NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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2:00 p.m. ET

Operator: Welcome to the conference. Thank you for participating on today's Cost and Resource Use Steering Committee's conference call.

This conference call will be open to measure developers and the public. However, please remember, this is the Steering Committee's time to deliberate and discuss the very important issues. Measure developers and the public will have the opportunity to provide comments that will help to inform the Steering Committee decision when invited to do so by the Steering Committee Chair, Co-Chairs, other members of the Steering Committee, or NQF staff.

Please note that this call is being recorded and transcribed. The recording and transcription will be posted to the project's page on NQF website within 7 to 10 business days of the conference call.

Thank you very much for your interest and participation. Please standby.

(Evan): Hi everyone, welcome to the Steering Committee conference call. We're excited to have everybody join us today. I'm going to turn it over now to one of our Co-Chair, Eugene Nelson, just to give a brief welcome and we'll proceed with the call.

Eugene Nelson: Thank you. I would like to welcome everyone that was able to make this call and we're looking forward in the next, up to two hours to discuss the comments on number 2165, Payment-Standardized Total Per Capita Cost Measure for Medicare fee-For-Service Beneficiary. And I believe everyone

have the benefit of seeing the agenda and the background materials that NQF staff prepared so well. I think we're ready to proceed.

(Evan): Great. Thank you. At this time, we'll turn it over to the measure developer to present the slide deck to go through some of the issues that we discussed at the in-person meeting and some of the responses. So now we'll turn it over to CMS.

Michael Wroblewski: Thank you and good afternoon. My name is Michael Wroblewski, and I'm the Director of the Division Value-Based Payment here at CMS. And I'm on the measure development team for Measure 2165, Payment-Standardized Total Per Capita Cost Measure for Medicare Fee-For-Service Beneficiaries. I'd like to thank the committee for this opportunity to provide an update on all of the analysis and research that CMS and our research partner Mathematica Policy Research had done subsequent to the committee meeting in May.

The committee made many suggestions for further analysis during that meeting and I'm happy to say we've had a chance to research almost all of them. I'd like to begin by quickly recapping the key features of the measure specification. If we can turn to slide two.

As an overview and a reminder, the measure, the total per capita cost measure is a comprehensive whole person per capita cost measure of resource use. It measures total annual Medicare Parts A and B, Fee-For-Service costs. Its payment standardized, geographic adjustments, as well as risk adjusted using the CMS hierarchical condition category model. It assesses – importantly, it assesses group level performance, not individual physician performance among groups of 25 or more eligible professionals and at least 20 attributed beneficiaries. And it uses an attribution rule to encourage shared accountability within a group and to reduce fragmented care.

CMS developed the measure in response to statutory requirements to improve and reward physician performance through both the Medicare Physician Feedback Program and the Physician Value-Based Payment Modifier which is due to begin in Calendar Year 2015.

On slide three, is really an index of the Steering Committee's concerns and these are the ones that I will address in the subsequent slides and that we addressed in two memorandums to the committee, one dated June 27th and the other one dated August 16th. Before I get into the – I'm on slide four right now. Before I get into reviewing at least the first two of those committee concerns dealing with attribution, I thought it made sense just to give a quick review of the two-step attribution approach that we adopted for this measure.

First, the first step is really – it's a pre-step in some ways and we identify all beneficiaries who have had at least one primary care service and you'll see at the bottom of the slide how we defined primary care services rendered by a physician in the group. And then we use a two-step attribution process. Step one, we assign beneficiaries to the group who at the plurality of primary care services rendered by primary care physicians. And if there any unassigned beneficiaries from that pre-step, we then proceed on to step two and which we assign beneficiaries to the group practice who's affiliated physicians, NPs, PAs and clinical nurse specialist together to provide the plurality of primary care services.

The end of that process, some beneficiaries may go unassigned.

Turning on to slide five, you know, we recognized that the committee have several concerns about this approach, and I'd like to give some background on why we settled on this two-step attribution approach. As I just mentioned, the attribution approach really focuses on the delivery of primary care services. Now, we understand that the committee had some concerns about this and really about the potential of primary care physicians or specialist may have limited ability to control costs ordered by other physicians or incurred by other facilities.

Our data analysis showed, however, that the average group, using this methodology, accounted for a significant majority of the attributed beneficiaries primary care services. It was about 68 percent or five of seven visits over the course of the year. So, it was our belief that the attributed beneficiaries to the medical group were being attributed to the group that was

really well positioned to be responsible for overseeing overall care and associated costs.

There were two other reasons that we were persuaded to use this attribution rule. First, we implemented it in rule-making in last year's annual physician fee schedule rule, really in response to stakeholder feedback in which we've had in last year's rule proposed to attribution methodologies, the one that I just went through, as well as the one that we had used previously for group quality reporting and for group physician feedback reporting in which we used an approach that focus on the plurality of E&M charges and make sure that the group had a two visit minimum.

What we found was that the reasons why, I would say, a slight majority of those who commented on this issue favored the approach that we adopted, meaning the approach that focuses on primary care services. And the rationale that they gave and what ultimately persuaded CMS was that, and it really kind of dovetails with the committee's recommendation that CMS payer cost measures with quality measures.

And this same attribution methodology is used for our Group Quality Reporting Attribution Program. As many of you all know, we have a physician quality reporting system in which we as one of the mechanisms for groups to report is to report on a common set of primary care and preventive care quality measures. And the way that mechanism works is we attribute beneficiaries to that group and then we take a sample of those beneficiaries for each of the quality measures that we have, and I think there are over 20 of those types of measures.

So what happened was those measures were really quality measures, were really focusing on services that primary care physicians, primary care services and other primary care physicians, or in some cases, specialist were providing to members of that group. And so it was our thought that it was reasonable to – if we were attributing a certain set of a population for quality purposes to a group that was reporting on primary care, preventive care quality measures that they will also be responsible for overall total per capita cost as well. So it

would be the same population for both quality reporting as well as for the attribution for this particular cost measure.

And that group reporting option is made available in 2013 for groups all the way down to 25 or more eligible professionals which is what the specifications are for this measure.

