THE HEALTHCARE QUALITY COALITION

September 8, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1631-P; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule

Dear Acting Administrator Slavitt:

We write to provide comments on the CY 2016 Medicare Physician Fee Schedule proposed rule with regards to the Physician Value Based Payment Modifier and implementation of payment reforms in the Medicare Access and CHIP Reauthorization Act. Overall, the Healthcare Quality Coalition (HQC) strongly supports the development of the value initiatives at CMS. Our members believe 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. Combined, 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 CY 2016 Physician Fee Schedule proposed rule regarding the Physician Value Based Payment Modifier and implementation of the Medicare Access and CHIP Reauthorization Act.

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

The HQC supports the goals of the physician value modifier to transition Medicare Part B to an active purchaser of high quality, efficient healthcare. We support continued implementation of the value modifier and we believe the payment adjustment must be of significant weight in order to

drive systematic change toward high quality, low cost care. In addition, we encourage CMS to continue to find ways to align the physician value modifier program with other value-based purchasing initiatives in preparation for transitioning into MIPS. Our specific comments and recommendations relating to the value modifier are set out below.

Payment Adjustment Amount for CY 2018

Comment: The HQC supports and appreciates the increased weight CMS finalized in last year's rulemaking cycle for the physician value modifier in 2017 at +/- 4%. Due to the transition into the new Merit-Based Incentive Payment System (MIPS) commencing in CY 2019, we support the continuation of 4% of payment at-risk for 2018 as proposed.

The CY 2016 proposed rule implements the Physician Value Modifier for CY 2018, the final year the value modifier exists as a separate payment program. In the proposed rule, groups and solo practitioners that meet minimum Physician Quality Reporting System (PQRS) reporting criteria will receive a payment adjustment based on quality tiering methodology for CY 2018. Groups of 10 or more eligible professionals (EPs) will be eligible for an adjustment up to +4.0x/-4.0% of their fee schedule payments depending on how they are classified under quality tiering methodology. Provider groups of 2 to 9 EPs and physician solo practitioners will be eligible for a payment adjustment only up to +2.0x/-2.0%. For groups who fail to meet minimum PQRS reporting requirements, the value modifier will be automatically applied at -4.0%. These adjustment factors are the same as those previously finalized for CY 2017.

In past rulemaking cycles, the HQC commented in support of a continuous increase of the amount of payment at-risk. Incentives with minimal impact will not result in widespread delivery system reforms. We believe a stronger financial incentive will better reward value and will drive meaningful changes in how health care is delivered. However, we recognize that the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 put in place a new value-based payment system that begins in CY 2019, and therefore we support CMS' proposal to set the payment adjustment at +4.0x/-4% for large groups and +2.0x/- 2% for small groups and solo physician practitioners.

Cost and Efficiency Measure episodes and Price Standardization

Comment: We continue to support the inclusion of robust cost measures in the Physician Value Modifier, equally weighted with quality. As any quality and cost measures, we ask CMS to ensure accuracy by including the Medicare Spending per Beneficiary (MSPB) measure at a stronger level of reliability. We also remain concerned regarding the use of current proxy input measures in the price standardization methodology for the cost measures in the value modifier.

We appreciate the continued use of cost and efficiency measures in the value modifier. The strength lies in a set of cost measures that carry a counter balance with measures of quality. The proposed rule seeks to modify the number of episodes used to trigger a MSPB measure, increasing from 20 to

100. Although this revised policy would decrease the number of groups eligible for a MSPB measure from nearly 30,000 to 8,500, we ask CMS to ensure strong measure reliability greater than the current 0.40 threshold.

We would also like to comment regarding the price standardization methodology designed to remove the effect of geographic adjustment factors. For example, the Geographic Practice Cost Index (GPCI) work adjustment was developed to create a mechanism that compensates physicians at the same "real" rate across the country. This is intended to incorporate geographic disparities in costs such as physician earnings, amenities (e.g., access to colleagues; sharing of on-call obligations; available technologies) and other economic factors causing differences across geographic areas, and to adjust payments accordingly. Better data exists for measuring the real rate of physician work, such as recruitment compensation surveys and physicians employed at federally qualified health centers.

