follow-up to some of your comments and thank you very much, what comes to my mind do – will associations, hospitals, physicians be willing to survey patients? Because obviously to address you know some of the domains of care that you feel that we should both be measuring and making composites out of you know require information from the patients themselves.

Tanya Alteras: Yes and you know we recognized there are a lot of challenges to doing patient experience surveys but we feel that the importance of the data and understanding how patients actually experience the care that they've received and how that experience then translates to outcomes to help outcomes for the patient that you know those are challenges that we – there are ways to meet them and a lot of providers and hospitals are meeting them.

Bruce Kelly: Bruce Kelly again with Mayo Clinic. I wanted to address the composite issue and then I had a question for Curt I want to ask at the end, excuse me.

Bearing in mind what I said earlier, we've talked about using states or regions or hospital service areas but I think this principal applies no matter what the measurement is. We talk about a value modifier or value index concept as being sort of a simple equation of quality divided by cost and so the numerator, the higher your quality the bigger your numerator and the denominator, your cost, the lower your cost the lower your denominator.

And you divide them you get an index of you know one point something or zero point something if you're below.

So we think that's a fairly simple concept to begin with and looking at both the numerator and denominator to think about comparing to a benchmark, a national average of some sort. So the numerator let's say quality. If your quality was five percent above the benchmark than your numerator is you know one point something, the same with your denominator if your quality is,

or excuse me your cost denominator of cost is low, your cost is low. Then you've got a smaller number there again compared to a benchmark. So anyway it's sort of a formulaic way of thinking of it but I think it's relatively simple and straightforward to grasp the concept.

I did want to ask Curt, you mentioned in one of your slides there on the risk adjustment for resource use about standardizing cost for geographic variation, could you explain what that meant. I think you talked – are you talking about just standardizing for price differences or does it go beyond that?

Dr. Curt Mueller: Well no, we have both been experimenting with adjusting for differences in risk as well as kicking around issues related to standardizing both for geographic area but also site of service and differences in the payment systems that may impact different providers in different ways.

These are all issues that we've been exploring and kicking around. We haven't made any final decisions on where we're going yet in those areas. That we are aware that standardizing for geographic area and resources use are issues that we want to think about.

Dr. Sheila Roman: Just before we go into the next comment in the room, Niall or Curt do you want to react to any of the comments?

Niall Brennan: No. I thought they were great comments.

Dr. Sheila Roman: OK.

Dr. Curt Mueller: Yes I think the suggestions that you've made concerning risk adjustment are not new to us. That's a hard topic to try to summarize in a forum like this and we've been working on this for a while and we've got – these discussions are ongoing.

Please be free to send written comments if you want to provide more detail on the point you're trying to make.

Thank you.

Jason Scull: Jason Scull, Infectious Diseases Society of America, I'd just like to actually echo what Chip from Anesthesia said regarding the difficulty for hospitalized patients and let me preface that, preface that by saying that ID physicians primarily practice in the hospital. The difficulty for their patients who are often the sickest and most complex in the Medicare population to actually access publicly reported resource use data if Medicare does find a way to publicly report this data in the future.

Moving beyond what they currently report which I believe is only that physicians have participated in a PQRI, but they should consider whether it would be a benefit to the Medicare population and the inpatient setting to actually report certain specialties or at least their hospital data. Such as ID and anesthesia, it would be hard for to me to imagine a patient who is in the hospital, in their bed actually pulling up a laptop and seeing that Dr. Schmitt is a great performer in resource use.

Thank you.

Camille Bonta: Hello again, Camille Bonta, American Society of Gastrointestinal Endoscopy. In the physician fee schedule proposed rule comments that were submitted by the gastroenterology community we commented that the minimum plurality– it's been a long day, right -- attribution model is acceptable for Phase II but we encourage the amounts to analyze whether this attribution model results in fair and accurate reports.

And so let me lay out – it seems like for every attribution model that's put out there that may work for a society or specialty there's always an exception to that. So let me present a scenario where I think some analysis as you go through Phase II might be, might be warranted.

So for example a patient comes in to see their primary care physician and they're, the physician says I think you have anemia and refers the patient to a GI for workup and he or she performs a new patient encounter, the new patient encounters billed, they have a colonoscopy and colon cancer is found.

And then the patient's going to be referred onto the radiation oncologist or oncologist and so at that point when the patient makes a transfer for the, for

their cancer treatment the patient's probably going to have very little interaction with their primary care doc and perhaps no further interaction with the GI.

So you could see a situation where if you're doing the attribution for resource use based on 20 or 30 percent of the E&M , the GI doc is billing for a new patient encounter. You could see where that might, under that scenario, it might fall, the attribution for the cost, might fall to the GI doc. It might fall to the primary care doc. But all of the costs are really going to be incurred as that patient's going through their oncology treatment. So I just, I throw that out as a possible scenario that where, you know, the, you know, one attribution model might work for the bulk of services. For a particular specialty, there's always going to be these exceptions and I think that that's what makes this so difficult and perhaps rather frustrating. Thank you very much.

Brian Whitman: Hi. Brian Whitman from the American College of Cardiology yet again. I think we'll provide some more written detailed comments on some of these kind of detailed methodology issues. I think these are things that have kind of been discussed at length in sort of academic settings. And sounds like you're all up to date on all those things.

But just on a more narrow point on construction of composite measures, when you're putting together quality and costs, I think, our position would be that quality needs to be the most important element of that. We'd hate for physicians to be rewarded if they have poor quality and managed to have low resource use along with that poor quality. I think what we really want to have is high quality and have efficient use of resources along with that.

Ashley Thompson: Ashley Thompson from the American Hospital Association. I just wanted to piggyback on that prior comment about attribution and how difficult it's going to be. We would encourage you, similar to my previous comments about the episode including not just per-capita resource use, would encourage you to look at the many different types of attribution models out there,

including the six that were identified in the HHS/ASPE report by the RAND Corporation. To look at each of those. That would be great.

Sharon McIlrath: Sharon McIlrath, AMA. But I'm basically speaking not for the association. We will send some comments in. I actually have a couple of questions. Do you, I mean, do you read the law as saying you have to have a single composite measure? Because as a consumer, I think I would like to know what the quality composite was and what the cost composite was. I might choose to go to the more costly place if it was closer to my house. So I, as a consumer, I would actually like to have both. And I might like to also have some, you know, of the individual quality indicators, depending on what disease that I had. So I hope we won't, you know, roll it up so much so there won't be any information for the patient. And I had a question...