So with that, notwithstanding kind of – that kind of background on why we chose to use this two-step approach, the committee raised two issues, and I'm turning to slide six now, about broadening the first step so that we would include nurse practitioners and physician's assistance in the first step. And as you recall what I just kind of went through is the first step, really just looks at attributing beneficiaries to the group when primary care physicians in the group provided the plurality of primary care services.

So what we did is we did an analysis to include NPs and PAs in that first step. And what we found was that the number of beneficiaries attributed to a group increased somewhat, it was about 2.6 percent. But I think importantly, over 97 percent of the beneficiaries where attributed to the same group under both attribution rules.

So our conclusion was, since the vast majority of beneficiaries were attributed to the group, there was really limited evidence of misattribution of beneficiaries. But we recognize that these clinicians have a growing role in primary care services, and under our statutory obligations, we are able to expand not only the Physician Feedback Program but also the value modifier to include PAs and NPs into both of those programs starting in 2017. We will certainly look to ways to kind of adjust the attribution to account for those professionals in our first step of the attribution.

The second issue that the committee raised regarding attribution is on slide seven, and this was regarding whether federally-qualified health centers or rural health centers, since we had not include them in our testing, whether they make a difference if we put them in the first step of the attribution methodology. And unlike the NPs and PAs that we just talked about, I'm putting FQHCs and RHCs in the first step of attribution. Had a difference,

you know, about 8 percent of beneficiaries who are originally attributed to a physician practice under the old rules, now would then have been attributed to an FQHC or RHC under the revised rule.

And so our conclusion from this was that, you know, including FQHCs and RHCs in the first step really reduces the misattribution to specialist practices who provide primary care services. And including FQHCs and RHCs in the first step is really consistent with what we have adopted in last year's rule. And so CMS will be including FQHCs and RHCs in step one of our attribution for this particular measure starting in this year, 2013.

I'm on slide eight now. You know, there was a lot of discussion on yesterday's call about whether to adjust either of the two measures that CMS has put forth for endorsement on whether dual eligibility status should be used as one of the factors in the risk adjustment model. And the total per capita cost model, we use the HCC model which includes a factor or a coefficient for dual eligibility status. And we believe it's important to do so for two reasons. One is that, not only does it convey socioeconomic status, whether they're eligible for Medicaid but it also really imparts some clinical information. A literature showing that it – it shows that there's significant differences in frailty, in functional status between dual-eligibles and non-dual eligibles.

In our data analysis, which when we examined the health status of dual-eligibles versus non-duals in our sample, we found that duals have a worse health condition than non-dual health – than non-dual-eligibles. They had twice as many conditions that were part of the risk adjustment model and that – they had statistically higher proportion of dual-eligibles had, you know, nearly all – of all of the conditions in the model and duals had more conditions.

So with that, I'm now turning to slide nine. With that, our conclusion was that, you know, dual eligibility status for an annual per capita cost measure is really – it's a proxy for clinically meaningful differences and attributed beneficiaries. And we thought that including the dual eligibility status in the risk adjustment improves the comparability of annual cost for these providers and who are caring for more of these patients.

So our decision was really to retain the dual eligibility factor in our risk adjustment methodology. We thought it was prudent to do so, but we will, you know – there was a discussion on the call yesterday, we will of course wait for further guidance from NQF on how to include socioeconomic status in a risk adjustment model for resource measures and the work that the NQF is going to be undertaking later this fall.

On slide 10, with the next issue, and this was the committee's concern about our decision to exclude part-year beneficiaries. And in this context for this total annual per capita cost measure, part-year beneficiaries include those who have died, but also include those who are newly enrolled in Medicare and those who have maybe partial enrollment in Medicare Advantage.

And to give you a sense of proportion in terms of how many fall in each category. In terms of our sample, about 50 percent of part-year beneficiaries were new enrollees. About 20 percent were – had Medicare Advantage for part of the year, and about a third died during the year. What we did is we then kind of redid the total per capita cost analysis by including part-year beneficiaries.

And what we found was, although we've increased the absolute value of the total per capita cost measure for a group, the rank ordering of the groups in the distribution changed very little. In fact, there was the correlation between the two rankings with more than 0.98, and over 90 percent of the groups that were either in the highest or the lowest quintiles remained when part-year beneficiaries were included.

So our thought was then including part-year beneficiaries had a trivial effect on comparative cost. Then including part year beneficiaries have some down sides because we would have to annualize cost which will require the amputation of cost for beneficiaries which may systematically disadvantage some groups who actually provide care just by nature of the services they provide for those in the last years of life.

So our decision was to maintain the exclusion criteria to ensure accurate comparison among the groups.

Just – on slide 11, and these last two issues were, I would say, relatively smaller issues compared to the ones that I just went through in terms of the committee's concern. The first one was the measure does not include cost for Part D or pharmacy-related cost. We – as many of you know, only about 51 percent of Medicare fee-for-service beneficiaries are enrolled in a Medicare Part D Plan. So including those would – we believe, would incorrectly indicate higher cost for those beneficiaries compared to others who don't have a Part D Plan.

Not withstanding that, we are looking at ways to include Part D cost in our annual physician feedback reports, we call them the QRURs, and we are looking at ways to develop an agency-wide approach to standardize and to kind of operationalize how we would get the Part D data, which is really very much of a commercial plan, how we would bring that in and be able to standardize it and use it in a total per capita cost measure that stratify based on those who have Part D and those who don't.

So, we very much heard the Steering Committee's concerns in looking at that as we move forward. We're unable to complete that during the timeframe between when the, you know, the committee met back in May and the meeting today.

Finally, at slide 12. There were some concerns about the usability and the actionability of the total per capita cost measure. We currently include the measure in what we call our QRURs, which are the annual feedback reports to physician groups. And we included a summary level. But then we break it down by specific categories, specific cost categories for different clinical services, so we break it down by total per capita cost measure at the summary level into various service categories, E&Ms, hospitalization, imaging, post-acute care.

We'll also be including the measure in the value-based payment modifier which is, as I mentioned earlier, will begin with groups of 100 starting in 2015. But I think the most important thing that we have done, and this is really at the very bottom of the slide, is that we're now including in our

physician feedback reports, to really make this measure actionable, some drill-down information for groups to be able to use the cost information in a way to improve the quality of care and to facilitate care coordination.