As we have commented in prior rulemakings, we are concerned about the inaccuracy of 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 for measures of cost will be directly impacted, and we are concerned it may be carried over in the cost measures in the future Merit-based Incentive Payment System program.

Request for Input on the Provisions Included in the Medicare Access and CHIP Reauthorization Act (MACRA)of 2015

a. Merit-based Incentive Payment System (MIPS)

In the proposed rule CMS seeks comment on the implementation of the Merit-based Incentive Payment System (MIPS) as authorized in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Set to begin in CY 2019, the MIPS is comprised of four categories of measures: Quality, Efficiency, Electronic Health Record Meaningful Use, and Clinical Practice Improvement activities. In the first year of MIPS, eligible professionals will be subject to an adjustment of up to +/-4% to their Part B payments. The applicable percentage gradually increases to 9% in 2022 and beyond. CMS highlighted a number of provisions regarding implementation of MIPS on which it seeks comment.

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

Overall Infrastructure Design and Attribution

Comment: The HQC supports using existing infrastructure for the implementation of MIPS. This guiding principle ensures a smooth transition without creating overlapping, redundant quality reporting mechanisms. In addition, we ask CMS to consider improving patient attribution methodologies that recognize providers that work with patients to keep them healthy.

In transitioning from the current reporting and value-based payment programs, we urge CMS to provide a seamless transition into the MIPS. We recommend building MIPS from existing reporting and value-based programs, including the Physician Quality Reporting System (PQRS) and Physician Value-based Payment Modifier to minimize administrative burden. In addition, we ask CMS to transition the program measures currently used in these programs into MIPS, with an emphasis on outcomes-focused quality measures and robust cost/efficiency measures.

In transitioning to a new value-based payment system, the HQC also believes there is opportunity for improvement in patient attribution methodology. In continuing towards value-based care, providers should be recognized for keeping patients healthy but also not be dis-incentivized from caring for patients with multiple chronic conditions. Improved patient attribution with robust risk adjustment methodology better reflects value-based care and population health. This would provide an important balance between caring and managing high-risk patients while being recognized for maintaining and improving quality outcomes.

Clinical Practice Improvement Activities

Comment: We ask CMS to clearly articulate what clinical practice improvements will be available for providers to satisfactorily meet the MIPS category. Overall, we recommend flexibility in meeting clinical practice improvement activities, and urge inclusion of existing programs as part of the MIPS domain. In addition, we request CMS provide a plan for measuring clinical practice improvement activities.

Under the provisions of MACRA, 15% of the MIPS payment adjustment will include Clinical Practice Improvement activities. Although specifically undefined, activities will be classified into sub-groups, including:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an alternative payment model

We ask CMS to clearly articulate what clinical practice improvement activities will be made available, and how providers and groups are to satisfactorily meet the parameters of the domain. As a general

matter, we recommend the identified activities be attainable, but also that they require sufficient engagement and effort to ensure that providers are being rewarded for their effort toward improving clinical practice. In addition, we request CMS to recognize current quality improvement programs and opportunities as the foundation for meeting the parameters of Clinical Practice Improvement Activities domain in the MIPS.

As such, we ask CMS to consider the following programs for inclusion as options for providers and health systems as part of the Clinical Practice Improvement criteria:

- Membership in a regional health improvement collaborative (RHIC).
- Successful completion of a formal quality improvement initiative sponsored by a RHIC.
- Attendance at one or more "learning events" sponsored by a RHIC.
- Membership and participation in a CMS Partnership for Patients Hospital Engagement Network

Many state and regional-based collaboratives were created as a means of convening and facilitating quality improvement initiatives with multi-stakeholders. Organizations and groups such as RHIC's and several others exist to facilitate new models and quality improvement initiatives. Included in MACRA is funding for technical assistance for RHIC's for providers in rural and medically underserved areas. Allowing for RHIC involvement in clinical practice improvement activities and other initiatives will provide an important link between funding and goals of MACRA and the new payment system (MIPS).