Dr. Sheila Roman: That's a very important point. Thanks.

Sharon McIlrath: I had a question about the risk adjusters. Do you think it would make sense to look at doing some risk adjusters that are specific to the specialty or the condition? I mean the groups that have done this and have the most experience at it have sort of, I mean, have done it for their particular procedures.

I wonder what you're going to do about snowbirds, when you start trying to do the attributions. I mean do you just, if you see that they got, I mean can you tell where they got the care. And when it moved to Florida, what do you do with that? Do you put it in a different bucket? Or is it in the same bucket?

And finally, you raised the question of, you know, what's an adequate sample for a physician? And I think that we all are afraid or pretty sure that there are going to be some physicians where you don't have an adequate sample. And so what are your choices? You end up rolling them up into a big region. And so they're judged, you know, depending on what everybody else in their region did as opposed to, they may be far better or far worse. It just seems

like there's just sort of basic dilemma that we have where we want to do this for everyone but, you mean, you have to do it for everyone according to the law. But it may not make sense to do it for everyone.

Dr. Sheila Roman: Thank you. I mean I think those are very important points. As Niall pointed out, I think we do know where people, where the claims come from. What we will do about it, I think, you know, is an open question at this point.

Niall Brennen: There is some, we have done some work on looking at risk by condition. We're certainly aware of the desirability of doing that if possible. There is also in our quest for an episode grouper approach to measuring costs, we're certainly cognizant of the fact that a general risk adjustment model doesn't necessarily work very well when you're focusing on an episode of care of a particular type.

Barbara Tomar: Hi. I'm Barb Tomar from the College of Emergency Physicians. And I know you heard from Dr. Hill this morning as a practicing emergency doc. But just to tag on to what Sharon and also what Chip and a few others said about attribution.

We're really struggling in emergency medicine to try to figure out where we're going to fit into all of this, you know, the episodes, the accountable care organizations, the re-hospitalization and the physician resource use. Because if, you know, you're seeing a patient who decompensated after being discharged, they generally are going to come through the emergency department to get readmitted.

And then if you're only seeing a patient every once in a while, you don't have your whole own group of patients so you're never going to sort of rise enough to the threshold for attribution. We're really struggling with how we're going to fit in. And how, as you're going to try to roll out the program from 1,500 to 1,600 docs to several hundred thousand docs, how you'll be able to work

these thresholds. So just a query. You're probably struggling with it as much as we are.

Dr. Sheila Roman: Yes.

Shawn Medalia: Hi. Shawn Medalia, American Society of Radiation Oncology. Also wanted to sort of follow up on Camille's comment from the GI Society about the colon cancer patients. And with radiation oncology, we do have a code for weekly treatment management that is sort of the RO's sort of E&M code. And so I'm wondering, you know, that's potentially is a solution for that scenario. And if you dig deeper within the CPT book if there are other codes where you can identify E&M services for specialists?

Dr. Curt Meuller: I think it's an excellent point and then the issue with not only do the codes exist, but that they're used.

Shawn Medalia: Our code is definitely used.

Dr. Curt Meuller: Well that's good to know.

Dr. Sheila Roman: OK, further comments in the room? If not, Simon could you queue the comments from the phone please.

Operator: We will now open the lines for comments. To state your comment, please press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity.

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

One moment please for your first comment. Your first comment comes from the line of Christi Sarasin. Your line is open.

Christi Sarasin: Hi. Thank you. Curt, I want to thank you for answering my question that I had earlier. But I wanted to just, as a consideration because you had asked, the other, you know, we have compliance and non compliance as a factor to the risk adjustment and specific things that would feed into why that's occurring.

But you know, there's also the situation where you have resource consumption as a result of an inability to transfer patients to a more appropriate setting or facility. And so this, you know, to the extent that that happens, I would hope, you know, that that would be a consideration.

You know, at one point CMS had said that there were, what, $15 billion attributed to readmissions of Medicare patients. And that 18 percent of those beneficiaries that were discharged were readmitted within 30 days. That accounted for $12 billion of that $15 billion. And to the extent that non compliance and compliance contributes to that, I just think it's an important number to find out.

And then the only other thing that I was wondering about is when you ultimately come up with your methodology, will that be publicly available like Health Grades has their information out there? Or will this be information that can only be accessed through the QualityNet users?

Dr. Sheila Roman: What was the ending of that? I didn't quite...

Christi Sarasin: Well...

Dr. Sheila Roman: Only can be accessed through?

Christi Sarasin: Through the QualityNet.

Dr. Shelia Roman: You know, I think we're not that far down the line but I think our intention here is to be as transparent as possible. I think that we feel that the only way to bring this forward in a way that is fair to the practicing community as well as implementable by CMS is by being transparent so that everybody is on board with the methodology and understands where, how the numbers are being arrived at. But I think more is to come.

Christi Sarasin: Can you tell me where written comments should be sent to?

Pamela Cheetham: We actually do have a post box. And let me get the address for that and we'll announce it before the end of this session. It hasn't been widely used. We will certainly post it on our website as well. And we have asked people to, in fact, it's in the Federal Register notice for this meeting. But we will announce it before the end of the meeting.

Christi Sarasin: Thank you.

Operator: Your next comment comes from the line of Jennifer Eames Huff. Your line is open.

Jennifer Eames Huff: Hello. And as a reminder, I'm with the Pacific Business Group on Health and also a member of the Consumer Purchaser Disclosure Project. I get, the first comments I'd like to make are in regards to the composites. And I think, you know, some of this discussion is, I think, difficult because I think the hope is that the measures that will be included in the program, especially the quality measures, will be greatly expanded upon.

And I think, you know, what gets included in the program as a, helping to determine what some of the composites should be or how you should go about

doing that. So I think that's a bit challenging. But I will say sort of some high level comments.

I think, you know, you also want the composites to address policy goals that the program is trying to achieve. And I think at the macro level for the quality versus the costs, I don't think we'd want efficiency to be at the expense of quality. So when considering how to weight this composite, that should be considered a factor in determining what they should be.