And the two sets of information that we're giving, and this is really the first time that we're giving them to groups in our – this is like the third year of doing physician feedback reports. First, we're giving all the attributed beneficiaries to a group, so we're giving beneficiary-specific data to every group. So they'll be able to see what beneficiaries were attributed, the gender, the date of birth, what their risk score percentile was, the number of primary care services provided by the group, and the percentage provided the group as opposed to the percentage provided outside of the group, a break down of those cost categories so they can see what are driving the cost for those beneficiaries, and to see if there is some any unexpected patterns. And then we're also providing, whether certain beneficiaries fall into certain chronic condition subgroup.

And then I think the richest data set that we are providing to the groups is really a list of all the hospitalizations of these beneficiaries. So we're looking to see, OK, these are the reasons for – these are the beneficiaries who were hospitalized, this was the admitting hospital, this was the principal diagnosis. Whether they were in any of the numerators for – or and denominators for the – some of the preventive care measures, the ambulatory care sensitive condition measures, as well as the all-cause hospital readmission measure, and then we're also providing discharge status.

So, you know, going back to the kind of the original comment about why we were using this two-step attribution process is in some ways we try to unify a patient population and then to give groups information not only about the cost but about the quality about the beneficiaries – about the quality of care furnished to these beneficiaries and to then allow the groups to be able to act on this information.

So, in summary on slide 13, in terms of attribution, we'll be including FQHCs and RHCs in the first step of the attribution rule effective this year. We're exploring ways to include Part D data in the total per capita cost measure, and

in the future to include nurse practitioners and physician assistants in the first step of attribution. We're continually looking to solicit and consider input from stakeholders on the actionability of the information and we're actually eager to get the, you know, our reports to go out on September 16th, and so we're actually quite excited about giving them to all groups of 25 or more eligible professionals in a couple weeks. And of course we'll continue to evaluate the measure methodology and update the measure (inaudible).

And with that, (inaudible), and open up for question. Mathematica, our partner, will also be available for questions as well. Thank you very much.

(Evan): Thank you very much, Michael. At this time, I'd like to open it up for Steering Committee questions to the measure developers. So, go ahead.

Brent Asplin: This is Brent Asplin. That was very helpful summary. Thank you.

Some of the – one of the themes in the comment was around specialist in multi-specialty groups being attributed for the purposes of the value-based modifier in using this total per capita cost measure when it doesn't necessarily apply to their specific work and they feel like they didn't have the ability to control those cost, how will, in a group of greater than 25 eligible providers or even greater than 100 in 2015, for the purposes of the value-based modifier, when you have a multi-specialty group with one tax I.D. and you have specialists who are – specialties who are also developing measures for purpose of specialty-specific value-based modifiers, how will the specialist in a multi-specialty group be treated in 2015? Will they be subject to the value-based modifier driven by this total per capita cost measure, provided that they're working in a group that also has primary care physicians? Or would they be subject to their specialty-specific value-based modifier to the extent that such a modifier exists?

Michael Wroblewski: That's a great question. Let me – I'll break the answer down into two parts. So for groups of a hundred for the value-based payment modifier, all groups of a hundred for the performance year for the value-based payment modifier in '15, it's actually this year at 2013, and all groups have to choose between one of three group reporting, quality reporting methodologies. They

can report actively on that GPRO web interface that I talked about earlier. They can take – they can report claims at the group – measures at the group level, measures of their own choice using a registry, or they can use a set of kind of CMS-derived really, I would say, very primary care claims-based, administrative claims-based quality measures.

And we're doing that because we're doing the value-based payment modifier at the group level. We are not taking a group and giving different, say, of a group of a hundred, we're not giving different modifiers to different physicians in that group, we finalize a group approach because our – one of the principles that we adopted for the value-based payment modifier was to encourage shared accountability among the group.

And so as long as the group provides primary care services as we define them, they would be then subject – then we will be able – they may had 20 beneficiaries who had been attributed to the group. That whole group's cost would be measured using this total per capita cost measure and then the quality measures that would be used would be of their choice, whether they wanted to use kind of the three methods that I went through which were kind of a common set primary care measures which, you know, which is a define set that they can input on, a define set of primary care measures that are really just derived from administrative claims, or they can choose measures to report quality measures, and we have like 262 measures that can be reported at the group level. But it's group – unit of analysis is the group. And I think that's a really important point.

Brent Asplin: That's helpful. Thanks. And so to the extent that other resource use measures are being developed by specialty societies or, if you will, the denominator options of the value-based modifier, those would most likely be used by large 100 or more single specialty groups, not by multi-specialty groups that deliver primary care services for the resource component of the value-based modifier.

Michael Wroblewski: At this time, we have not put in other than this total per capita cost measure, and then we look at this total per capita cost measure for beneficiaries with – for a specific condition. But other than those kind of five measures, we don't – we have not made any proposals on taking any, I would

say, specialty-specific cost measures into the value modifier. I think that's our future vision.

And as you know, CMS is required to develop kind of episode-based cost, which obviously would be a better indicator of pulling specialty care and that those will be pulled in at that point, but we have – you know, we're just in the beginning of developing that episode grouper and have not made any proposals on how to put in kind of specialty-specific episode cost into the value modifier.

Brent Asplin: You're reading my question exactly right. But it was not directed at 2015 but beyond that for the last category, those episode groupers.

And third, you go down that alleyway, but I think that's important relative to how, you know, some of the comments read from multi-specialty grou1ps about accountability relative to this measure.

Michael Wroblewski: I think, you know – yes, I agree.

(Evan): Thank you. Do we have further Steering Committee questions?

Andrew Ryan: Hi, this is Andrew Ryan. One question I have about attribution is the potential for practices, particularly smaller practices, to reconstitute under a different tax I.D. if they perform poorly in the program and thereby avoiding any payment adjustment. Do you have any comment on the feasibility of that? And if there's been a need that CMS has given any consideration to that unattended consequence?

