The Voice of Accountable Physician Groups

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Acting Administrator Slavitt:

We appreciate the opportunity to comment on the CMS Quality Measure Development Plan (MDP): Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) Draft. CAPG represents 200 multi-specialty physician organizations across 40 states, Washington, DC and Puerto Rico. Our members participate in value-based payment models across Medicare Advantage and traditional Medicare. CAPG members have successfully operated under risk-based payment models for over two decades.

The MDP will provide the strategic framework for the future of measure development for clinician quality reporting to support the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). We offer these key considerations for CMS as it finalizes the MDP:

- **CAPG Standards of Excellence Serve as a Guide for the Transition from Fee-for-Service to APMs.** For a decade, CAPG's physician executives have developed and improved a survey examining the attributes of successful risk-bearing physician organizations. We encourage CMS to use the Standards of Excellence as a guide for MIPS development.

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- **Align Medicare Reporting and Performance across Programs**. MACRA presents an opportunity for greater alignment across fee-for-service Medicare, traditional Medicare APMs, and Medicare Advantage APMs.
- **Encourage Participation in APMs**. MACRA charts a bold new course for physician payment in traditional Medicare by providing bonuses for APMs that take risk and meet other statutory requirements. We understand that some APMs in development may not be considered bonus-eligible APMs, and therefore would have to participate in MIPS. However, those organizations participating in an APM that are not bonus eligible should have some protection in MIPS from the maximum penalty amounts. That is to say, they should not have the same penalty exposure as physicians or groups that are not participating in any delivery system reforms. We encourage CMS to develop the MDP so that it is consistent with the overall goal of advancing APMs at all levels of readiness.

CAPG Background

Our members' preferred model of risk-based coordinated care is pre-paid capitation. This model best aligns the incentives for physicians to provide high quality coordinated care. Under this model, the payment amount does not fluctuate based on the volume of services provided. Instead, the physician organization is paid a set amount per-member-per-month.

In this capitated model, the physician organization has the flexibility to tailor payments to its individual contracted or employed physicians (paying a salary, sub-capitation, or even fee-for-service in some cases). Our member physician organizations hold their employed and contracted physicians to robust performance standards, with a portion of the downstream payment often depending upon performance on different metrics.

Capitated payment allows our members to deploy proven techniques and innovative approaches to improve patient care. The model incentivizes a physician-led team-based approach, whereby health care professionals such as care managers, nurses, social workers, care navigators, pharmacists and others are deployed as part of the care team. Each member of the team is encouraged to practice at the top of his or her license. This primary care team-based approach improves patient outcomes.

These arrangements also incentivize physicians to provide the right care, at the right time, in the most effective setting. For example, rather than trying to maximize fee-for-service payments in high cost settings, patients are treated safely in lower cost settings, such as their home, when appropriate. Our experience is that this approach is better aligned with patient preferences.

Overall, this model offers superior quality and care experience for patients. We believe that the model can and must be encouraged and developed across the country.

Aligning the MDP to Overall MACRA Goals

When Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA), it sought to transition traditional Medicare away from its reliance on a flawed, volume-driven, fee-for-service reimbursement model to risk-based alternative payment models, including capitation. This intent is evidenced throughout the law. Most notably, beyond the 5 percent incentive for APM participants, in 2026, MACRA permanently implements a favorable payment update for APMs. Rather than an APM strategy of limited experimentation, MACRA clearly contemplates systemic change.

Consistent with this overall goal, the Merit-Based Incentive Payment System (MIPS) creates an opportunity to prepare physicians and physician groups to transition to risk-bearing relationships. MIPS measured development should be viewed through this lens – preparing physicians and physician groups to move into risk relationships with payers. To guide the development of MIPS and APM quality measures, the MDP should include and be geared toward this overall transition of the delivery system to new payment models.

Building on What Works: CAPG's Standards of Excellence™ (SOE™)

Ten years ago, CAPG's board of directors created CAPG's Standards of Excellence™ (SOE™) program to measure the attributes of risk-bearing physician organizations. Today, SOE serves as a roadmap for physician organizations on the journey to greater levels of financial risk and clinical accountability. The SOE™ Program measures, publicly reports, and recognizes physician organizations' achievement of the core competencies necessary to succeed and thrive in risk-bearing relationships with payers. Highly relevant to today's policy landscape, the SOE™ provides a roadmap for the types of clinical practice improvements and administrative capabilities critical to success in this new environment. This tested tool can and should serve as a foundation for CMS as it develops MIPS.

Below is a brief introduction to the competencies covered by CAPG's SOE™. For more information, including the complete survey tool, a list of participating organizations, and the scores for past participants, visit our website.

Identify and Stratify the Patient Population. Risk-bearing physician organizations will allocate their resources to implement programs tailored to the unique health status of the population served. This process often begins by analyzing the patient population and stratifying individuals into appropriate segments according to their needs. Risk stratification requires the support of a strong technology backbone, including electronic medical records, disease registries, and robust and accurate clinical data. The SOE™ survey awards points for developing health information technology capabilities, such as the use of disease registries and meaningful use of health information technology.

