THE HEALTHCARE QUALITY COALITION

September 4, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1590-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Acting Administrator Tavenner,

We write to provide comments on the Medicare Physician Fee Schedule Value Based Payment Modifier described in the Medicare Physician Fee Schedule (PFS) proposed rule for CY 2013. 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.

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 value modifier that accounts for physician performance on quality and cost metrics. We agree with the goals CMS has outlined in the proposed rule, including (1) recognizing and rewarding high quality care and quality improvements; and (2) promoting more efficient and effective care through the use of evidence based measures, reducing duplication and fragmentation of care. We support implementation of the value modifier and we believe that the value modifier must be of significant weight in order to drive physician behavior toward high quality, low cost. 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 proposal are set out below.

Recommendation: CMS should ensure that the value modifier is of sufficient weight to provide incentives for physicians to provide high quality, low cost care.

In the proposed rule, CMS proposes that for groups that meet certain Physician Quality Reporting System (PQRS) reporting criteria, the value modifier would be 0.0%, unless the group

elects the quality tiering methodology. Under the quality tiering methodology, depending on the group's performance on quality and cost metrics and the risk of the patient population, the group could be eligible for a value modifier increase of +3x or a decrease capped at -1.0%. For groups who fail to meet certain PQRS reporting requirements, the value modifier will be -1.0%.

The proposed value modifier adjustments ranging from +3x to -1.0% are not sufficient to drive changes in physician behavior. We believe that a much more robust value modifier is going to be required to create a value-based delivery system. We understand that CMS is concerned about phasing in the modifier and the overall impact of multiple quality reporting and pay-for-performance initiatives that impact payment under the PFS. Therefore, in the event that CMS determines that the weight cannot be increased in the final rule, we would like to see from CMS 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 that the amount of the payment differential should be approximately 10%.

Recommendation: CMS should increase participation in the value modifier for the first two years of the program in order to facilitate smoother application of the modifier to all physicians in 2017 (as required by law).

In the proposed rule, CMS proposes applying the value modifier to groups of physicians with 25 or more eligible professionals. CMS proposes participants in the Medicare Shared Savings Program and Pioneer Accountable Care Organization (ACO) programs be excluded from application of the value modifier.

We encourage CMS to apply the value modifier to smaller physician groups (e.g., groups of 10 or more) in order to develop a larger pool of physicians to whom the value modifier initially applies. In 2015, physician groups of 25 or more participating in the value modifier should be automatically enrolled in a value adjustment mechanism (either tiering or total performance score). Also beginning in 2015, groups of 10-25 shall participate in value modifier with the option of greater risk (i.e. what is currently proposed for groups of 25 or more). We believe that allowing broader participation in the first year of application will lead to a smoother transition to ultimate application of the value modifier to all physicians and physician groups. Additionally, individuals and small groups who meet reporting requirements during early implementation should be given the option to participate in the value modifier as all physicians will be subject to the payment adjustment in 2017.

As to the calculation of group size, we note that CMS proposes to include all eligible professionals in calculating the size of the group (which would include physicians, other practitioners, certain physical or occupational therapists, or qualified audiologists). We would like to clarify that the value modifier would apply to Medicare Part B Fee Schedule provider payments, including payments for non-physician eligible professionals including in calculating the size of the group. We believe that including these provider payments under the fee schedule is consistent with the intent of the law and will foster a team-based approach to achieving value.

In addition, CMS states in the proposed rule that it would like to exclude groups of physicians with 25 or more eligible participants beginning in 2015 that are participating in the Medicare Shared Savings Program or the Pioneer Accountable Care Organization (ACO) program from application of the value modifier. CMS seeks comments on whether these groups should be permitted the option to participate in the value modifier in earlier years. Consistent with our mission of 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 that 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 participate in the value modifier for the 2015 application year. We note that providing ACOs this option would also promote alignment with the Hospital Value-Based Purchasing Program, which ACOs are permitted to opt in to participation.

Recommendation: The HQC supports the PQRS measures and outcome measures as proposed in the rule. However, we encourage CMS to transition the value modifier to a pay-for-performance program for all physicians and physician groups.

As proposed, the value modifier is largely based on the Physician Quality Report System (PQRS). For groups not electing the quality tiering option, the amount of their value modifier will be determined based on whether the group is a satisfactory PQRS reporter. In the proposed rule, CMS outlines the various reporting requirements for successfully satisfying the PQRS program.

In general, our members support the use of the PQRS system as a foundation for the value modifier. However, we encourage CMS to move quickly away from allowing reporting to satisfy the requirements of the value modifier. We believe that measuring performance on quality measures will be the only way to truly drive quality improvements in the system.

The HQC supports quality measures that are vetted and nationally endorsed through entities such as the National Quality Forum (NQF). For the value modifier, the proposed rule includes four outcome domains for quality measures, including 30-day post operation visit, all-cause readmission, acute composites and chronic composites. The HQC supports the inclusion of these outcome measures as the goal should be to incrementally move beyond structural and process measures to reward outcomes and coordinated patient care in the value modifier. We encourage the agency to continue to develop measures that better assess the aspects of healthcare we are trying to improve. Our organizations have experience in other sectors with measures that focus on keeping patients healthy, either by preventing illness or treating chronic diseases at a documented “best practice” level. We believe that the value modifier represents an opportunity for CMS to continue to drive improvements in quality measurements and that many of our members can use their work in this area to show what works when it comes to selecting measures that drive value.

Finally, we encourage CMS to continue to seek ways to align the various quality reporting systems in which physicians participate, including the Medicare Shared Savings Program,

Medicare Pioneer ACOs, meaningful use, electronic prescribing, and others. Unaligned efforts contribute to higher operational costs and burdens on providers. We believe that the large number of reporting requirements being imposed on physicians can be better aligned to achieve the results of better care at a lower cost and encourage CMS to continue its efforts to harmonize these programs under the National Quality Strategy. We look forward to continuing to work with the agency as the value modifier develops over the next few years.