Michael Wroblewski: You know, we've seen – we've received comments actually when we went with a group approach, you know, using a tax I.D. number as you indicate. And we indicated in when we finalized this approach that we would monitor whether that behavior occurred. The one thing that heartened us though is that a tax I.D. number has many other ramifications other than just for Medicare billing. And so, there – it's not as though you can – not that it can't be done, but there are more – there are more kind of legal ramifications with the tax I.D. number. And so our thought was that we would monitor it, but we did not think that would happen.

Andrew Ryan: I see. Thank you.

(Evan): Do you have any last questions? Go ahead.

Matthew McHugh: This is Matthew McHugh. I have a question about the N.P.-physician issue. And the developers presented – but I think we discussed at the meeting or kind of anticipation around the size of what attribution problems would be, but I don't know that the response necessarily covers some of the concerns.

And what I'm trying to understand is, you know, why the misattribution maybe smaller than that in FQHCs, for instance, if we look at those two numbers. It's still a known misattribution that will probably grow and there's a note that they will likely consider this for the future so I'm trying to understand what – that the known misattribution issue, and it's likely to be changed – what the justification is for not correcting the measure now?

Michael Wroblewski: That's a great point. We had finalized this measure through rule-making and so any changes that we would make to the measure has to be done through rule-making. And we felt uncomfortable to change something seeking NQF endorsement as pre-judging our decision going – before going through rule-making. So that's kind of the legal answer and that may (unsatisfied) treatment.

Matthew McHugh: Well, how does that relate to the change regarding FQHCs for instance?

Michael Wroblewski: That's a great point. We actually – the FQHCs and RHCs were actually included in the methodology we adopted last year, we just did not put them in our testing for the NQF and that was in oversight. And so we actually thank the committee for pointing that out, and can include them in for 2013. And that should be consistent with our rule without having to make any rule-making changes.

Matthew McHugh: And is there – I'm sorry, go ahead.

(Gene Richard): Yes. (Gene Richard), Michael. If you like, I could spend a minute more on some of the nuances on PAs and NPs that we're running into looking at claims data.

Michael Wroblewski: Why don't we just hold on for just a quick second and see if the question – I have one additional question there.

Matthew McHugh: You know, so I just wanted to – so, and the kind of the administrative issue that's, I think, understandable, but then, was there a particular threshold for determining kind of what was the degree of acceptable misattribution related to this issue or was there something that you are looking for that led to your conclusion or is this really an administrative issue?

Michael Wroblewski: I would say it was the latter.

Matthew McHugh: OK. This is – because I – well, I think just having some clarification so, you know, what the rationale is? Is it helpful? Is it something that you can't change versus something that you're choosing not to change because of some other reasons?

(Gene Richard): Well, so I think the information that I can have maybe helpful here because …

Matthew McHugh: Sure. Go ahead.

(Gene Richard): … you know, we are providing CMS information. And, you know, we thought their decision – well, as Michael said, there were some sort of administrative and regulatory reasons for this, their data is used to that we think are relevant. I think, probably, everybody on the call is aware of (intimate) to billing in the Medicare Program and the fact that…

Matthew McHugh: Sure.

(Gene Richard): … many PAs and nurse practitioners bill under their collaborating physician name for the reason that's been – you know, the full fee-for-service payment can be received by the practice.

So, you know, so we – and based on other survey resource that you folks are probably aware is it is expected that most PAs and NPs are billing most of

their services into the (two). So we're simply not observing many of these. And so, you know – and then the other issue is that we know, you know, through survey data that slightly, over 50 percent – well, around 50 percent of PAs would likely practice largely in specialty settings, and a substantial minority of NPs practice in specialty settings.

So, you know, and we don't have a mechanism to currently know with confidence when an N.P. or a P.A., when they are billing in a multi-specialty group or as a collaborator in a single specialty (care) that those NPs or PAs are functioning in the primary care role.

So all of these things make, you know, interpreting, you know, and sort of the – putting a – universally calling NPs and PAs always primary care and in the first step of the rule. You know, it's complicated into the two billing reasons and for the other forms of practice that NPs and PAs are in. So, you know, I think, you know, so we thought CMS' decision to monitor this and the, you know – consider how to address these issues and attributions in the future were reasonable based on the fact that it wouldn't, you know, really make a material difference now. And, you know, these issues really needed further exploration.

Matthew McHugh: That's helpful information. So – and I appreciate that and I appreciate you looking at the issue. I think that if anything that's probably going to grow and will need to be – continued to be monitored. Thank you.

Jack Needleman: This is Jack Needleman. I've got a couple of follow ups to Matthew's question. One is, you comment at the, you know, category two billing where they bill under the physician number doesn't – you know, we're probably underestimating the amount of services provided by NPs and PAs but it doesn't affect the attribution at all in that sense. If, you know – if they will be accounted, it would happen under either circumstance where they're billing under their own number, billing under physician number. So if anything, you know – what you're saying is it probably covered.

But the other issue of the specialty billing that – you define this measure in terms of primary care service billing not the specialty of the people billing the

bill, and I'm just wondering why the same rules on identifying primary care services won't carry over to the NPs and PAs

(Gene Richard): Well, let me just clarify. I apologize. And so, remember the first step, the attribution rule only applies for physicians who are in primary and specialties that are, you know, defined as consistent with primary care. So that is – so, you know, and the – and we tested was that we assumed that all N.P. and all P.A. billing were primary care billing as we assume that all family practice billing of primary care services are primary care billing.

So that's the, you know – that, so we work into – the first step of the rule both consider the specialty of the physician billing. Does that clarify?

Jack Needleman: Yes. Yes, it does, OK.

I appreciate the data problems, then (with half) of the PAs, you know, in specialty practice that's a pretty severe data problem. But I just want to go back to one of the earlier comments on the original consideration which is separate parts from how big the data issue it offers, 97 percent still classified the same way, 2 percent additional attribution. Fundamentally, given that you're trying to attribute the sources, who got – where – which groups of people got primary care from? The concept of excluding the PAs and the NPs is fundamentally flawed.

It doesn't match the face validity of who's providing primary care services. I think in the development of this measure, leaving aside that the data issues has been a commingling of whose eligible to get paid bonuses under the VBM, and who's providing primary care services. And the attribution does not have to be restricted to those who are eligible for the value-based, the VBM. And I think in that sense, it's fundamentally flawed methodology on its face because it ignores where people are getting primary care. But my – but I appreciate the data problems and getting it right because you want to identify primary care services. So, when you say "consider" in the 2017 re-write that's a very weak word, what do you mean?