Caring for High Risk and Complex Patients. Once the population is stratified, the physician organization can develop care processes and systems for the sickest, most complex patients. These are the patients that represent the best opportunity to improve care, control costs, and

enhance quality. Risk-bearing physician organizations must excel at slowing the progression of disease, keeping patients out of the hospital, and managing chronic conditions. The SOE™ awards points for physician organizations that have a system in place to identify and enroll high acuity patients in high complexity case management programs. The survey also examines the makeup of the multi-disciplinary care team that staffs the high complexity case management program. High performing physician organizations will have a care team that spans the full continuum of care and consists of a variety of healthcare professionals to meet the mental health, substance abuse, social, and environmental factors affecting a person's overall health.

Commitment to Advanced Primary Care Capabilities. In risk-bearing models, incentives are aligned to keep patients healthy, rather than provide a high volume of services. A core component to achieving this goal is having robust, advanced primary care capabilities. The SOE awards points for multi-disciplinary care teams, including non-physician team members, each practicing at the top of his or her license. The survey also examines the information technology supports for the care team. Finally, the survey awards points for reducing the disparity in payment between specialists and primary care providers (PCPs).

Reducing unnecessary hospital admissions and readmissions. In a capitated or risk-bearing environment, incentives are aligned to reduce and ultimately prevent unnecessary hospital admissions and readmissions. Risk-bearing physician organizations deploy several methods to achieve these goals. First, these physician organizations typically employ or contract hospitalists and physicians to provide care to hospitalized patients. Hospitalists communicate back to the primary-care led team and help coordinate post-hospital discharge care. Second, physician organizations will typically have in place a plan for post-hospital discharge care coordination, transitioning the patient out of the hospital, and ensuring follow-up with the patient's PCP. Third, the physician organization will typically offer options other than the emergency room for after hours and weekend appointments. The SOE awards points for use of hospitalists, sophistication of the post-hospital discharge care coordination program, as well as extended access options.

Robust participation in quality and resource use measurement programs. Performance measurement strives to ensure that financial targets are achieved without sacrificing quality of care. Risk-bearing physician organizations typically participate at the organization level in externally facing or public quality reporting programs, such as the Medicare Advantage 5 Star program or state-wide quality reporting initiatives. In addition, physician organizations use internally facing physician report cards to rate quality based on a targeted set of measures at the individual physician level. The SOE survey assesses the organization's active performance measurement participation.

Defining the allocation of financial risk between medical group and payer. In risk-bearing arrangements, physician organizations must come to an agreement with payers as to which services are the medical group's financial responsibility and which are the payer's responsibility. The SOE™ survey asks groups about this division of financial responsibility, specifically inquiring

as to which services are the physician organization's responsibility. These aspects of the survey are not publicly reported.

Responsibility for downstream payment to employed or contracted physicians. In a risk-bearing arrangement, typically the physician organization takes risk at the organization level. The organization must then pay its employed or contracted physicians through sub-capitation, fee-for-service, salary, or some other payment model. Typically, these downstream arrangements include a performance incentive payment tied to achievement on internal quality and resource use metrics. The SOE™ examines these types of relationships, however, the results are not publicly reported.

The SOE is aligned to the overall goal of preparedness for risk-bearing relationships. It has been in practice and tested by CAPG members for ten years. Rather than starting from scratch, particularly when it comes to the clinical practice improvement category within MIPS, we encourage CMS to build from this successful program as it implements MIPS.

Aligning Medicare Performance Measurement and Reporting

MACRA presents a significant opportunity to create alignment across programs. Rather than viewing traditional Medicare and Medicare Advantage as separate components, CAPG has long called upon the agency to harmonize its requirements across all of Medicare. Quality measurement and reporting poses a substantial opportunity to work toward this objective.

Aligning Medicare Advantage Quality Measurement with Medicare ACO Quality Measurement

We continue to believe that the agency's ultimate goal should be empowering consumers to choose providers across fee-for-service, Medicare Accountable Care Organizations, Medicare Advantage, and Medicare Advantage Alternative Payment Models with "apples–to-apples" quality information to guide their decisions. MACRA represents an important opportunity to create such an alignment and to facilitate true comparisons for patients and their families.

CAPG recommends that the agency take this opportunity to align the MIPS and the APM measures in Traditional Medicare to the CMS Medicare Advantage (MA) 5-Star Rating Program. We believe that the MA measures that are applicable to physicians and physician groups are a better indicator of provider performance. Specifically, we have isolated the measures in Medicare Advantage for which physician organizations are directly responsible, a list of these measures is attached.

We also call on CMS to include the Medicare Advantage quality ratings information at the physician organization level on Physician Compare.

Existing law required CMS to develop the Physician Compare website. The website contains information about Medicare physicians and other eligible professionals that participate in the Medicare Part B Physician Quality Reporting System. The first phase of Physician Compare launched at the end of 2010. Since then, CMS has increased the amount of information it includes

about physicians. In the most recent Medicare Part B Physician Fee Schedule Proposed Rule, CMS proposed adding quality performance information to the Physician Compare website.