I think within quality in those composites we'd want to have greater weighting on measures and activities that we think are higher value or of greater importance. I would say that falls in the line of clinical outcomes, functional status measures and patient experience. I think within the quality realm though, there is also the possibility of having all or none composites, especially when you're looking at process measures that if you have a set of process measures that together attribute or combined will help you achieve an optimum outcome, that they may be an appropriate place to have all or none. So I think, you know, there are multiple ways to be using composites and different ways that they can show up in the program depending on the measures and the policy goals.

In regards to the risk adjustment, I would just say I guess one of the cautions that I would have is to try and find the most important measures that should be included in the risk adjustment model instead of trying to get every possible measure. Because I think, socioeconomic status was brought up earlier. And I think in some instances, that may affect the results. But in some instances, it doesn't. So I don't know if I'd say across the board that should be included in all the models. I think it would depend on the particular measure in that model.

And I think there was a question raised around patient experience and will providers do it? You know will providers survey their patients? And I think there is a lot of experience out there that shows that providers are willing to do

that. I think in the hospital arena with HCAHPs, you know, across the U.S., hospitals are doing this as a part of the CMS MAC approved program. There are a lot of regional collaboratives that are doing patient experience assessment for physicians or physician groups, you know, including California, Massachusetts, Kansas City, Memphis, Grand Rapids, Michigan. So there's quite a few places out there that are doing this.

And then let's say on top of it, physicians themselves have shown an interest in this. You know, this is eventually there'll be a component that will be included as a part of many of the maintenance certification programs. So I do, I do feel like there is an openness and a willingness of providers to assess patient experience. Thank you.

Dr. Sheila Roman: Thank you. The next in line?

Operator: Your next comment comes from the line of Elizabeth McNeil. Your line is open.

Elizabeth McNeil: Hello everyone. My name is Elizabeth McNeil. I'm with the California Medical Association. I have a cold today so forgive my voice here a little bit.

We sent you comments on Monday and are trying very hard on sending you some more detail on how to actually implement the pieces of this value modifier but I do want to thank CMS for inviting comments. I don't think anyone has done this what you've been charged with doing around the country all in one program. So we do sympathize with you in the charge you have ahead of you but also offer our assistance.

In California on just the feedback programs in general, many of our medical groups around the state have established some very successful feedback programs on both the quality side and the utilization and cost side.

And so we are hoping to get you more detailed examples of how those programs and how they work very well. They worked well in the group level. It has not worked as well on the individual physician level but we are eager to show you some of those examples and successful models.

On the composites we would absolutely urge you to have to two separate composites. One for quality and one for costs and that's what our group here – our medical group here have done.

A third point I wanted to make and I don't have details for you on how to implement this. we're going to be sending that to you in more detailed comments, but I do want to make the point that we think that there is a mandate in the law to adjust for socioeconomic health status as a patient.

And that this is a very crucial issue that has to be addressed. Not to pick on our friends at Mayo Clinic in Minnesota have been commenting this morning but I just want to make the point that for instance if you compared Los Angeles in California to Minnesota, we have a 40 percent poverty rate there and in Minnesota it's 12 percent.

We have black – African-Americans and Latinos that make up 60 percent of the population in LA versus nine percent in Minnesota. They have an uninsured rate there of 25 percent versus in Minnesota it's nine percent.

These are socioeconomic factors that create a huge as we all know healthcare disparities and our physicians are very challenged to provide access to care for this patient population in our urban centers in California.

And we fear that if these factors are not included that we will have – physicians will be discouraged from taking these patients and we have to make sure that we don't widen the gap in disparities for these patients.

So that's a very crucial issue for us that we think you should take into consideration. I also think that you need to make sure that you continue to adjust for geographic practice costs--our ramps and physician office expenses in California are much higher than they are in other areas of the country. And the wages – our physicians have to pay their nurses, billing clerks, et cetera. There is a wide variation around the country in these practice expenses that have been well documented and that we would just urge you to take that into consideration as well. MedPAC did a study on this in December and you may

want to look at some of the methodology they employed in looking at some of these issues.

I just want to add to the comments on patient compliance. That's been an enormous issue here in our quality reporting programs and because of these patient populations we have in our urban centers, that's another factor that needs to be taken into consideration.

And the last point I wanted to make was on attribution and some of the other issues just bigger picture issues on quality reporting. We've had quality reporting in California probably for 15 or 20 years now that's worked quite well on the group level but it took us a long time to get there.

We had started to try some programs on the individual physician level that we believe are not producing accurate quality information. So when we look at attribution and methodology and other factors like that, they're going to be very important that we work to get this methodology correct so that we are producing accurate information on the individual physician level.

We have sent you detailed comments on our experiences with programs here in California so that we can learn from those and hopefully implement a program that will accurately reflect the quality and cost of and help physicians improve the quality and costs of services they're providing.

So thank you again for an opportunity to participate today.

Dr. Curt Meuller: Thank you for your comments. There has been a couple of references to composites and I just wanted to hopefully try and clarify. You know the way this program is going to work is that we have to take a range of quality measures and range of resource measures and figure out ways of aggregating and weighting them in order to make a determination of how to ultimately adjust the conversion factor.

I don't think at least that there is any suggestion you know the only thing we would report would be a single composite and in a way there are two pathways. There is the adjustment that will be made to the conversion factor

and just you know mechanically we're going to have to figure out a way to do that, taking all these different things into account.

Then there is the you know transparency around the resource use reports both you know. But for physicians too it's not very helpful for a physician or a consumer to get a single number or even two numbers for cost and quality.

I think what the power of composite measures is they can show you how groups of measures aggregate together and give a sense of overall directionality so you know if a provider is that composite for resource uses, 0.9 that tells you generally – and that physician uses fewer resources than normal and their quality might be 1.2 which suggests that their quality is higher than normal.

Then you can drill down and see the reason their resource composite is 0.9 is because of A, B, C, D and the reason their quality is 1.2 is because of you know HIJK. So just want to try and clarify that. At least that's the intent.

Dr. Sheila Roman: And I think that's where you know the two Sections 3003 and 3007 you know really merge because it will be in the confidential physician feedback report that this information at these lower levels will appear for physicians so that it will be broken down to most likely to the lowest levels of measure performance and build up from there.

So that they can actually see how their modifier, what their modifier is composed of. And you know I would certainly agree that the agency is you know not interested in pushing physicians to be low cost, low quality and that the quality score will be of great importance as we you know proceed down the road here.

Any other comments from the phone Simon?

Operator: There are no further comments on the phone at this time.