Michael Wroblewski: That's a great question. I mean I think we will – as Gene said, we will do additional work to be able to look to see whether it makes sense and what the

extent of the data problem is. And I cannot commit to you, I'd love to be able to commit to you right now that we'd be able to include it in and everything will be fine. But I can't, OK. We are – we will certainly look at this in terms of our research and the proposals we put forth to the department as we make, you know, future rule-making. But I can't sit here right now and tell you that in the rule that we put out next year, there's going to be a proposal to put in PAs and NPs in. I wish I could, but I can't not.

(Crosstalk)

Michael Wroblewski: … everything underneath.

Taroon Amin: Can I just jump in here? This is Taroon Amin. I just wanted to remind the committee that the purpose of today's call is to evaluate the measures that's in front of you for general application. But not to evaluate how the measure will be used in a particular program. And although they're obviously very interconnected in this application, we'd like to keep the discussion focused in terms of the measure specification that applies to the criteria in front of us.

So, you know, while this conversation certainly is helpful in terms of some of the issues that are raised by the committee, I just want to refocus us in terms of some of the issues that were raised in terms of measure specification. So maybe I'll turn it over to (Evan) in terms of going over some of the comments and the themes that were raised from the committee, from the public.

(Evan): Great, thanks Taroon. All right, so at this point I'll pull up the memo that you also received with the meeting materials and we'll go over the comments that were received from the public and members through our commenting period.

So as a summary, we received comments from 18 organizations and individuals. I would say that several commenters shared support for the concept and intent of the measure, but they urged CMS to make revisions to the attribution approach, risk adjustment algorithm, reliability and validity of the measure, and to bring the measure back to NQF at a future day.

In addition to support for the concept, intent of the measure, one commenter also acknowledged that provider concerns over the attribution of total cost of

care to primary care physicians who are not part of an organized health system – but purchasers have come to expect care to be coordinated among providers and see the need to incentivize such coordination.

Moreover, a measure such as this one will help primary care physicians to understand cost implications of their referral or recommendations.

So as you can see, we provided a suggested serving committee response that we will discuss today, and we'll read that here.

So the Steering Committee raised several concerns with the construct of the measure, which the developer has to work and to analyze and address during the past few months. Responses to the concern and additional analysis performed by the developer will be shared with the committee in their August 28th call, so that's what we just went through. And then the Steering Committee will have the opportunity to review all comments and developer's analysis and to revote on the measure if the comments and analysis call to question the original endorsement recommendation.

So at that point, the measure is not recommended for endorsement and to (inaudible) work with the developers to determine the next time it can be reviewed for endorsement. This will happen when the next cost and resource use project is schedule.

So the Steering Committee unanimously agreed the cost and resource use measures must be paired with quality measures in order to understand and make decisions about care. The committee agrees with the commenters that measures of efficiency and ultimately value our critical tools needed to improve the efficiency of the U.S. healthcare system, specifically encouraging shared accountability in a team-based care. Steering Committee acknowledge that the consumer perspective that care should be coordinated among providers. However, the Steering Committee raised a concern that it maybe inappropriate to hold primary care providers accountable for the cost of care provided to patients by other specialists through inpatient care or through post-acute care as primary care providers had limited ability to control these costs.

In the current state of care delivery, healthcare is accessed in many ways, many patients select their own primary and primary – and specialty care physicians making decisions to see providers on their own without coordination with their PCP or PCP group. The committee stated this maybe appropriate markets with integrated care delivery networks or where patients identify with the PCP or PCP group voluntarily or by assignment probably in the current fragmented state of care delivery this attribution approach is not supported.

So that was our general committee response. So we open it up for discussion on the response.

Great. Hearing none, we'll move forward. So the first – yes?

Male: I'm sorry. You know, I'm really struggling. In fact, I like the way the commenter worded the comment about not being part of an organized health system. But purchasers and other have come to expect this from providers of care to beneficiaries. So I wouldn't want us to be on record and I don't recall us being on record collectively as a group. I remember us being pretty split on whether the fact that providers, eligible professionals who are not part of integrated delivery systems may not perform as well on this measure because they're not part of an integrated system.

To me that's frankly the whole point, right? So that's not a rationale not to endorse the measure recommended for endorsement. As far as I'm concerned, that's the whole reason why we would recommend it. I feel like we're missing an opportunity here and I made a comment at the meeting and I make it again which is, if the reason you have higher cost is tied to the fact that you're not organized, whether you are employed by the same organization or you're not, it's not about employment, then I have frankly very little sympathy for you. Get organized.

David Penson: This is David Penson. That's fine and good. I think a lot of people at the meeting had concerns more about the methods and the way the measure was put together as opposed to the practice of the organizational structure I'll stay affront if I still have those concerns.

Male: David, I don't think that's what this report says.

Lina Walker: This is Lina Walker. I'd like to add that I feel that this comment doesn't reflect this kind of this split decision regarding this measure and so I echo – I'm sorry didn't catch your name, what was said earlier that I, you know, the way it's worded, it sounded as if there was consensus about the committee's concern that this is an inappropriate measure because of the lack of integrated or delivery system today. But I certainly – but that was just my concern and I wouldn't want the response to misrepresent the committee's discussion during that time.

David Penson: Yes, I think that's a reasonable point. I mean I think there a lot of the pushback regarding this measure. There are different reasons for different people in the room and I think it's quite reasonable to change the statements so it doesn't reflect that particular element of it.

Jack Needleman: Yes, hi. This is Jack Needleman. I really want to echo that comment.

Some folks may have been opposed to the measure on principle because of the assertion that people are operating in an organized system, and for others it's forcing measure and that actually has validity and the concerns were technical over specific issues of the measurement – of the measure rather than the basic (inaudible).

(Evan): OK, thank you. We can update this comment to reflect, but this raised the discussion. So we will update that.

Male: Good.

