The Voice of Accountable Physician Groups

September 6, 2016

Andy Slavitt
Acting Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: *CMS-1654-P, Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Releases; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model*

Dear Acting Administrator Slavitt,

We appreciate the opportunity to comment on the Medicare Physician Fee Schedule Proposed Rule (proposed rule). CAPG represents nearly 300 multi-specialty physician organizations across 40 states, Washington, DC and Puerto Rico. Our members participate in value-based payment models across all of Medicare, including Medicare Part B. We represent a number of high-performing Medicare Shared Savings Programs and Next Generation Accountable Care Organizations, as well as physician groups who are further along in the risk-continuum in their relationships with commercial payers, Medicaid, and Medicare Advantage health plans.

Our members' two-sided risk bearing payment model avoids incentives for high utilization associated with fee-for-service, and instead aligns incentives for physicians to innovate and provide the best care to improve the health of entire populations, particularly seniors. Our members' value-based payment arrangements create incentives for: (1) a team-based approach that emphasizes primary care; (2) physician

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organizations to provide the right care at the right time in the most appropriate setting; and (3) a care team that addresses the patient's total care needs, including mental and behavioral health and the home environment.

Our comments address the following topics in the proposed rule:

- Medicare Shared Savings Program
- Diabetes Prevention Program
- Improving Payment Accuracy for Primary Care, Care Management and Patient-Centered Services
- Expansion of telehealth services
- Medicare Advantage provider enrollment

Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP) has taken on new significance for physicians and physician groups in light of the Medicare Access and CHIP Reauthorization Act (MACRA). As you know, the statute creates two paths: (1) the merit-based incentive payment system (MIPS), a fee-for-service path that establishes a nationwide pay-for-performance program; and (2) an advanced alternative payment model (APM) path that rewards physicians for taking financial risk in traditional Medicare. Based on the proposed rule, it is clear that much of the opportunity to succeed in either path is rooted in the Medicare Accountable Care Organizations (ACOs), and more specifically in MSSP. More specifically, the agency has proposed certain advantages for Track One MSSPs that will participate in MIPS and Tracks 2 and 3 of MSSP are two of just six available options to participate as a bonus-eligible advanced APM. Clearly, the program is intended to play a pivotal role in the future of the Medicare delivery system.

For this reason, policy and regulatory changes to the MSSP are particularly relevant. In general, we support policies that will simplify, clarify and reduce administrative burdens on physicians and physician groups participating in MSSP. Particularly as we enter the first year of MACRA performance, we call on CMS to clearly communicate program standards to the stakeholder community and to engage physicians to develop policies that can make Medicare ACOs more successful for patients and providers alike. Our specific comments on the proposals in the rule are provided below.

a. Proposed changes to the Medicare ACO quality measure set

In the proposed rule, CMS is suggesting changes to the existing quality measures that Medicare ACOs are required to report. The agency states that it is making specific

changes in this instance to better align the ACO quality measures to the ACO measure set recommended by the Core Quality Measures Collaborative (the Collaborative).

CAPG is pleased to serve on the steering committee of the Collaborative. This effort brings together physician professional associations, health plans, national quality organizations, consumers and employers with the intent to streamline quality measures across programs. CAPG recently released a *Guide to Alternative Payment Models* featuring case studies on physician payment at the group and individual physician level.[1] One key takeaway from the Guide is the sheer volume of quality measurement and reporting that is currently required across programs for sophisticated physician organizations. Our members reported different sets of measures for commercial ACOs, Medicare ACOs, Medicare Advantage, statewide pay-for-performance programs, and more. Streamlining the measures across programs is a high priority for a high functioning delivery system capable of meeting the needs of a growing, aging population.

To begin to address the program, the Collaborative has developed seven core measures sets intended to streamline quality measurement and reduce the reporting burden on physicians.[2] One of these sets was specific to accountable care organizations.

Consistent with the Collaborative's recommendations, CMS is proposing to add ACO-12 medication reconciliation post-discharge and ACO-44 use of imaging studies for low back pain. CMS is also proposing to retire or replace several of the ACO measures, resulting in a set of 31 individual measures and 30 total measures for scoring purposes.[3]

CAPG Comments:

CAPG supports the proposed changes to the ACO quality measure set. The proposed additions and deletions to the quality measures set align with the work of the Collaborative and we are pleased to see the agency moving ahead with the recommendations of that multi-stakeholder group.

As MACRA is implemented in 2017, we encourage CMS to continue to monitor and adapt to the circumstances of ACOs. In particular, for the Track One Medicare Shared Savings Program ACOs, who will use their performance on the MSSP measures to satisfy

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[1] The CAPG Guide to Alternative Payment Models is available at www.capg.org/apmguide.
[2] More information on the core measures collaborative and the measures sets is available on the CMS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html.
[3] Proposed Rule, 81 Fed. Reg. 46,423.

the quality component of MIPS, the accuracy and relevance of the MSSP quality measures is increasingly important. CAPG looks forward to continuing to work with CMS and the Collaborative to ensure that the measures set accurately and appropriately represents the performance of MSSP ACOs in MIPS.

b. Proposed changes to ACO auditing

In the proposed rule, CMS suggests that it will make changes to ramp up the auditing of MSSP participants. In its current audit process, the agency selects a subset of Web Interface quality measures and then selects a random sample of 30 beneficiaries for each measure in the subset. The ACO then provides medical records to support the data reported in the Web Interface. A measure-specific audit performance rate is then calculated using a phased audit process. In the first phase, eight randomly selected medical records are collected for each audited measure and are reviewed to determine whether the records match what was reported. In the second phase, the remaining 22 records are reviewed for any measure for which there is a mismatch in phase one. If less than 90 percent of the medical records support what was reported, the process moves to phase three. In phase three, CMS educates the ACO about correct reporting and the ACO has an opportunity to resubmit the measure(s) in question. If at the end of phase three there is a discrepancy greater than 10 percent between the reported quality data and the medical records, the ACO does not get credit for meeting the quality target for any measure(s) for which there is a mismatch. CMS notes that it has gained experience with conducting audits and believes that audit rules should be updated to better align this program with other CMS auditing initiatives.

