THE HEALTHCARE QUALITY COALITION

August 28, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1612-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1612-P; CY 2015 Physician Fee Schedule Proposed rule comments

Dear Administrator Tavenner,

We write to provide comments on the CY 2015 Medicare Physician Fee Schedule (PFS) proposed rule with regards to the Physician Value Based Payment Modifier. 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.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Our provider systems have more than 19,000 licensed hospital beds, employ more than 21,000 physicians, and have more than 225,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value and are pleased to provide comments on the future policies impacting the Physician Value Based Payment Modifier.

N. Physician Value-Based Payment Modifier and Physician Feedback Program

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' CY 2015 proposed rule are set out below.

Increase in Payment Adjustment Amount

Comment: The HQC supports and appreciates the increased weight CMS is proposing for the value modifier, which increases the amount of payment at risk to 4% in 2017. This step is critical to driving value in a predominantly fee-for-service environment. As all physicians become accustomed to value-based reimbursement, we recommend CMS continue to increase the amount of payment at risk to provide meaningful incentives for physicians to provide high quality, low cost care.

In the proposed rule for CY 2017, groups and solo practitioners that meet certain Physician Quality Reporting System (PQRS) reporting criteria will receive a payment adjustment based on quality tiering methodology. Groups of 10 or more eligible professionals (EPs) will be eligible for an upward adjustment or at risk for a downward adjustment of up to -4.0% of their fee schedule payments depending on how they are classified under quality tiering methodology. Provider groups of 2 to 9 EPs will be eligible for an upward payment adjustment only, and will not face financial penalties in CY 2017 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 -4.0%. The amount of payment at risk in CY 2017 – 4.0% – represents an increase from CY 2016 adjustment policy, which capped penalties at -2.0%.

The HQC supports the increase in payment at risk for CY 2017. We believe a stronger financial incentive will better reward value and, once it is applied to all physicians, will drive meaningful changes in how health care is delivered. We understand CMS intends to gradually phase in the value-based payment modifier and when more experience is gained in the program, CMS will continue to consider ways to increase the amount of payment at-risk, which we support. Additionally, we would encourage CMS to create in the final rule a plan to increase the weight of the value modifier over time in a more prescribed manner. Incremental increases ensure that the value modifier has the desired effect of improving performance on quality and cost metrics. Under a fully implemented value modifier, we believe the amount of the payment differential should be closer to 10%, increased incrementally from 4.0% while subject to annual review.

Mandatory Quality Tiering

Comment: The HQC supports the application of quality tiering methodology to all physicians and physician groups. However, we are concerned that, as currently applied, only a small percentage of physicians will see any payment impact, and the vast majority will see no payment effects at all. As such, we would seek additional information on CMS' rationale for this structure. Specifically, we seek to understand whether a pay-for-performance program that holds approximately 85% of practitioners in a neutral payment adjustment can be considered a meaningful initiative, and whether developing additional tiers would better recognize variations in performance and appropriately reward high-value care.

As proposed, the value modifier is largely based on participation in the Physician Quality Report System (PQRS). For the CY 2017 payment year, CMS is proposing to apply quality tiering methodology to all participating groups, while holding harmless groups that are new to the value modifier. For 2017, groups with 2-9 eligible professionals and solo practitioners will be held

harmless, meaning that CMS 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 support CMS' proposal to apply quality tiering methodology to all participating groups. However, we are concerned that CMS has stated that the overwhelming majority of providers subject to the modifier will not see any payment impact this year or in future years. In contrast to the hospital value based purchasing program that calculates performance scores and distributes incentives and penalties based on actual net performance and individualized variable rates, the physician value modifier program uses categories of performance. Despite numerous studies indicating significant variation in Medicare spending and quality across the country, the value modifier program as currently constructed will only result in 6-7% of providers gaining bonuses in 2015. CMS has also stated in the proposed rule that in 2017, it only expects that 6% of providers will earn upward adjustments, 11% will receive downward adjustments, and the remaining 83% will not see any payment impact. This is intriguing considering the use of standard deviation methodology for quality tiering, which generally holds that 68% of the sample is average, falling within +/- 1 standard deviation from the mean, while the value modifier is expected to hold 83% "average".