Next Steps: Key Milestones

Dr. Sheila Roman: OK I think I'd like to keep moving forward then and talk a little bit about key milestones for the Physician Feedback Reports and our modifier program.

OK, the intent of this little section is really to try to put it all together a little bit for you and to again you know bring to the forefront that although we're talking about 2015 and 2017 that the work that we have to do really has to start now.

And we actually have real products that we have to be bringing to you in 2012 and that on your end, the physicians who are affiliated with you need to really think how they might be approaching their practice of medicine differently so that they can meet the Triple Aim of better health, better quality and better costs.

So as I reviewed this morning in 2008 and through the end of this year, we have had dialog with small numbers of stakeholders regarding report design, content and methodology and that we have engaged physicians, groups and specialty societies.

We've been in the physician fee schedule for several years now and we will continue to use that process as we move forward with the specifications for the program, including the measures and including the specifications for the underpinnings for the measures as well as for the composites.

We expect to continue to have public listening sessions and technical expert panels and I'd also like to invite you to contact us to come in and discuss with us you know how we might work together. And you know I think that will come up a little bit further when we move into any remaining comments.

So in 2009, as I said this morning we had a very small dissemination. We expect in 2010 to have a somewhat bigger dissemination and to do retrospective analysis on this bigger dissemination to 1,600 individual physicians in 36 medical groups. I think what will be of utmost importance is to receive feedback from the groups who do receive reports that they do see themselves as groups, they don't see themselves as groups.

You know we're working from a TIN-based tax I.D. world and that may not have a lot of relationship to the relationships that physicians have with each other in the way that they practice. So I think that's a message that we'd like

you to carry back is that we really do need feedback as to whether what we call a group actually is a functional group.

For 2011, we're thinking at this time that we're going to have a – in order to meet the goals, which we've set for ourselves, that every physician who is going to come under the value modifier in 2015 should receive at least one dry run report before they have a value modifier applied to their services that we're going to have to scale up pretty quickly.

So we're thinking this year of a scale up of reports to 10 to 20,000 physicians with possible enhancements of the reports. When we open up for comments again I would like to elicit some comments on what possible enhancements you think would be useful to your constituencies in this scale up.

I'd also – will also be posing the question of you know how do we do this scale up you know who – who's the target population. I think we've heard from the Mayo Clinic several times today that we should be producing – you know proceeding in a – in a statewide approach. I'd like to hear if others agree with that or if there are other suggestions as well that we should be thinking about.

In 2011, which as you know is really right around the corner right now, we'll be beginning and having further dialog with stakeholders in choosing the measures, both of cost and quality. I'm not sure we'll get as far as creating composite scores, but we will certainly be having discussions about the choice of quality and resource measures that we should be doing.

And the sub bullet there lists for you our various ways of interacting with you, we would also invite you to come to us. And of course we'll be continuing research as well as stakeholder input on methodology considerations on constructing measures. We'll be looking at price standardizations, attributions, risk adjustments, peer groups, benchmarking, minimum case size, cost and quality, composites work in our analysis of the data that you know we'll be accumulating.

You know I think we also do have the opportunity at this time since we are so early on in the game to test out different methods as we move forward. And

that's something we'll be giving some thought to and something else that I'd like to have feedback from the audience on, as well.

For 2012 I think that will be a very crucial year for both you and for us. As we will be by law held to publishing the initial performance period for the 1/1/15 value modifier through rule making. We'll also be publishing the measures of quality and resource use that will be going into the value modifier and I would like to emphasize again that you know that first list will almost certainly – will not be the final list that we'll be working on this for and perfecting this for years to come.

So we'll be interacting with you, I think, for years to come on this and as we meet the challenges to measures, both from the perspective of quality and resource, we'll be improving the measures that actually go into the value modifier.

And, of course, you know we'll continue to enhance the feedback reports themselves. And we'll be – we'll be headed up a very large hill of a scale up of reports that quantify and compare patterns of quality and cost. I don't you know I don't want to speculate on a particular number of reports that we'll be putting out in 2012 but it's obviously going to be significantly more than 10 to 20,000 if we're going to meet our goal of getting reports into the hands of physicians for whom the value modifier will start to apply in 2015.

And then 2013 through 2017, in 2013 we'll begin implementing the value modifier through rule making and essentially what that means is that we'll make available through rule making the analytic methods to convert measures to a modifier for your comments.

I think we'll have multiple other venues for you to bring comments to us. And obviously again I want to say that you can always request to come in and meet with us and share with us your thoughts about the direction that we should be going.

Twenty-thirteen we'll see a further scale up distribution of feedback reports with the value modifier for 2015 of cost and quality with the goal of sending a report to all the applicable Medicare physicians and those would be those

specific physicians who will be receiving application of the value modifier in 2015. Twenty-fourteen, we'll complete implementing the value modifier through rule making so that the specification – the analytic specifications for 2015 will be solidified in 2014.

And then as we've said earlier we'll begin applying the value modifier, 1/1/2015 for specific physicians and groups and in 2017 for the services of all physicians and medical groups. So with that I'd like to re-open the floor here for any remaining questions that people want to react to what I've just said or questions that have come up, the questions you didn't get to answer--or to ask rather--earlier, and as well open up on the phone.

I'd also like if Mr. Curtis, if you could put the other slide deck of questions that you have ready for the PowerPoint.

Remaining Public Comments

Jason Scull: Jason Scull, Infectious Diseases Society of America, just one quick point of clarification. Given that you've already asked for comments on the value-based payment modifier in the 2011 proposed rule and I guess according to the ACA's timeline and what you laid out in your PowerPoint presentation do you foresee publishing a proposed value-based or the proposed value-based payment measures of quality and resource use in the 2012 proposed rule?

Dr. Sheila Roman: I think if we have measures ready that we think gel with other projects that we will be publishing in the 2012. But you know I think that's with a grain of salt and speculation at this point.

Jim Blakemen: Jim Blakeman, Senior Vice President, Emergency Groups Office. And I want to thank you the agency as others already have for their very definite transparency and willingness to hear from the provider community. I very much appreciate that and want to ask the agency to be sure in the implementation process that you are looking at ways for providers to appeal their reports and the information they're getting back to question the data in the early phase in a PQRI.

Those of us who were early adopters you might say there was no money on the line early on and the data sometimes didn't make sense that we got back. But we didn't say a whole lot about it and then all of a sudden when it rolled out and everybody was participating there was no appeal process.