Physician Compare is intended to provide meaningful, actionable information to consumers over time. By providing information about quality performance, patients will be able to eventually evaluate physician options in their area and select the best provider for their specific healthcare needs.

However, Physician Compare contains no quality information for patients in the Medicare Advantage program. Today, about 30% of seniors are enrolled in the Medicare Advantage program and enrollment continues to grow. For these seniors, quality information about health plans is available through the Medicare Stars Rating program, however, no quality information at the physician level is made available by CMS. Omitting this data leaves out a crucial piece of the picture necessary for informed consumer choices.

The omission of Medicare Advantage quality information also creates an incomplete picture of physician performance for those physicians that participate in the Part C program. For example, some CAPG physicians have such a small amount of Part B business (less than 2% of the patients a physician treats). Thus, their results on Physician Compare will simply read "N/A." This does not reflect what might be a large share of Medicare patients treated because those patients are enrolled in Part C.

CMS Should Add Medicare Advantage Quality Information to Physician Compare

We encourage CMS to develop a strategy to incorporate an apples-to-apples comparison of quality performance in Medicare Advantage and FFS. We suggest two steps for accomplishing this goal. First, we believe that quality data at the physician group level exists in the Medicare Advantage Stars program. For example, the Integrated Healthcare Association (IHA) has developed a quality ranking program at the physician group (rather than health plan) level. Using existing measures in Medicare Advantage quality assessment, IHA creates a 5 star quality score for the physician group and publishes the results on the IHA website. We encourage CMS to consider how it could similarly post quality information for physician groups participating in Medicare Part C on the Physician Compare website.

Second, to accomplish a true comparison, there will need to be further alignment of physician and physician group quality measures across traditional FFS Medicare, Medicare ACOs, and Medicare Advantage. We encourage CMS to develop a plan for aligning these measures and then publishing comparable performance results on Physician Compare. We believe that this will create the best, actionable information for consumers looking for information about their Medicare choices.

Incorporate the Work of the Core Quality Measures Collaborative in the MDP

CAPG serves on the Steering Committee of the Core Quality Measures Collaborative (CQMC), a multi-stakeholder group consisting of CMS, America's Health Insurance Plans, the National Quality

Forum, consumer groups, physicians, and purchasers. The CQMC has worked intensely to create initial core sets of measures across certain areas that bring harmonization to the efforts of government and private payers. The MDP references this important and ongoing work. We agree that the CQMC's efforts should be a guiding factor in the alignment of measures across programs going forward.

Reduce Reporting Burden on Physician Organizations

As we think about the four MIPS Categories of quality, resource use, meaningful use, and clinical practice improvement, as well as the 11 proposed subcategories in category 4, we are concerned about the overall number of measures that CMS plans to develop for purposes of MIPS. We encourage CMS to be mindful of the overall number of measures that must be reported to be successful in MIPS. We believe that a tailored set of measures aimed at preparing providers to take on financial risk will best achieve the overall delivery system goals. Again, we ask CMS to look at the work of CQMC as a guide to be used for core measures in the MIPS program.

Encouraging the Development of Non-Eligible APMs on the Path to Bonus Eligibility

As we understand MACRA, the statute creates the potential for a broad universe of Medicare alternative payment models and a narrower subset of "eligible APMs" that will qualify for a five percent incentive payment. This means that there will be APMs that do not qualify for the five percent bonus (i.e., not every APM is an eligible APM). Those APMs that are not bonus eligible will have to participate in MIPS.

While this construct aligns with MACRA's overall goals of moving providers to risk-based arrangements, we believe that there should still be incentives for organizations to get "on the ramp" to risk. That is to say, for MIPS purposes, an organization in a Track One ACO should not be treated the same as an individual or organization that is not engaged in any alternative payment model. A Track One ACO and other non-risk bearing alternative payment models are still taking steps toward risk, beginning care coordination activities, and otherwise preparing for risk arrangements, and those steps should be recognized in the MIPS program in some way.

One way to do this is to give credit or partial credit in one or two of the four MIPS categories, such as quality and clinical practice improvement. As for quality measurement, many alternative payment models already base payment of shared savings on quality performance. Therefore, affording a non-eligible APM some credit in this category could provide some relief while still encouraging high quality performance. As for clinical practice improvement, we believe that these activities should be the type that APMs are already undertaking to fulfill their obligations under the model. Therefore, it may make sense to afford the APM some credit for their score on this category as well. MACRA explicitly contemplates some credit for this type of participation, stating that "participation by a MIPS eligible professional in an alternative payment model . . . shall earn such professional a minimum score of one-half of the highest potential score for the

performance category . . . ."[1] We believe that this MIPS partial credit approach will encourage organizations to stay on the path to risk without dampening the incentive to move to two-sided risk and capitation.

Conclusion

MACRA creates a significant opportunity to work to better align quality measurement and reporting to support a transformation of America's healthcare delivery system. We look forward to working with CMS to achieve these goals. Please do not hesitate to contact us for additional information.

Sincerely,

DONALD H. CRANE
President & CEO

[1] MACRA, Public Law 114-10 (April 15, 2015) at 129 Stat. 102.