September 6, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1600-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1600-P; CY 2014 Physician Fee Schedule Proposed rule comments

Dear Administrator Tavenner,

We write to provide comments on the CY 2014 Medicare Physician Fee Schedule (PFS) proposed rule with regards to the Value Based Payment Modifier and Geographic Practice Cost Indices. Overall, the Healthcare Quality Coalition (HQC) strongly supports the development of the value initiatives at CMS. Our members believe that properly structured incentives to provide high value care (i.e., high quality, low cost care) will result in better care for patients at a lower cost for payers.

As background, the HQC represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve.

Physician Value-Based Payment Modifier

The HQC supports the goals of the Medicare physician value modifier to transition Medicare to an active purchaser of high quality, efficient healthcare. We look forward to working with CMS to develop a robust program that accounts for physician performance on quality and cost metrics. We support continued implementation of the value modifier and we believe the payment adjustment must be of significant weight in order to drive physician behavior toward achieving high quality, low cost care. In addition, we encourage CMS to continue to find ways to align the value modifier program with other value-based purchasing initiatives. Our specific comments and recommendations relating to CMS's CY 2014 proposed rule are set out below.

1. **Comment: The HQC supports the increased weight CMS places on the value modifier, and recommends CMS further plan to increase the amount of payment at risk to provide sufficient incentives for physicians to provide high quality, low cost care.**

In the proposed rule, for CY 2016, groups that meet certain Physician Quality Reporting System (PQRS) reporting criteria will receive a payment adjustment based on quality tiering methodology. Groups of 100 or more eligible professionals (EPs) will be eligible for an upward adjustment or at risk for a downward adjustment of up to -2.0% of their fee schedule payments depending on how they score under quality tiering methodology. Groups of 10 to 99 EPs who are new to the program will be eligible for an upward payment adjustment only, and will not face financial penalties in CY 2016 for poor performance in the reporting period. For groups who fail to meet minimum PQRS reporting requirements, the value modifier will be automatically applied at -2.0%. The amount of payment at risk in CY 2016 – 2.0% – represents an increase from CY 2015 penalties, which are capped at -1.0%.

The HQC supports the increase in payment at risk for CY 2016. We believe a stronger financial incentive will lead to better value. However, we believe the modifier is still not strong enough to drive real change in our system. We understand CMS intends to gradually phase in the value-based payment modifier and that as it gains more experience with the program it will consider ways to increase the amount of payment at risk. We support CMS' intentions to increase the amount of payment at risk, and we would like to see a greater reward/financial risk in the final rule for payment year CY 2016. Alternatively, we would encourage CMS to create in the final rule a plan to increase the weight of the value modifier over time. Incremental increases ensure that the value modifier has the desired effect of improving performance on quality and cost metrics. Eventually, we believe that the value modifier should represent a larger percentage of physician payments under the PFS. Under a fully implemented value modifier, we believe the amount of the payment differential should be closer to 10%, increased incrementally from 2.0% and subject to annual review.

2. **Comment: The HQC supports the expansion of the value modifier to apply to groups with 10 or more eligible professionals, and recommends that CMS reconsider its decision to exclude Accountable Care Organizations from the program.**

In CY 2015, the value modifier will apply to groups of 100 or more eligible professionals. Illustrated In the CY 2014 physician fee schedule proposed rule, in CY 2016 CMS proposes applying the value modifier to groups of physicians with 10 or more eligible professionals. CMS previously finalized its proposal to exclude from the value modifier participants in the Medicare Shared Savings Program and Pioneer Accountable Care Organization (ACO) programs.

We fully support the expansion of the value modifier program to apply to groups of 10 or more eligible professionals. This expansion ensures a large pool of physicians to whom the value modifier will apply. However, consistent with our desire to see broader participation in the value modifier, we believe that Medicare ACOs of both types (MSSP and Pioneer) should be permitted to participate in the value-modifier program. We believe to the extent these groups provide high quality, low cost care, they should have the opportunity to be rewarded for their practice. We

also believe that having a broader array of participants in the early years of the program will facilitate the full-scale implementation in later years. Therefore, we recommend that ACOs be permitted to optionally participate in the value modifier or provide a plan of addressing innovators participating in the Medicare ACO programs on their role in the full roll out of the value modifier. We note that providing ACOs this option would also promote alignment with the Hospital Value-Based Purchasing Program, in which ACOs are given the option to participate.

3. **Comment: The HQC supports the application of quality tiering methodology to all participating physicians and physician groups and the transition to a pay-for-performance program under which all physician groups are subject to quality tiering.**

As proposed, the value modifier is largely based on participating in the Physician Quality Report System (PQRS). For the CY 2015 payment year, groups may elect the quality tiering option and be eligible for an upward, neutral or downward payment adjustment based on their performance. For groups that do not elect the quality tiering option, the amount of their value modifier will be determined based on whether the group is a satisfactory PQRS reporter (a "pay for reporting" option). For the CY 2016 payment year, CMS is proposing to eliminate the pay for reporting option and apply quality tiering methodology to all participating groups. CMS is also proposing to hold harmless groups that are new to the value modifier – i.e., groups with 10-99 eligible professionals – and will not apply any downward adjustments to these groups (assuming they meet minimum PQRS reporting requirements) even if they perform poorly on the selected measures.