And so eventually the agency found that there were problems with the data and there was attempts to correct that. So I'm just asking that the agency consider in the implementation process some way to hear back from the provider community before it rolls out to all 600,000 physicians in some meaningful way that does challenge us to provide to you the problems that we see so that from the provider community we don't just whine and say "but we're different than everyone else."

You know that we bring to you the data that you need but that there is a mechanism and defined process for doing that.

Dr. Sheila Roman: I think that's a very important point and I guess I would ask the audience both here and on the phone what is the best way for us to set up a formal appeals process--for it to go through specialty organizations …?

Jim Blakeman: Specialty organizations are one way because they do aggregate the concerns, they do hear from their members but I think direct you know a means to hear directly from providers about their specific reports. Now that can grow into a very difficult, complicated …

Dr. Sheila Roman: Absolutely.

Jim Blakeman: … you know item-by-item and very costly and sometimes very inefficient mechanism. But if there is some way to hear the same kind of complaint coming over and over again, the same sort of data not quite looking the way you thought it was looking that the provider can come to you with data saying well here's what I can see, here's what I know.

And so there is some way to bring that back to you. I think specialty organizations are one mechanism but I might suggest that there be an independent means to do that, as well, so that that's – and that you given very

careful thought obviously to your implementation benchmarks. But – and your process but this might be one to consider as well. Thank you.

Mary Patton: Hi, Mary Patton from Association of American Medical Colleges. I just wanted to go back to your point of what is a group. I think there was a comment from the first part of the day that there are cases--I guess faculty practices in academic centers--there are many cases where you have like all the faculty under one tax ID number.

Other cases where it's like each department has its own tax ID number and those reasons were done for business reasons and you know but they do have some consistency across the departments. I know you're asking for ways how you might assemble those groups and we can try and work with their members to get some detailed processes that might work.

One method could be to have groups come together and say you know really we're all part of the same institution, we all work together, we share the same offices, share the same facilities you know and do you have some kind of mechanism for them to self-nominate through that process.

But obviously you need something that works with your own system. So we'd certainly be willing to work with you, as well.

Dr. Sheila Roman: Thank you.

Chip Amoe: Hi, Chip Amoe with the American Society of Anesthesiologists. As you go about the timeline and the implementation I would just very much encourage you all to make sure that you also keep an eye on the progression of the HITECH implementation. I know you're already raised that already and I know a couple of other folks have brought up you know PQRI and the programs that are going on.

But as you know as we move along I know CMS has different silos but to really keep an eye on how the progression is going, do the you know are the various specialties in which you're now going to be sending reports are they getting up to speed with respect to electronic reporting? To make it a lot easier so we're not duplicating efforts and if that means starting off smaller

with respect to the measures that you're putting out early on so that you can get it ramped up you know then so be it.

But I think is should definitely coincide with the implementation of the HITECH so that everybody is on the same page.

Dr. Sheila Roman: Thank you.

Ashley Thompson: Ashley Thompson, AHA and my comments also piggybacking off of the last two. As you're thinking about rolling out – well as you're thinking about the measures the consolidation of the measures would be really helpful if you're thinking about the institutional setting that has to implement all of them.

So for large clinics or hospitals or large faculty practice plans you know the 180 or so PQRI measures are tough and expensive and if we could focus on something smaller, like 50 or so where you could get the biggest bang for the buck that would be really helpful.

And similar to that the importance of aligning hospital and physician measures over time and I think you mentioned that in your opening statement which we appreciate. Knowing that we're kind of in a transition phase I'd hate to set up a really complicated process when the end goal is going to be more like bundling or ACOs and so perhaps we should be looking at those care coordination measures and the transitions of care measures and all that just so that again we're aligning incentives across all providers. Thanks.

Brian Whitman: Brian Whitman from the American College of Cardiology. This is a question, just trying to work my way through the timeline here. So 2015 you begin implementing the value modifiers for some physicians but the rule making for that does not conclude until 2014.

But because you're likely measuring chronic conditions where you would need a year of claims data, the earliest you could use would be 2013 data--is that a good assumption?

Dr. Sheila Roman: I think that's probably a good assumption. It's not a declarative fact.

Brian Whitman: OK so that could mean if that was the case – let's say that was the case then that means the rule making for the implementation of value modifiers would not be concluded until after the year in which you're measuring potentially the quality and resource used.

And I've – that's just to clarify for me. Potentially that could be the case, yes?

Dr. Sheila Roman: Hi, say that again I'm not sure I really followed.

Brian Whitman: Well no I – this may or may not be important. It just sort of occurred to me though. So you're still implementing the value modifiers or rule making in 2014 saying you know this is how we're going – I know you have to propose the measures in 2012 but there would still be more rule making on how you might …

Dr. Sheila Roamn: Right but we will …

Brian Whitman: … use those measures and …

Dr. Sheila Roman: Right we'll specify the period and I guess our belief is that the community will start to pay attention to the measures and to change practice you know probably before the value modifier is applied to anybody's services.

Brian Whitman: OK, well I think that makes sense. Just trying to work my way through these rather complex timelines.

Dr. Sheila Roman: Right, right and I think you know there is give and take obviously in what's here.

Brian Whitman: Thank you.

Dr. Sheila Roman: But we will be announcing in 2012 the you know the effective time period.

Tanya Alteras: Hi, Tanya Alteras, Consumer Purchaser Disclosure Project. I just want to thank you for the whole day's presentations. It's very informative and really helpful. I just wanted to make one comment although if you could answer the question it could be a question as well.

While the Affordable Care Act obviously directs this program to be for Medicare we are just wondering and hoping that there might be some outreach to the private sector in bringing in your know other payers into this type of program and sharing information and really expanding upon all what we hope will be positive effects of this type of program into the larger healthcare system.

And so I don't know if you can answer that question, whether there is a plan to do outreach and work with the private sector and if you can't answer then I would just say that we are – we've very supportive of that type of effort and hope that that's what happens.

Dr. Sheila Roman: I can't answer that with any certainty except to say that we know we can learn from what's already been in the private sector. Transparency may be somewhat of an issue. Any other comments in the room right now? If not, can we go to the phones--Simon is there remaining questions on the phone?

Operator: We will now open the lines for comments. To state your comment please press star followed by the number one on your touchtone phone. To remove yourself from the queue please press the pound key.

Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity. Please note your line will remain open during the time you are speaking so anything you say or any background will be heard in the conference. One moment please for your first question. And your first comment excuse me comes from the line of Jerome Connolly your line is open.

Jerome Connolly: Thank you very much for the opportunity to make another comment and ask a question and thank you again for this listening session today it has been very informative and quite helpful. I understand – and I apologize if this question has been asked previously addressed but I believe that the Affordable Care Act also directed an Institute of Medicine study that is a study that would be to identify a modifier for – to determine quality.

And I understand that they're going to begin to undertake that endeavor in November with some reports due to CMS sometime in mid 2011. My question is how will this work interface with what we've heard today and what sort of collaboration is expected?

Dr. Sheila Roman: I think that we are aware of the IOM activities that are related to the value modifiers at this point I'll speak for myself that I can't tell you with any certainty how they'll relate. I can tell you that we'll be meeting internally in the near future to try to understand how those different but quite related activities will interact with each other. So we are not siloed on that issue but thank you for bringing it up here.

Jerome Connolly: Thank you.

Operator: And there are no further comments on the phone at this time.

Dr. Sheila Roman: OK well we're at 3:00 and I don't want to hold us very late but I do have some questions, which I won't make us go through but I do want to ask the first question. So – because this is something you know it's very easy to say we're going to ramp up to 10 to 20,000. And again, I will say that I heard loud and clear from the Mayo their recommendation to proceed on a state-by-state basis to ramp up and we'll be certainly thinking about that and taking that internally for further discussion.

But you know I wanted to pose this question that as we scale up the development of the physician feedback reports you know which populations of physicians should be the ones for the initial focus. What criteria should we use in making this determination? I've made a couple of suggestions here: linkage with other ACA initiatives, interest of specialty societies and partnering with CMS other possibilities. And you know I'd be interested if there's a response from either the audience here at CMS or on the phone to that question. Does that mean all of the above?

Bruce Kelly: Bruce Kelly the Mayo Clinic, I just want to go back a second about when we talked about states as the potential unit for this modifier. We weren't thinking of phasing it in state-by-state but rather starting with using the state as the unit

of measurement so that all physicians within the state would be measured by these statewide quality and cost measures.

And then over time as data became available and we got better at this you could take that to lower and lower levels of specificity such as you could go from state down to metropolitan areas or hospital service areas, accountable care organizations, group practices, et cetera so that you'd be getting more and more granular over time. So that's sort of the way we think that's the way it should work.

Dr. Sheila Roman: OK thank you for that clarification. Any other …

Pam Cheetham: Let me ask a related question to that. We find a lot of practices and groups that overlap states. Have you thought about how one would deal with those issues?

Bruce Kelly: I think what you'd be looking at most likely would be where the patients come from is the way you would measure – I don't know exactly how would measure cost on a per-capita basis where the patient lives is that theoretically how you would do it. I mean if you're looking at total cost per-capita.

To be honest with you I don't know exactly how that might play out. The way we had viewed it is you would – you would use the data for the state where people live. Now granted some people cross state lines some people get care in multiple states, but as a starting point that seems the simplest way to approach it.

Pam Cheetham: Thank you.

Steve Schmitt: Hi, Steve Schmitt, Infectious Disease Society of America. We would be interested in partnering with you on all this stuff but to say that we'd be interested in partnering on both clinical payment issues and the non-clinical value issues that we talked about earlier.

Dr. Sheila Roman: Any comment on – oh, one more comment in the room here.

Brian Whitman: I'm sorry Brian Whitman from ACC again, just quickly. Just I would say that ACC does not necessarily agree with the state as the unit of measurement. We would typically prefer a physician group level as a more appropriate opportunity for intervention to improve quality.

I think looking back at the legislative history there was a specific kind of geographic intention of this initially and that was taken out and I think there is a reason for that. In terms of your questions here, I think you're not getting a lot of reaction just because I don't think you know personally we want to over commit.

I think we're very interested in working with CMS on this process to make sure it's done properly. You know looking at the list of the conditions that are targeted I suspect that cardiology will be high on the list so, I'll give a qualified interest in working with you on this in the near future.

Dr.Sheila Roman: Any comments from the phone please.

Operator: We will now open the lines for comments. To state your comment please press star followed by the number one on your telephone – oh, sorry on your touchtone phone. To remove yourself from the queue please press the pound key. Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity. Please note your line will remain open during the time you are speaking so anything you say or any background noise will be heard in the conference. One moment please for you first comment. And your first comment comes from the line of Donna Kenny your line is open.

Donna Kinney: Hi, this is Donna Kinney from the Texas Medical Association. I just wanted to reiterate Elizabeth McNeils's earlier comments about looking very carefully at the effect that any of this is going to have on areas where poverty and high prevalence of un-insurance and physician shortages are impacting what's happening in medical care.

And I'm very concerned that among the groups that are currently involved in the reporting pilots that maybe none of those areas are you know have those characteristics. And I think if you develop a whole program without including

careful, careful looks at those factors I think we may end up with very adverse unintended consequences.

Dr. Sheila Roman: Thank you for that comment. Any other comments from the phone please?

Operator: There are no further comments on the phone at this time.

Dr. Sheila Roman: OK there was one further comment in the room here.

Chip Amoe: Hi, Chip Amoe ASA again. I think you know to echo previous comments you know the specialty societies are certainly willing to partner with CMS and I think what we would encourage you to do is as you're moving through the process to reach out to this individual specialty societies with enough advance notice to say you're up next. Or you know we're moving down that line.

And then you know to have individual meetings where we can sort of hash this out as opposed to having to deal with it you know in a proposed rule or something in the final where we can kind of talk it out. Talk about the different pressures because I think a lot of the problem that we get at least from our own members is they have this notion that it's CMS doing this to us and we all know the fact is that you're under statutory you know mandate to do these things by a certain date.

And so they need to be prepared for that and we would definitely welcome the opportunity to partner with you and to try to test out some of this methodology before it goes live so that we get the appropriate feedback back to you.

Dr. Sheila Roman: Thank you, thank you. And another comment.

Aaron Fischbach: Aaron Fischbach from the Office of Rural Health Policy. I would encourage you to include cohorts of rural primary care physician's primary care physicians generally but rural often there aren't specialists available in those areas.