(Evan): OK. At this point we'll move forward to some of the specific issues here and the first, I think, discussed during the CMS presentation is Attribution. So just to summarize the comments, several commenters agree with the committee that primary care physicians or specialists who maybe attributed patients because they provide primary care services to that patient, have a limited ability to control the cost of care provided to patients by other specialists through inpatient care or through post-acute care. The majority of

commenters agreed that it maybe inappropriate to all of these providers accountable for this cost of care.

Commenters also agreed that this maybe appropriate in markets with integrated care delivery networks. However, current fragmented state of care delivery attribution approach is not supported. So that was the summary of those comments.

Additionally, several commenters share the Steering Committee concerns that patients and their associated cost may potentially be attributed to specialist who provide primary care services that are Medicare-allowable charges and question to the appropriateness.

Furthermore, we had several commenters share the Steering Committee concern that this is with PAs and NPs are not taken into account in the attribution model until the second stage, and non physician providers are increasingly delivering more primary care.

Additionally, given the various concerns about attribution approach, several commenters call the question of the reliability and validity of the measure and they know that the Steering Committee has put forward as to where the measure was valid.

So we also have a suggested response. And here it was said that the Steering Committee acknowledges the same concerns with the attribution approach. The Steering Committee stated concern that patients and their associated cost may potentially be attributed to specialists who provide primary care services that are Medicare-allowable charges. It is particularly significant in the case of patients who receive long-term care for chronic conditions who may receive many primary care services from specialist treating them for their chronic conditions, who are then attributed to a medical group practice based on the plurality of Medicare-allowable charges.

The committee noted the distinction that specialist can provide primary care services other than primary care visits.

Additionally, the committee stated that primary care physicians or specialists who maybe attributed patients, because they provide a primary care services that patient had limited ability to control the cost of care provided to patients by other specialists, their inpatient care or their post-acute care. Consequently, the Steering Committee raised concerns that it maybe inappropriate to hold these providers accountable for this cost of care. Further, the committee stated that it's maybe appropriate markets with integrated care delivery networks, however, in the current fragmented state of care, attribution approach is not reported.

And finally, the Steering Committee also agreed that – with commenters that there are issues with the both the first and second stage of the attribution approach. And the first stage visits with non-physician providers are not taken into account in the attribution model until the second stage as non-physician providers are increasingly delivering more primary care for their PCS visits may not always represent actual primary care visits by primary care providers. The committee encourages CMS to update this attribution approach.

Do we have any further comments? I know we had some discussion earlier that we can yet update.

Jack Needleman: This is Jack Needleman. I know, the comment is very similar to the comment on the one before at which, you know, in some sense this language doesn't capture the – has split the committee once on this measure. It's written as though the Steering Committee was speaking with one voice. I think all the points that are here were clearly concerns of many members of the Steering Committee and contributed to the non-endorsement, but it's hard to talk about the Steering Committee positions here when Steering Committee was so split so my question to the NQF staff is how have you dealt with that language? What kind of language have you used in the past to capture results where the committee has been split where it was a closed vote as opposed to a near unanimous vote?

(Evan): Taroon?

Taroon Amin: Yes, I can start with that. I think the feedback that we've gotten is helpful. I think what we should – what we've done in the past is kind of described both sides of the committee's discussion a little bit more. You know, what we've done here I think is a little bit more directive in terms of how we felt the majority of the committee felt on some of these issues but I think what we've heard very clearly from both Brent and Jack like what you noted here is that, you know, maybe describing in a little bit more the committee was split on some of these issues and these were some of the issues raised but by no means the single factor that determines the committee's decision ultimately on the measure.

So we can line up the language based on some of our previous other sort of split discussions that we've had in the past really the other measures.

(Helen): And just to add to that, this is (Helen). I agree with Taroon. We can certainly do that. I think there was – the commentary also reflected some of the comments that had come forward which is why it was written in that particular way and as you know the committee will have an opportunity to reconsider the measure and we vote so more to come.

Male: Great.

Eugene Nelson: This is Gene Nelson. As point of clarification, the purpose of the committee responding to the comments from the public, can you give us an indication as to why we're making the responses the committee to diverse thoughts and comments from the public?

(Helen): Sure, I can take that Gene. This is – this is (Helen) again. So actually part of our role as a consensus standard setting organization is that every comment is adjudicated. And so we usually do require that we have some response that a commenter feels as if their comment was taken into consideration by the committee.

Eugene Nelson: Thank you. That – (Helen), does that indicate that all of the 18 responses on 2165 should have a response?

(Helen): Should have some response although many of them were still similar that we can do more groups (theme-ing) responses as we've heard them (Evan) layout at least the preliminary suggested draft today.

Eugene Nelson: Very good. Thank you, (Helen).

(Evan): OK, so at this point we'll move on to – keeping that where we discussed in mind, move forward to exclusions which was our next major theme. We say that one commenter expressed a concern at the exclusions of death in Medicare Advantage beneficiaries impacted the usability of the measure, and that one commenter expressed a concern that Medicare Part D was excluded from the measure.

So our suggested response here is that the committee agrees that the measure specified that now allow for active comparisons of physicians based on the cost of care being provided to Medicare beneficiaries. We say that the committee was split on reliability and validity of the measure, but ultimately agreed that the exclusions of death lessens the utility of the measure as end-of-life care is a high cost area for Medicare.

Additionally, the committee agreed that Medicare Part D payment is an important area for measurement and improvement, and CMS shouldn't consider approaches to including this data for beneficiaries with Part D coverage.

Brent Asplin: Yes. Thanks, (Evan). Brent again. A sort of variation on the theme I think – you have tough job because it was a very rich discussion over two days and I think we all had questions about the measure. Personally, I feel unless I'm misreading and I could be, at least I think it does allow for accurate comparisons of groups of physicians on total cost to care and it's essentially the same methodology that CMS, as you think, for both the MSSP and – well, not same as Pioneer but for Medicare Shared Savings Program. So it's sort of the same theme that we commented at. The first line feels little too cut and dry to me, but thank you.

(Evan): OK. Yes, we can definitely update that. Do we have further comments on the exclusions response?

Hearing none, we'll move on to reliability.

So, one commenter requested the measure developer not publicly report results for any provider group with reliability scores less than 0.7. Another commenter stated that the measure is only reliable for groups of 25 or more eligible professionals, however, nearly half of all Medicare physicians practice in groups of fewer than 10 eligible professionals, and as the measure will be used as part of CMS as a value-based modifier calculation. The commenter questioned how this will impact smaller physician groups and solo practitioners.