We fully support CMS' proposal to eliminate the pay-for-reporting option, and apply quality tiering methodology to all participating groups. We believe measuring performance on quality measures will be the only way to truly drive quality improvements in the system.

4. **Comment: The HQC supports implementation of the Medicare Spending Per Beneficiary (MSPB) cost measure using either the "plurality of services" or "hybrid" attribution approach, and recommends that CMS set the minimum number of episodes at 10 rather than 20 for purposes of attribution.**

For the CY 2013 reporting year and CY 2015 payment year, CMS established a policy to include five cost measures in the value modifier cost composite. These include: (1) total per capita costs (Parts A and B) and (2-5) total per capita costs for beneficiaries with four specific conditions: COPD, heart failure, coronary artery disease, and diabetes. In this proposed rule, CMS proposes to expand the cost composite to include an additional measure – the Medicare Spending Per Beneficiary (MSPB) measure – which would be included in the total per capita costs for all attributed beneficiaries domain. CMS also proposes to attribute an MSPB episode to a group subject to the value modifier where any eligible professional in the group submits a Part B Medicare claim under the group's TIN for a service rendered during an inpatient hospitalization. CMS is proposing that only those groups who are attributed a minimum of 20 episodes during the performance period will have the MSPB measure included in the value modifier cost composite.

The HQC supports the inclusion of the MSPB measure as an additional cost measure. We believe that a robust cost measure set will further transform the Medicare payment system to a system that rewards efficient, effective care and helps address the critical issue of health care costs. The MSPB measure, by focusing on an episode of care will encourage care coordination and reward clinical integration. We recommend, however, that CMS adopt a policy that applies a 10 episode minimum instead of a 20 episode minimum. As CMS notes in the proposed rule, with a minimum of 10 cases, the MSPB measure is still very reliable at .70. Further, the 10 episode minimum would enable more groups to receive an MSPB measure performance rate for inclusion in the cost composite. Finally, the HQC supports inclusion of endorsed risk adjustment methodology to recognize illness severity and health status.

CMS is also considering various other attribution models. The first alternative under consideration is attributing an MSPB episode to physician groups who billed a Part B claim at any time during the episode (from 3 days prior to an index admission through 30 days after), which would place even stronger emphasis on shared accountability for care and would enable approximately 14,400 groups to have an MSPB measure included in their cost composite (as opposed to the approximately 11,400 groups that would be eligible under the proposed approach). The second alternative is to attribute an MSPB episode only to the group that provided the plurality of Part B services billed during the episode or index hospitalization (the "single-attribution approach"). The third alternative is a "hybrid attribution" method which would attribute an MSPB episode to groups from which an eligible professional provided services representing at least 35 percent of the total Medicare Part B payments during the episode or index hospitalization. The HQC supports the inclusion of alternative methodologies of either "plurality of care" or a "hybrid attribution" approach that best captures the care provided by the core group of practitioners during a MSPB episode. .

5. **Comment: The HQC supports CMS' efforts to ensure the cost composite methodology is applied fairly across all physician groups, regardless of their size or specialty composition.**

CMS is proposing to refine its methodology for determining the cost measure composite score to account for the specialty composition of group practices. CMS has analysed 2011 claims data and found that its current peer grouping methodology could have varied impacts on groups of physicians that are comprised of different physician specialties. Certain physician specialties furnish services that have higher than average or lower than average costs, and thus can affect the groups cost measures. CMS also acknowledged that relative risk adjustments do not fully offset these results. Therefore, CMS is proposing a new method to account for a group practice's specialty composition to the quality tiering methodology that produces fair peer group comparisons.

CMS is proposing to apply the "specialty adjustment" method for the CY 2016 value modifier, which would involve adjusting the standardized score methodology to account for a group's specialty composition. Under the methodology, CMS would first create a specialty-specific expected cost based on the national average for each cost measure. Next, CMS would calculate the "specialty-adjusted expected cost" for each group by weighting the national specialty-specific expected cost by the group's specialty composition of Part B payments. Finally, CMS

would divide the total per capita cost by the specialty-adjusted expected cost and multiply the resulting ratio by the national average per capita cost to convert the ratio to a dollar amount. The resulting dollar amount would be used to determine whether a group can be classified as high, low or average cost.