MIPS Performance Scoring Methodology

Comment: The HQC is concerned the current Physician Value Modifier program scoring methodology creates performance categories (tiers) rather than attributing an adjustment to actual performance. In the first few years of the Value Modifier we have been disappointed to see this methodology has produced so few high performers and so few low performers. We are concerned about a methodology that yields similar results in the MIPS. In the development of the MIPS program, we strongly encourage CMS to propose a performance methodology that resembles composite scoring and linear distribution, such as the method used in the Hospital Value-Based Purchasing (VBP) Program. The Hospital VBP program assigns an actual payment adjustment based on a hospital's individual performance rather than categorically grouping. Based on experience in the physician value modifier to date, over 75% of providers are considered "average"[2] despite acknowledged variation in performance.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services. 2015 Value-Based Payment Modifier Program Experience Report. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-VM-Program-Experience-Rpt.pdf

In contrast to the hospital VBP 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, in 2015 the value modifier program had over 75% of providers considered "average" and only 13% of providers electing quality-tiering gained bonuses. CMS has also stated in the CY 2015 proposed rule that in 2017, only 6% of providers are expected to earn upward adjustments, 11% will receive downward adjustments, and the remaining 83% will not see any payment impact. We remain concerned this type of scoring methodology will be continued into the Merit-based Incentive Payment System (MIPS) beginning in 2019.

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.

The HQC questions the extent to which this is an appropriate application of the physician value modifier and are concerned this type of scoring will carry over into the MIPS. As CMS provides further rulemaking on MACRA and implements MIPS set to begin in 2019, we strongly encourage CMS explore additional ways to recognize differences in performance in a more meaningful way than the physician value modifier that appropriately recognizes actual performance. Providers who are investing in value-based reforms to their practices should be rewarded, and the reward should be something more than the avoidance of a penalty. Rather, it should be a positive and meaningful financial reward.

b. <u>Alternative Payment Models</u>

In addition to implementation of the MIPS, the MACRA also provided incentives for providers to develop and implement Alternative Payment Models (APMs). MACRA creates a separate payment track for professionals participating in "eligible alternative payment models." Professionals who meet the criteria for this track will be excluded from the MIPS and will receive a 5% bonus on their Part B revenue from 2019 through 2024. An eligible APM is defined to include Medicare Shared Savings Program (MSSP) Accountable Care Organizations, certain Centers for Medicare and Medicaid Innovation (CMMI) models, or models tested under other demonstration authorities. The APMs must also require meaningful use of electronic health records (EHR); pay based on quality, and, unless the model is a medical home, bear financial risk. To be considered a participant in an eligible APM, a professional must show that a minimum percentage of payments (or counts of

patients) are attributable to Medicare Part B services furnished through the eligible alternative payment entity.

The HQC believes physician-focused APM's will be instrumental in driving delivery system reform, coupled with a new robust value-based fee-for-service payment system. The proposed rule explains that a future Request for Information (RFI) will be focused squarely on APMs as authorized in MACRA. However, CMS requests any questions to be submitted in this proposed rule for use in the forthcoming RFI. As such, below are some initial issues we urge CMS to consider in developing the upcoming RFI specifically on APM's:

1. Identifying APM participants: Will provider groups be allowed to participate in both MIPS and an APM, such as where some professionals in the group are in an APM and some are not? (i.e. will an APM be defined at the Taxpayer Identification number?)
2. Measuring participation in an APM: Will CMS allow professionals to demonstrate participation based on patient counts, as allowed for under MACRA? If so, how should "patient counts" defined for purposes of APM eligibility? Would this be the number of unique patients or number of patient visits?
3. Quality measurement: What quality measures will need to be used in an APM and how will they need to be reported?

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 goals of better quality and lower cost. We look forward to continuing to provide feedback on the implementation of the new payment programs in MACRA.

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