We understand the need for CMS to reward only meaningful performance variation, and we are not advocating that CMS force variation among providers where not warranted. However, based on our review of the 2012 Quality Resource Use Reports, there appears to be a $5,000 to nearly $10,000 difference within the range of the *spending per beneficiary* standard deviation denoted as "average" spending. Therefore, a physician group could have a spending measure of $21,500 per beneficiary for heart failure, while another group could have $30,500 per beneficiary spending, and both groups would be placed in the same cost tier. This represents approximately 30% variation within the same quality tier. We question the extent to which this is an appropriate application of the value modifier, and ask CMS to respond and provide clarification on using deviation categories for performance. Further, we suggest CMS explore additional ways to recognize differences in performance in a more meaningful way, and thereby expand the percentage of physicians who will see a payment impact under the program. One way may be developing additional tiers in the quality tiering methodology as a means of recognizing meaningful differences in performance, such as illustrated in the above example.

Applying the Value Modifier to All Physicians

Comment: The HQC supports the application of the value modifier to all eligible practitioners as required by statute in 2017, including Shared Savings and Pioneer Accountable Care Organizations and other CMS innovation center models. The HQC also urges CMS to ensure a seamless integration into the value modifier for ACO participants, given the substantial resources providers have invested in entering ACO arrangements.

As previously finalized, in CY 2015, the value modifier will only apply to groups of 100 or more eligible professionals, while in CY 2016 CMS will apply the value modifier to groups of physicians with 10 or more eligible professionals. In this proposed rule, for 2017, all eligible practitioners will be subject to the value modifier, including physicians participating in Accountable Care Organizations and other payment models. The HQC supports the full implementation of the value modifier, as called for by statute, to reach all physician groups and solo practitioners. We believe

that a broad application of the value modifier is the best way to drive value-based change nationwide.

The proposed rule outlines various scenarios to which the value modifier would apply to Shared Savings ACOs and Pioneer models. We appreciate CMS' recognition that groups participating in such arrangements are at the forefront of care innovation. We urge CMS to take an approach with ACOs that ensures as seamless integration of the value modifier as possible given the investment of resources of entering into ACO arrangements.

In the proposed rule, CMS seeks to recognize differences in cost and quality measurement methodologies that exist in the Medicare Shared Savings and Pioneer ACO programs. We agree that all physicians serving Medicare beneficiaries should be subject to value-based payment that includes quality and cost measures. However, given the complexity and investment by ACOs should be recognized and not be required to report measures twice or report additional measures when they already subject to significant reporting. We believe CMS should carefully review how the physician value-based payment modifier program would be integrated into the ACO program and whether that integration serves the correct purpose.

Additionally, we want to ensure benchmarks are applied properly to MSSP ACOs. If providers in a Medicare ACO have their payments increased or decreased based on the Value Modifier, CMS must then rebase the ACO's benchmark to reflect this payment adjustment. For example, if the payment adjustment is an increase in payment to the ACO providers, then CMS must appropriately increase the benchmark so that initiatives are aligned to the extent where programs are being served dual purpose without competing achievement benchmarks. Failing to do so may add complexity for organizations enrolled in ACOs.

Treatment of Hospital-Based Physicians

Comment: The HQC supports CMS' consideration of hospital-based physicians. We recommend moving forward by allowing hospitalists the option of using cost and quality measures from the Hospital Value-Based Purchasing (VBP) program. This recognizes the unique circumstances of hospital-based physicians and follows our support of cross-program alignment.