CMS also considered a second method – the "comparability peer grouping" method – which would construct peer groups for each physician group practice by identifying group practices with the nearest comparable specialty mix. CMS would calculate a benchmark for the peer group and then use the benchmark to calculate the group's standardized score for that measure. We believe that while the speciality-adjusted expected cost method seems to be simpler to calculate, the "comparability peer grouping" method would likely achieve greater transparency. Although equitable adjustment is critical, we recommend further exploring this method during the implementation of the physician value modifier that could potentially provide for increased transparency on performance.

6. **Comment: The HQC recommends CMS alter the performance period for the value modifier performance period to close the current one year gap between the close of the performance period and the start of the payment adjustment period.**

CMS has proposed to use CY 2015 as the performance period for the value modifier that will apply during CY 2017, meaning there will be another one-year gap between the end of the performance period and the beginning of the payment adjustment period. The HQC supports alterations to the performance period that would strengthen the connection between the performance of physicians and groups and the financial incentives for quality improvement. We therefore recommend that CMS adjust the performance period for quality data reported through PQRS and calculate the total per capita cost measures on an April 1 through March 31 basis, thus closing the gap by 3 months.

Geographic Practice Cost Indices (GPCIs)

Section 1848(e)(1)(A) of the Social Security Act requires CMS to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, practice expense (PE), and malpractice expense (MP)). In the proposed rule, CMS states that the agency has completed a review of the GPCIs and is proposing new GPCIs, as well as a revision to the cost share weights that correspond to all three GPCIs.

Comment: The HQC strongly supports value-based payment policies. As such, accurate input measurement is critical to standardizing performance amongst providers across the nation for an "apples to apples" comparison. Therefore, as evidenced by the Medicare Payment Advisory Commission, we urge CMS to consider the recommendations concerning the physician work adjustment that currently reduces payments to providers in many areas.

To calculate the physician work GPCIs, CMS has historically used wage data for seven professional specialty occupation categories, adjusted to reflect one-quarter of the relative cost differences for each locality compared to the national average, as a proxy for physicians' wages. As healthcare continues to become increasingly integrated, recognizing physicians as employees of a health system is an improved approached rather than using proxies of "similar" professionals in an area. Dynamics unique to the health professional workforce, such as availability, shortage, access, and geography, play a key role in compensating healthcare professionals and may be unreflective of the overall market dynamics.

In the preamble of the proposed rule, CMS notes that the Medicare Payment Advisory Commission (MedPAC) was required by section 3004 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) to submit a report to the Congress by June 15, 2013 that assesses the appropriateness of an adjustment to distinguish the difference in work effort by geographic area and, if appropriate, what that level should be and where it should be applied. In the report, MedPAC also assessed the impact of the work geographic adjustment under the Social Security Act, but CMS did not have sufficient time to review this report, which was issued on June 14, 2013.

The MedPAC Report found:

- There is evidence of the need for some level of geographic adjustment of fee schedule payments for professional work because there is geographic variation in the cost of living and the earnings of professionals in the reference occupations.
- However, the current index is flawed both conceptually and in implementation.
- Conceptually, the labor market for professionals in the reference occupations (lawyers, architects, etc.) may not resemble the labor market for physicians and other health professionals.
- Implementation of the work GPCI is flawed because there are no sources of data on the earnings of physicians and other professionals of sufficient quality to validate the GPCI.

Absent this earnings data, which has never been included in CMS calculation of resource cost differences among localities, we conclude CMS has inaccurately measured geographic adjustment of physician payments.

MedPAC studies have confirmed that the data sources currently relied upon for geographic adjustment bear "no correlation" to physician earnings. Additionally, CMS officials have admitted that the proxies utilized for the purpose of geographic adjustment have never been validated, and there never has been a new data source utilized in the twenty years since the fee schedule was implemented. MedPAC data show that the geographic adjustment reference occupations predict earnings of rural physicians to be 25-30% less than physicians in metropolitan areas as adjusted by the current GPCI methodology. Conversely, MedPAC data show that earnings of primary care physicians in rural areas are, in fact, 13% higher than physicians in metropolitan areas. Since there is no statistical basis of support for disparities in payment, we recommend CMS take steps to recognize the higher cost of wages for providing care in rural areas. Having a source of credible data and a sustainable payment mechanism is critical to maintaining access to primary care services in rural areas for our patients we serve.

Finally, in furthering the goal of moving towards a system of rewarding value in healthcare delivery, input measures and data used in geographic adjustment policy play a key role in standardizing performance under the physician value-based payment modifier.

Conclusion

The HQC appreciates the opportunity to comment on this important proposed rule and supports the goals set forth in the physician value modifier proposal. Representing hospitals, providers, and associations including integrated healthcare systems, we urge CMS to work together with hospitals and physician groups to ensure quality measures included in value-based payment programs are working in tandem to achieve the similar goals of improved quality and lower cost. We look forward to continuing to provide feedback on this important initiative. Please contact us if we may be of any assistance as you further refine the value modifier and GPCI.

Sincerely,

The Healthcare Quality Coalition

The Healthcare Quality Coalition represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve. www.qualitycoalition.net