So they are going to have unique reporting and I think you're going to find that you might have to also work with medical societies and others to enhance technical assistance to them. Seen lots of complaints about the complexity of

their reporting under PQRI and others, so they're going to need some help on that front. So running some of them through this early would be helpful for you.

Dr. Sheila Roman: OK. Thank you for that comment. OK, there's – I'm not going to torture you with a lot more questions, but there is one other question that I do want to buzz by, and that really is the first two questions on this slide, and I will read it for the people on the phone. And that is you know we really do want these physician feedback reports to help physicians change the way that they practice and to help physicians improve care. You know so how can these – you know are we delusional, or …

Pam Cheetham: That's not the question.

Dr. Sheila Roman: … or how do you see these reports? What can we do to make these reports actionable for physicians to improve care, to decrease costs, to lead to better health?

Yeran Acpiava: Yeran Acpiava of Rural Health Policy. I would just strongly encourage that the reports be accessible so that providers are able to do comparative data, and I don't mean just within their own regions, but across different types of providers, across various demographics so that there's a true comparative group and it allowed them to share some of their best practices with one another and be able to improve on the quality scale that's much larger than what they have readily accessible from a distance perspective.

Sharon McIlrath: Sharon McIlrath, AMA. We had actually – not the last set of comments, but I guess it would have been the 2009 rule of comments, we had actually gone out and queried some of our physicians about what would you like to see in a report, and we can send you you know that comment so you can see that. But in general, it was sort of split. There are people who want something that's really simple, and they didn't want as much as they got in that report. But there were a lot of people who wanted more. So it seems like you know if you've got it in a computerized thing, you can give them the short little thing on top and then let them drill down. And there were some additional data sets that – a couple of infection rates, I think, was one that somebody had

mentioned. And the other point is that there's this question about whether they're going to be able to get the name of the patients and the other physicians whose you know costs were attributed to them, and I don't know whether you know yet how you're going to be able to deal with that or not.

Dr. Sheila Roman: I think that we don't know, but there's discussion within the agency now, and it obviously involves the privacy issues on every side of the issue.

Female: The one that they really don't understand (inaudible) it's their own (inaudible), and I understand …

Dr. Sheila Roman: You want to go to the mic? Yes.

Female: They don't understand why they can't get – I mean it's their own patients, or at least people said they were their own patients, and it's sort of a catch 22. As I understand it, the problem – the privacy problem is that, well, somebody might have put somebody in there that wasn't your patient until you can't see that, but then you're getting dinged with their costs. And so I mean that was a concern that physicians I mean that was a concern that physicians had, I mean aside from the fact that they just want to be able to look at it and say, well, that patient looked like that because they had diabetes or whatever.

Female: In addition to Sharon's comments, which I completely agree with, I would just say, when it comes to getting the reports, I think people before have mentioned that the PQRI reporting process is very convoluted you know and we appreciate for the group practices that you are going through the practice administrator because they're going to be the ones who actually would be looking at these reports and actually accessing them, but making it so that it's fairly straightforward to get that information would be helpful. I would also that however you aggregate your report, to put it in a format, particularly for the group practices, in ways that they can aggregate and de-aggregate and slice and dice in ways that are meaningful for them so that they – so that they can make their reports actionable for their practices as well. You know in the early stages of PQRI, where they got these massive PDF files, it didn't do them any good because they had to sit there and spend hours making – putting it into a format that they could use.

Dr. Sheila Roman: Any comments on the phone, please? Thank you.

Operator: We will now open the lines for comments. To state your comment, please press star, followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to giving your comment and pick up your handset before speaking to assure clarity. Please note your line will remain open during the time you are speaking, so anything you say or any background noise will be heard in the conference. One moment, please, for your first comment. Your first comment comes from the line of Linda ClenDening. Your line is open.

Linda ClenDening: Hi. This is Linda ClenDening of Persian Yokli & Associates, and I come from a background of having been in operations in an orthopedic practice for the last 12 years, where we were very active or have been very active in the PQRI process. I'm going to kind of echo some comments that were made earlier and first of all say if you're delusional, I think we're all delusional. But that being said, I do think there's a lot of room in discussion around the reports to work with the specialty societies, I think somebody in the room had mentioned that earlier, to do some possibly in the meeting rooms of the specialty annual meetings sit down together to say here's the reports, here's what we believe the reports indicate. Maybe it happened differently in terms of cost of care and quality, and kind of have a dialogue.

I think – I know that's a costly way to try to go, and it does involve a lot of time, but I think that's a good place to start, especially currently right now with Phase II. You do kind of have a smaller number of folks that you possibly could randomly access and go that route of a dialogue. I think until we are able to go back and forth you know with the actual data, and I love the most recent comment, I think, about being able to slice and dice maybe some kind of – particularly for a group – for them to be able to access like an Excel spreadsheet or some kind of manipulatable data set would be very meaningful.

So I appreciate very much the time and effort that went into the meeting today. Thank you.

Dr. Sheila Roman: Thank you. Any other calls?

Pam Cheetham: Actually, I have a question for the last caller or the person in the room who was talking about being able to disaggregate group data. If we're not identifying individual physicians, would it still be helpful to – I mean we're talking about presenting data in aggregate. So I'm not quite certain what would be disaggregated.

Mary Patton: Mary Patton from the Association of American Medical Colleges. Well, I think to make – there could be multiple levels, I would think, ideally, of reporting, and certainly we can get together with some of our members to talk about this in more detail. But if you were to give a report on over 1,000 faculty members and say, OK, this is your average resource use, how are they supposed to take that and use that and really break that down? You need the patient information. You kind of need to know who's involved with the patient – who's involved, how do you use it. You may not report that aggregate externally, but you need some of that information so at least internally they can go in and try and make some operational pieces of information.

So I mean it's hard – it's hard to talk without seeing actually the final report, and you know I assume – I hope that we'll have another meeting afterwards, when you know we can talk about how Phase II went and talk about some of the issues you ran across in Phase II. You know and that will be an interesting case because you'll have both the individual reports and the group report for the same – for the same people. So you know that may be a better conversation to have afterwards.

Dr. Sheila Roman: Thank you. Any other comments from the phone?

Operator: Your next comment comes from the line of Phil Bongiorno. Your line is open.