And so the suggested committee response, here we have a – well, NQF does not require a specific cutoff for reliability testing. The committee does encourage CMS to report information on provider groups that have adequate reliability and performance for – in sample size.

This measure shall only be used for 25 or more eligible professionals since this is the scope of measure testing.

Do we have any comments about that suggested response?

Jack Needleman: Yes, this is Jack. You know, I've endorsed the last sentence.

(Evan): OK. Great. Any further comments?

Excellent. All right, we'll move on to risk adjustment. And here we have the fact that one commenter expressed a concern that the risk adjustment model might not adequately capture the differences in patient population for different specialties, particularly those who treat patients with uncommon and very severe diseases so from our comment (table), it was comment 3253.

Here they have – they appreciate the opportunity to comment on the measure. They have some concerns about the measure and its potential for use as a component of the value-based modifier. From the measure description and information provided, it is unclear how this measure would be applied. There are concerns about the broad nature of this measure and the fact that it looks

across different specialties rather than with any specialty. Understand that the risk adjustment takes into account the complexity of disease, however, they're concerned that the risk adjustment model might not adequately capture the differences in the patient population for different specialties.

Considering that the specialties, particularly cognitive specialists like rheumatology, caring for patients with uncommon and very severe diseases as whole might fare worse than others if the measures apply across specialties. In addition, they reviewed the risk adjustment model and do not believe it adequately captures the scope and complexity of conditions that rheumatologist care for. The exclusion of consideration of specific patient populations in the risk adjustment model would for providers or centers to treat a large number of these patients at a disadvantage and they would urge any assessment of providers for efficiency to look within a specialty rather than across specialties and that the risk adjustment model thoroughly reviewed through specialty societies.

Furthermore, several commenters stated that the HCC model, which was developed for the Medicare Advantage Program does not adequately account for risk and purposes of analyzing physician group, resource use as it was designed, to risk adjust large patient populations for insurance rate determination.

And our suggested response is that the committee generally agreed that all the HCC risk adjustment model was developed for Medicare Advantage. It was a appropriate but weak in this application. The committee will discuss whether the risk adjustment model is sufficient to detect patients with uncommon or very severe diseases.

Do we have any comments about the suggested response?

Great. So at this point, so, the next point is the action item for the Steering Committee and …

(Lindsey): (Evan), this is (Lindsey). I just – point of the committee (to) discuss whether the risk adjustment model is sufficient do detect patients with uncommon or very severe diseases, any comments on the community on that?

(Evan): OK.

(Dolores): Are you asking us now whether we have comments about that question or (inaudible) …

(Lindsey): Yes, in response to the comment that (Evan) laid out for you all the question as to whether or not the risk adjustment model was sufficient to detect patients with uncommon or very severe diseases, the community have any opinions on that or response to that comment?

(Dolores): I'll just make it general response. This is (Dolores) from IHA, I think that in general, most of risk adjustment methodologies are not really good at the tail end of the distribution. So, those that have – those really kind of uncommon things are generally really hard to appropriately risk adjust for. But we also have to keep in mind that this is at a group level. So, that's going to smooth out some of those kinds of differences. And I think it depends on whether there are actually groups that would have, you know, disproportionate share of particular types of members with those kinds of uncommon diseases.

David Redfearn: This is David Redfearn. I think the question kind of – is relevant to using the HCC model. The HCC models got 70, I think 70 diagnostic categories that it uses to build that risk model whereas the – the commercial – the risk models have, you know, 260 or 360 or something like that and it's obviously going to do a better job of picking up relatively rare diagnostic categories and assigning risk to them.

So I think the HCC model is admittedly a very simplified version of the overall risk approach. And in that sense, it's not going to be as good as it could be speaking of this kind of rare condition. So I would say that I think that criticism is probably a relevant criticism given that the HCC model is being used.

Jack Needleman: Well, what David – this is Jack Needleman. What David says suggest that one of the types of data we would have to analyzes, particularly given this comment, some very specific disease is rheumatoid arthritis mentioned specifically was whether for specific, you know, is there – one of the question,

this is a factual one, are even if the risk model is not as nuance as some of the commercial models, does it identify the high risk patients and that are most concerned, rheumatoid arthritis being one example. And the other is if you identify those patients and look at their per capita spending over the whole thing relative to the average of the risk adjustment for those folks look like it's fully adjusting for their higher risk.

And I don't recall getting – I haven't looked at the HCC list to see whether rheumatoid arthritis specifically is on it, but I also don't recall the analysis really focusing on the high cost – any of the risk adjustment analysis focusing on high cholesterol patients and whether that would materially affect some – the groups that treat them.

(Evan): OK. Do we have any other comments on this?

Hearing none. OK. So the next thing we'll do is – there's snapshot in here for the committee. You should have received the survey, both yesterday and today, we're able to change our evaluation on any of the – on the overall recommendation that indicate which of the evaluation criteria would have changed. We also have the opportunity to confirm your vote from the original in-person meeting and that's all provided through the in-person survey. Before we get in the call, we're going to open this up for public and member comments.

So this time, (Nan), if you could get that started.

Operator: Thank you. At this time, if you have a comment or would like to ask a question, please press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Again, that's star 1 for a comment or a question.

And there are no comments or questions at this time.

(Evan): Great. Well, I'd like to thank everybody for participating on today's call. David or Gene, would you like to say anything else?

David Redfearn: This is David Redfearn. I have just a general question before we sign off. Is it correct that these two measures, whether we approve them or not, are going to proceed? CMS is going to use them, is that correct?

Male: Good point, David.

David Redfearn: I mean – look, I'm just trying to get context in terms of how I should evaluate the measures because I have concerns and (inaudible) committee have had concern. And it's – I almost think that NQF needs to set a very high standard for approval. And so, we need to be very picky about how we do it. And our approval or disapproval is – as my understanding, are not going to affect how these are going to go forward that if we disapprove it, then that's going to indicate that the developers need to do some additional work and to come back again with enhanced measures to present and that's probably a good idea. But I'm just trying to get a context about what are votes up or down does here.

