August 7, 2013

Sent Via Electronic Mail

National Quality Forum
1030 15th Street NW, Suite 800
Washington DC 20005

Re: Public Comment on NQF#2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB) and NQF#2165-Payment Standardized Total Per Capita Cost Measure for Medicare Fee-for-Service (FFS) Beneficiaries

Dear NQF Cost and Resource Use Steering Committee:

The North American Spine Society (NASS) is a multidisciplinary medical organization dedicated to fostering the highest quality, evidence-based and value-based, ethical spine care by promoting education, research and advocacy. NASS is comprised of more than 8,000 spine care providers from several disciplines including orthopedic surgery, neurosurgery, physiatry, neurology, radiology, anesthesiology, research and physical therapy.

NASS welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) cost measures, #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB) and #2165-Payment Standardized Total Per Capita Cost Measure for Medicare Fee-for-Service (FFS) Beneficiaries, that are being evaluated for NQF endorsement. NASS supports efforts to accurately measure the cost of patient care as part of ongoing movements to evaluate healthcare efficiency. While NASS appreciates CMS’s efforts to construct cost measures, we have some concerns regarding the validity and applicability of these measures. These measures are to be used in the calculation of a provider’s cost measurement score under the Value-Based Payment Modifier; thus, impacting Medicare payment for tens of thousands of eligible providers. NASS urges the NQF to delay endorsement of these cost measures until CMS resolves the following issues.

NQF#2158 Payment-Standardized Medicare Spending Per Beneficiary

NASS is concerned that the risk stratification for MSPB does not have adequate granularity to differentiate significant cost drivers. Specifically, the proposal to stratify cases by major diagnostic category (MDC). There is significant evidence that MDC classification does not accurately encompass the factors that contribute to cost of care, and there are significant inaccuracies in the administrative data that contributes to the MDC Classification.\(^1\)\(^2\) Risk stratification using MDC criteria alone is inadequate and will introduce significant variability in the MSPB rating based upon patient-specific and
diagnosis-specific factors that are not adequately encompassed in the MDC classification. A more comprehensive classification that includes an algorithm that includes CPT codes and procedure specific information would be more useful than a stratification based upon MDC alone.

NASS shares similar concerns with NQF reviewers regarding the appropriateness of excluding the dual eligible population in the risk adjustment model. Dual eligible patients, or patients who qualify, in some way, for both Medicare and Medicaid coverage, are a costly group to Medicare. These patients are of lower socioeconomic status, are more susceptible to societal issues, are typically less educated and tend to report lower health status compared to other Medicare beneficiaries. While CMS has shown, through model testing, that dual eligible patients report a higher number of conditions included in the Hierarchical Conditions Categories (HCCs) and suggests that these patients will already be risk adjusted, it is important to note that HCCs do not account for all of the disparities experienced by this population. Because dual eligible patients are included in the measure population, some level of dual eligible risk adjustment should also be included. Those providers who treat a higher percentage of dual eligible patients are vulnerable to being penalized for potentially higher costs due to their disproportionate care of these patients.

NASS also questions the limited testing that this measure has undergone at the small group and individual provider level. The measure is classified as a facility level measure. If the results are to be applied to small groups in payment year 2016 and individual providers in 2017 through the Value-based Modifier, it seems like a measure that addresses provider level care would be more reliable than one at the facility or a mixed facility/provider level. As shown through the Reliability of Medicare Spending Per Beneficiary Measure for All Tins with at Least One Eligible Professional Model, those providers with lower attributable MSPB episodes have less reliability with this measure compared to providers with a higher number of attributable MSPB episodes (200+).

In addition, according to the MSPB Measure Information Form, “The MSPB Measure evaluates hospitals’ efficiency relative to the efficiency of the median hospital.” While cost is a consideration in the measurement of efficiency, cost alone does not provide reliable and valid information on the hospital’s efficiency. NASS suggests that the measure description be re-worded to clarify that cost is the only episode considered in this measure.

NASS agrees with the NQF’s preliminary decision to not recommend the Total Per Capita Cost Measure. NASS shares many of the same concerns voiced by NQF reviewers and recommends that CMS continue to work with NQF to revise this measure until all issues are resolved. In particular, the Total Per Capita Cost Measure’s attribution methodology is severely flawed and doesn’t accurately account for services rendered by specialists. In 2012, eligible providers were first able to preview the application of this measure through review of their Quality and Resource Use Reports (QRURs). Since the launch of QRURs, NASS has expressed concern to CMS regarding the generalizability of this measure to healthcare.

According to its measure specifications, the Total Per Capital Cost Measure “includes a two-step attribution rule in which the first step attributes beneficiaries to a medical group with affiliated primary care physicians (PCPs) whose services account for the largest amount of Medicare allowable charges within the measurement period. If the beneficiary is not assigned in the first step, they are assigned to any medical group in which they have seen at least one physician in the group, regardless of specialty,
who has provided primary care services.”¹ Patient attribution to a medical group will be based on which medical group provides the largest amount of Medicare allowable charges to the patient during the measurement period. Through this approach, services rendered and services that are actually meaningful to the specialist are masked. Specialists and primary care providers alike have limited influence on the cost of care provided to the patients for which they are not accountable; therefore, providers should not be held accountable for costs for which they have no control. In order for this measure to be truly meaningful, valid, and fair, NASS recommends that any attributed costs should accurately reflect the cost of care provided to the patient by the individual provider.

In closing, NASS appreciates the opportunity to review and comment on the construction of these two cost measures. If you have any questions or need additional information, please contact Karie Rosolowski, Senior Manager of Research and Quality Improvement, at 630-230-3692 or krosolowski@spine.org.

Sincerely,

Christopher K. Kauffman, MD
Co-Chair, NASS Performance Measurement Committee

³ MSPB Measure Information Form. Available at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagemenu=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350
⁴ Detailed Methodology for the Total Per Capita Cost Measure for Medicare Fee-For-Service Beneficiaries. Available at: http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed_Methods_Total_Per_Capita_Costs_2-12-13.pdf