Phil Bongiorno: Yes. Hi. This is Phil Bongiorno again from the Society of Thoracic Surgeons. I just wanted to comment, reiterate the comment that was made by, I think, some of the specialty societies of our willingness to work hand-in-hand with CMS on this issue. We certainly want to be a partner in all of this

with you, and to the question of whether this is doable, I think we have demonstrated, at least on the quality reporting side, that we have data indicating you know we've improved clinical outcomes you know such as reducing complications, which has resulted in cost reduction. So that – you know that can play into this as well as you look at resource uses, there's also the issue of cost reduction. I'm not sure if I made that point before, but I just – I just wonder – just reiterate primarily that you know our willingness to be a partner in all of this. Thank you.

Dr. Sheila Roman: Thank you. Any other comments from the phone?

Operator: There are no other comments on the phone at this time.

Dr. Sheila Roman: OK, well, if you'll indulge me, I want to ask just two other questions; one on resource use and the other on quality, and then we'll close it up. So the questions that I'm interested in, resource use, are really the first two questions on this slide, which I'll read for the people on the phone. What concerns do you have regarding the clinical validity of resource use measures, and what types of resource use measures are actionable for you, and whether there are reactions from the audience here in CMS or on the phone?

Chip Amoe: Chip Amoe with the ASA. I think one – some of the concerns that we have is when you get into looking at the resource use measures is if you start tying that in to some sort of payment. You know for example, if you were to measure, theoretically, the things that anesthesiologists can control, which are the number of tests they order pre-op or the number of catheters or you know lines that they use. If you start getting into that, are we going to start having physicians start questioning whether or not they should even – I know the purpose is to question whether or not to do it, but to be making clinical decisions based on the resource utilization, I think, is – starts to get into an area where you're dis-incentivizing people to make good, smart decisions that are in the best interest of the patient without at this point in time having a good clinical understanding of how – of how those work. I think there needs to be a period of time where you're collecting the data, because I think up until now we really haven't aggregated the data and really been able to drill down and look at the different components and say does using XYZ type of monitor

really improve patient safety, yes or no? We haven't answered those questions, and so to start putting the – a payment modifier on that based on – without the knowledge of whether or not it actually makes a difference, I think, becomes really scary, as a patient myself, going in and having my physician question whether or not they're going to use a particular monitoring device or use a particular drug or order a particular test because they're afraid that they're going to get dinged when the society as a whole hasn't even decided whether or not it's appropriate or good or in the best interest of the patient yet.

Dr. Sheila Roman: Thank you.

Female: It's been quiet all day, but it sort of seems to me that you have a Hobson's choice, and that is that the episode groupers should be more useful. Honestly, I don't know how physicians are going to get anything actionable out of a per-capita measure. But the problem is, as you guys have pointed out, that the episode groupers that we have right now have a lot of problems with them. I mean hopefully you know the – what you've just put out will come up with something better, but I think you'll always have some problems, and one of the problems that people have pointed out with the current ones are that when you get down to the sub-subspecialty level, there are not enough adjusters in there, and those people are ending up always in the highest tier, and their patients are ending up always having to pay high copayments because the physicians that they need to go and see have been you know disadvantaged by the groupers.

So I don't know how you do that, but it seems like you almost need to have more subspecialty designations, and God knows I know nobody wants to do this, but in the Medicare, the list of specialties, I mean we're having similar problems now that the consultation code is gone with identifying new patients because you know there aren't enough distinctions in the list to really you know divide out who's doing you know separate things, and I guess I would just like to react to, I mean a comment that was made here several times today about comparing across different specialties. I think our preference is definitely to compare within the specialty.

Dr. Sheila Roman: Thank you. Any comments from the phone?

Operator: Again, if you would like to make a comment, please press star, followed by the number one on your touchtone phone. There are no comments on the phone at this time.

Dr. Sheila Roman: OK, this is, I promise, the last question, but I really want to ask this question to this audience, and that is this question; what will – what do you think is the best data sources for clinical quality measures given that this is a national program trying to reach 600,000 physicians with a report of their performance on quality measures?

Ashley Thompson: Ashley Thompson, I'm not sure it's claims data.

Dr. Sheila Roman: OK. Would you like to elaborate on that?

Female: Yes.

Dr. Sheila Roman: Is there anything else you'd like to say beyond that, because obviously claims data is where we go on in Phase II and where we have data accessible to us until you know the penetration of electronic medical records that can actually provide such data is sufficient, which is obviously not in the double-digits at this point. Any other comments? Any comments from the phone, and then we'll close the meeting.

Operator: Once again, to make a comment on the phone, please press star, then the number one on your touchtone phone. And there are no comments at this time on the phone.

Final Thoughts

Dr. Sheila Roman: OK. Thank you very much, Simon. I'd just like to tell you five key takeaways that I've taken from this meeting. One is the willingness of the people in the audience, the specialty societies, to work with CMS, and you know I think that we'll be availing ourselves of your experience as well as others. The importance of capturing patients' socioeconomic status in our calculation of the measures and attention to disparities as well as to rural settings and the impact of these measures, the importance of coordinating with

our other initiatives such as PQRI and HITECH. The availability of experience from other groups, such as in the private sector and other settings and locations that are relevant to this effort. And then, I think, lastly, what has come through to me is that a number of groups, specialty and otherwise, have particular unique circumstances to be addressed and how we address them, whether by substratifications or how we address them, but there's a definitely I heard that there are unique circumstances that need to be addressed.

So with that, I'd like to provide for you the website where we'd be very happy to get complete written comments from you. I'll let …

Pam Cheetham: Actually, let me first remind people that the materials for today, including the slides, and the draft report of the template for feedback for individual physicians are posted at www.cms.gov/center/physician.asp. There's also a mailbox where you can send written comments, and that mailbox is CMS PhysicianVBP@cms.hhs.gov. And we do anticipate having a new website. Obviously, if you go to the old one, you will be sent out into the new one, and we'll be posting materials on that. So please check it, probably starting in the next month.

It's actually posted at the physician – the center of physician website, and you'll see it under today's meeting. There are a number of zipped files there.

Dr. Sheila Roman: OK, I'd like to really thank everybody for hanging in with us. It's been a long day but a very informative day for us. I hope it's been informative for you as well, and you know we look forward to many more interactions as we move along – move ahead scaling up the program, increasing the number of reports and making you know very careful decisions on the measures of quality and cost that will comprise composites of cost and quality and ultimately wend its way to a value modifier as mandated in the legislation.

So thank you again, and have a good evening and a safe trip home.

END