In the proposed rule, CMS seeks input on applying the value modifier to hospital-based providers. Although no implementation date has been proposed, guidance is sought specifically in developing qualifying criteria, approaches to attribution of a hospital to a tax identification number, and measure extraction from the Hospital VBP program.

The Hospital VBP program calculates performance scores using a mix of process and outcome quality measures and a cost (spending) measure. CMS is soliciting input on:

1. Identifying groups or solo practitioners that would elect to include VBP performance data in their value modifier score (e.g., by allowing providers to self-nominate or by establishing specific criteria that a TIN must satisfy)

2. Determining which hospital or hospitals' performance would apply to a given TIN (e.g., by using hospital where TIN provided a plurality of services or by setting some threshold of hospital-based services provided)
3. Incorporating the hospital or hospitals' Total Performance Score(s) or some subset of the score(s) into the value modifier by either:
    a. Using the entire Hospital Value-Based Purchasing Total Performance Score in the cost composite;
    b. Utilizing the Efficiency and Cost Reduction domain score in the cost composite, and include all or some subset of the other domain scores in the quality composite (extract only those most applicable to hospital-based physicians); or
    c. Including some subset of the measures in the cost and quality composites.

The HQC recommends moving forward with this policy by allowing hospitalists the option of using cost and quality measures from the Hospital Value-Based Purchasing (VBP) program. This recognizes the unique circumstances of hospital-based physicians and furthers the goal of program alignment.

Total Per Capita Cost Measures and Price Standardization

Comment: We support the inclusion of robust cost measures in the Physician Value Modifier, equally weighted with quality. Additionally, we also agree with the National Quality Forum on including partial year Medicare beneficiary data for the purposes of cost measures in the program. However, we remain concerned regarding the use of current proxy input measures used in the price standardization methodology for the cost measures in the value modifier.

The proposed rule seeks to address concerns raised by the National Quality Forum (NQF) regarding attribution of the Total Per Capita Cost Measures in the value modifier. The first modification is to include mid-level practitioners in the initial step of identifying and assigning a provider or system to a Medicare beneficiary. This makes sense since primary care providers include others than physicians. Second, the proposed rule seeks to include additional beneficiaries in the cost measure methodology that are partial year enrolees in the Medicare program. The intention of this approach is to recognize costs incurred at the late stages of life. We agree that including as many Medicare beneficiaries in the program as feasible increases the accuracy of measurement and assessment of spending. Thus, we support CMS proposal to modify the measures for the program for implementation in CY 2017.

We would also like to make one additional comment regarding the price standardization methodology designed to remove the effect of geographic practice cost indices (GPCI), policy directed payments including bonus payments in rural areas, selected primary care bonuses, and Medicare disproportionate share payments. The GPCI work adjustment was developed to create a mechanism that compensates physicians at the same "real" rate across the country – that is to look at elements such as physician earnings, amenities (e.g., access to colleagues; sharing of on-call obligations; available technologies) and other economic factors that cause differences across geographic areas and to adjust payments across the nation accordingly. As we have commented in prior rulemaking, we have continued concerns on the GPCI proxy inputs that result in downward payment adjustments to many HQC members unreflective of the actual cost of physician practices.

MedPAC has affirmed issues with inaccuracy in the use of selected proxies for cost adjustment,[1] which currently extracts compensation data of other professionals, such as architects. The standardization methodology utilized in the cost measures for the physician value modifier is designed to reverse the impact of the GPCIs, but it does not cure the inaccuracies of the front-end inputs to the GPCI that continue to push payments to many HQC members downward. Until CMS takes action on correcting issues identified by MedPAC with the use of geographic adjustment, price standardization methodology used in the value based payment modifier will be directly impacted.

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 measures included in various value-based payment programs are working in tandem to achieve the similar goals of better quality and lower cost. We look forward to continuing to provide feedback on this important initiative.

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

[1]Transcript, October 4-5 MedPAC Meeting (2012) available at http://www.medpac.gov/transcripts/Oct12Transcript.pdf.