David Penson: David, this is David Penson. I'm going to jump a bit on that. I kind of think that's irrelevant. And the reason I think that's irrelevant is because of exactly of what you just said, which is we have to, as part of this committee, judge these measures on their, you know, on their methodology and on their size, whether or not they're appropriate and all the other – those criteria that we've got over. And I think we have to hold onto appropriate standards that each of us feel should be used.

So, I don't think that whether or not Medicare is going to used these (inaudible) this makes such a difference. And I don't think anyone on this phone and anyone in this committee should vote "yes" because CMS may use them all for that matter should vote "no" because CMS are going to use them and protest. I think you have to look at these measures just like we did when we met in Washington and CMS decides (inaudible) or not based on the comments that were made by the measure developers. If you've change your mind on the way you vote, you should do so.

As I said before, I have concerns and I'm not going to say which way I'm going to vote at this point but my point is I think people have to look at what's been presented today, what they saw earlier in the other meeting and make a

decision in isolation. But, you know, and what CMS does is not our concern. Is that makes sense?

Joe Stephansky: Yes. This is Joe Stephansky. I agree with that entirely. I very much dislike what CMS is doing with the hospital episode-based measure in practice. But, I for one, am probably going to have to vote to endorse it because I think it meets the NQF standards.

Taroon Amin: And this is Taroon Amin from NQF. I'll just, you know – I will reiterate I guess what the past two have said, Joe and David. You know, we really encourage you to evaluate these measures against our endorsement criteria and you know, whether CMS decides to use these measures or not is based in statutorial requirements that is outside the purview of NQF. But your decisions on this call in serving this committee represent the interest of our broad stakeholders in which, you know, you're representing obviously yourself, and not necessarily the membership, but you represent the broader community that – whether or not you believe that these are ready for broad application.

We can't say from other high profile projects that those that seek to use these measures certainly take the input of the committee very strongly and we've seen that already in terms of their responsiveness to the concerns that are raised whether this measure is moved forward or not. So, maybe I'll just leave it there with that unless (Helen) has anything else to add.

(Helen): That's perfect, Taroon. Thanks.

Female: Thank you for that clarification.

Jack Needleman: This is Jack Needleman, I just want to – I still haven't decided how I'm voting on each – or re-voting on each of this yet. But I think the issue – CMS was forced to pursue the measures to close the statutory requirements. I see an incredible amount of very hard work and seriousness with which the CMS folks and their contractors pursue these measures and try to get it, you know, right.

And I saw a tremendous amount of responsiveness to the committee's discussion and the comments we've received back. I think the issue remains is that the NQF steps have restated whether – given all of that work or despite all that work and the commitment to getting it right, we're comfortable it's right enough for endorsement yet, whether it's going be used or not. And I think that's the way I'm going to be trying to evaluate.

Brent Asplin: This Brent. I would echo Jack's compliments of the work that's gone in. And also, I really appreciated the committee's discussion and a – very complex issues. But it's great to have a group that's bouncing around with tough questions and …

(Larry): Yes, this is (Larry). I would – I did (know) all of that. I think work by all parties involved, staffs, developers, you know, (inaudible), and everybody tackled it and put forward, you know, (advance) forward. I think that's what it meant (inaudible) all about it (inaudible). Thank you to everyone.

Cheryl Damberg: Yes, this is Cheryl. I would concur.

Male: OK, good.

Eugene Nelson: Yes, this is Gene Nelson, another question or point of clarification. On page seven, with the paragraph that says that we vote on the measures if the comments and analysis call in to question the original endorsement recommendation. So, based on where we are now in the discussions that we've had today in the new material brought forth, how does the – how does an issue of re-voting look and what were the process for that be?

Male: Hi, Gene. Yes, so this is – we are re-voting on the measure that the link, the SurveyMonkey link, that was sent out yesterday and today, and those votes are due next Wednesday by the codes of business, so if you would like to change your vote, you can vote through that survey, or if you just want confirm your original vote, you would do that later as well.

Female: Yes. And just to be clear, we ask that everybody go to the tool and provide a vote regardless of whether or not that was changed from the original meeting to now.

Female: I'm sorry.

Male: But, it's hard to understand (where you're at).

Female: Sorry. I was saying, regardless of whether you're changing your vote from the in-person meeting or keeping it the same, we would ask that everybody please use the survey tool and submit a vote on both measures.

Eugene Nelson: OK. I haven't – this is Gene. And I haven't been on the site to see what it looks like. Will all of the members we asked to vote simply on an overall recommendation or on the individual criteria as well as the overall?

(Evan): It's an overall recommendation. And we also have a second – or follow up question that if you are changing the recommendation to please indicate which criteria caused you to change your recommendation and provide a brief rationale.

Eugene Nelson: Is it required that a certain number of the committee vote before that becomes the final vote? How does that process work?

(Evan): Yes. So we are asking everybody to submit a vote. We're tracking who submits a vote. Obviously, reminders to those who haven't vote or those who could possibly be on vacation this week, but we are asking that every committee member vote to provide their final recommendation.

Eugene Nelson: This then does become the final vote, is that correct, for this committee?

(Evan): That is correct.

Cheryl Damberg: And this is Cheryl Damberg. I have one other question, because the measure developers responded to a lot of the comments with a slide deck and I wasn't sure we had access to those slide decks. Is that something that you can make available to us?

(Evan): Yes. Yes, we can distribute that slide deck.

Cheryl Damberg: OK, thank you.

Martin Marciniak: It's Martin Marciniak. The question I have is when I look at the survey tool and the voting tool, so I get the principle that if you're not changing your vote, you don't necessarily need to comment, but if you want to comment, this is the opportunity to provide a further comment.

(Evan): Yes. Yes, you can provide a comment through the rationale mail box.

Martin Marciniak: Fair enough. Thank you.

(Evan): Great. Well, I want to thank everybody for participating on today's call. If you have any further questions, feel free to contact myself or any of the NQF staff and we'll be happy to respond. And we look forward to receiving your votes. And thanks again.

Male: Thank you and thanks for all the hard work.

Female: Thanks, everybody. Bye.

Female: Thank you. Bye.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END