Recommendation: The HQC supports implementation of the cost measures using total per capita costs and per capita costs for certain chronic conditions as proposed in the rule. We request that CMS continue to focus on the law's requirement that the value modifier be separate from geographic adjustment factors.

In the proposed rule, CMS restates the previously finalized measures for the cost component of the value modifier – total per capita cost, and total per capita cost for beneficiaries with four chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes). CMS also proposes using the Hierarchical Condition Categories (HCC) model of risk adjustment and a price standardization methodology.

In general, we support the cost measures and the HCC risk adjustment methodology. The cost measures allow for a global view of spending patterns, along with how well the physician community is in addressing prevalent chronic conditions against a national comparison group. Use of chronic conditions costs metrics also aligns with the proposed quality measures that include chronic illnesses. Also, CMS has indicated their intentions on submitting the measures for NQF endorsement. We support this as an important step in gaining recognition and validation as an effective instrument of cost measurement.

The HCC risk adjustment model is a reasonable approach for providers who treat patients that are high risk. Additionally, the proposed rule does not develop episode-based cost measures, but acknowledges testing in Physician Feedback Reports beginning in 2013. The HQC supports the movement to episode groupers initially focused on chronic conditions and urges CMS to continue developing and testing this methodology to align costs of common chronic conditions through the Physician Feedback Reports.

CMS is also using price standardization methodology 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. We have continued concerns on the GPCI proxy inputs that result in downward payment adjustments to many HQC members that are unreflective of the actual cost of physician practices. The standardization methodology proposed in the cost measures reverses the GPCI's, but the result is a perpetuation of the some of the inaccuracies of the inputs to GPCI that continue to push payments to many HQC members downward.

Recommendation: The HQC strongly supports the approach of using national benchmarks for quality and cost measures in the value modifier.

Equitable comparison of cost and quality measures are key features of the value modifier. Determining how well physician quality and cost are compared to a national benchmark ensure fairness and reward high-quality, low-cost providers while providing targets for improvement in underperforming groups. This aspect provides the incentive and measurement tool for comparison in a national program.

Recommendation: CMS should adopt the total performance score (TPS) methodology instead of the quality tiering approach. The TPS should be reflective of a value modifier as a function of quality over cost.

In the proposed rule, CMS proposes the quality tiering model, which classifies quality and cost into high, average and low tiers. Physician groups that elect the quality tiering option are then assigned a value modifier based on their placement on the tiers. CMS also seeks comment on an alternative methodology: the TPS methodology. The TPS would calculate a total performance score unique to each group of physicians based on attainment and improvement. As we understand it, this method would be similar to the approach used in the hospital value-based purchasing program. We believe that the TPS approach discussed in the proposed rule has certain advantages over the quality tiering approach, and we therefore recommend that CMS adopt the TPS methodology in the final rule.

First, we believe that the TPS approach will incentivize participation in the value modifier scoring option. Under the proposed rule framework, physician groups must opt in to participate in the quality tiering method, thus placing themselves at financial risk for high or low performance. Such a framework provides no incentives for a poor performer to elect the quality tiering methodology.

In contrast, on the hospital side, the value-based purchasing program allows hospitals to receive incentives for both achievement (high performance compared to other hospitals) and improvement (better performance as compared to the hospital's prior performance). The TPS approach, if aligned with the hospital value-based purchasing program, could provide similar incentives for both achievement and improvement. Such incentives will likely lead to broader participation, as it incentivizes the participation of low performers who work to improve their own performance. We believe that the TPS methodology as a function of quality over cost on the physician side will result in higher levels of participation in the value modifier's scoring option and better drive improvements in the delivery system.

Second, the TPS approach avoids the "cut off" problem that persists in the quality tiering option. The quality tiering method creates "cut offs" between the high performing and low performing physician groups by classifying physician groups' performance according to their performance. Each group is assigned a value modifier based on their position on the grid of cost and quality performance. In contrast, the TPS approach avoids the cut-off problem by giving each physician group its own unique score and applying a value modifier based on that score. We believe that assigning each group a unique score, rather than a tier, will better incentivize improvement among physicians and physician groups and will provide a fair measurement of each group.

Finally, organizations involved in the HQC represent physician practices, hospitals, integrated healthcare systems and associations. The HQC supports alignment between quality programs in order to simplify and harmonize value-based purchasing initiatives among various healthcare provider structures. Although TPS offers program alignment, simplification, and goals of improvement or attainment, if CMS uses quality tiering it should achieve: 1) a requirement that all physician and physician groups participate; and 2) be incrementally increased in weight to place more emphasis on Medicare physician payments on quality and cost. However, we believe that the TPS approach will facilitate harmonization and fairness in the value modifier program and encourage CMS to adopt the TPS approach.

Recommendation: CMS should adopt the "Plurality of Care" or "Plurality of Primary Care Services" (as included in the Medicare Shared Savings Program) attribution methodology.

CMS proposes using the plurality of care method to attribute beneficiaries for purposes of measuring quality and cost in the value modifier. CMS notes that the attribution methodology will be aligned with the final attribution methodology used for the PQRS GPRO web-interface. We believe the plurality of care model would provide a better transition into episode groupers than the degree of involvement attribution.

The HQC supports the use of either the plurality of care methodology or the methodology used for the Medicare Shared Savings Program. We believe that either of these methodologies would be more accurate than the degree of involvement method and either would facilitate the goals of program alignment and to minimize operational costs to the extent possible.

Conclusion

The HQC appreciates the opportunity to comment on this important proposed rule and support 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.

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