CMS is proposing a number of changes to the auditing process. First, CMS is proposing to increase the number of records audited per measure. The existing number of records reviewed ranges from 40 to 150 records per audited ACO. CMS does not specify a specific number of records that would be requested for purposes of quality validation audits in the future, but says that it would not anticipate requesting more than 50 records per audited measure.

CMS is also proposing to modify the regulations to conduct the audit in a single step; to provide an assessment of the overall audit rate rather than the audit rate at the individual measure level; to adjust the ACO's quality performance to the audit rate (as opposed to the current policy of giving the ACO no credit for quality performance on a measure with a mismatch rate greater than 10 percent); and modifying the regulations

such an ACO with a match rate of less than 90 percent may be required to submit a corrective action plan.[4]

CAPG Comments:

While we support the agency's goals of data validation and ensuring accurate quality data submission, we have concerns about the timing of the proposed increase in auditing for the MSSP program. We are increasingly mindful of the burdens placed on physician practices as they transition into new delivery system models, such as ACOs, and prepare to comply with MACRA. With all of these changes occurring simultaneously in 2017, we question whether now is the time to expand the auditing process as described in the proposed rule. We believe that clear guidance must be provided to ACOs in advance of such auditing and appropriate educational materials should be developed and disseminated by CMS to assist ACOs in complying with program audits. Given all of the other moving parts in traditional Medicare at this moment in time, we would ask that CMS phase in this audit scale up over a longer period of time.

c. Incorporating beneficiary attestation into ACO assignment

In the proposed rule, CMS indicates its belief that it may be desirable to incorporate beneficiary attestation into the MSSP beneficiary alignment methodology. CMS states that using beneficiary attestation to supplement the MSSP attribution model could help increase patient engagement, improve care management and health outcomes, and lower expenditures for beneficiaries.

CMS proposes to create a voluntary alignment methodology that asks the beneficiary to confirm their care relationship with a provider that is participating in the ACO. CMS is considering an automated process to allow fee for service beneficiaries to designate their "main doctor' or other healthcare provider they believe is responsible for their overall care. The automated system could use an existing system, such as Medicare.gov to allow the beneficiary to indicate his or her main doctor and then incorporating that beneficiary preference into the ACO's aligned population.

CAPG Comments:

CAPG supports the agency's proposal to incorporate beneficiary preference into the MSSP attribution model. One of the most pressing issues facing our Medicare ACOs is the issue of beneficiary leakage – aligned beneficiaries who seek care outside of the ACO "network." We understand that CMS intends to continue to hold true to its ideal in fee-

[4] Proposed Rule, 81 Fed. Reg. 46,424.

for-service that the beneficiary can see any Medicare provider. However, the agency's proposal represents an important step forward in acknowledging beneficiary preference and beginning to familiarize beneficiaries with the existence of coordinated, accountable delivery models.

We believe that the proposed automated methodology offers distinct advantages over a manual process and will reduce the burden on ACOs and their clinicians. As CMS designs this automated system approach, we think it is important that it be clear to the beneficiary at the point of election that the physician is affiliated with an ACO, the name of that ACO, and access to additional information about the benefits of participating in a coordinated care delivery model. We believe that it will be critical to the future of the ACO movement that patients become more aware of and engaged in delivery models like ACOs. Linking this information at the time of "main doctor" election is one way to begin that dialogue.

Finally, we encourage the agency to continue to work with ACO providers and other physicians practicing in accountable payment models to identify additional strategies to engage beneficiaries and reduce ACO patient leakage. CAPG would be pleased to serve as a resource for gathering such information.

Proposed Expansion of the Diabetes Prevention Program Model

The national Diabetes Prevention Program (DPP) consists of 16 intensive "core" sessions making up a CDC-approved curriculum in a group-based setting that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. The CMS actuary determined that the DPP is likely to reduce Medicare expenditures if made available to eligible Medicare beneficiaries.

CMS is therefore proposing to expand the duration and scope of the DPP model and proposes to refer to the expanded model as the Medicare Diabetes Prevention Program (MDPP). CMS proposes that the MDPP will become effective January 1, 2018.[5]

CMS proposes the MDPP to be a 12-month program using the DPP curriculum consisting of 16 core sessions over 16-26 weeks and the option for monthly core maintenance sessions over six months thereafter if the beneficiary achieves and maintains a minimum weight loss in accordance with the CDC DPP Recognition Program Standards and Operating Procedures. Beneficiaries who meet the coverage criteria would be able

[5] 81 Fed. Reg. 46,414.

to enroll in the MDPP only once, but those that achieve and maintain minimum weight loss would be eligible for monthly maintenance sessions if they maintain the weight loss.

CMS proposes that organizations recognized by the CDC to provide DPP services would be eligible to apply to enroll as a Medicare supplier. CMS also proposes to require that personnel who deliver MDPP services would need to obtain a National Provider Identifier to ensure that they are meeting CMS program integrity standards.

CMS proposes reimbursement for the MDPP services, with the payment tied to the number of sessions attended and achievement of a minimum weight loss of five percent of the baseline weight. MDPP suppliers would be required to attest to beneficiary session attendance and weight loss at the time claims are submitted to Medicare for payment. Coverage of MDPP services will be available for Part B beneficiaries who meet specific eligibility criteria.

CAPG Comments:

As CMS states in its preamble, diabetes is at epidemic levels in the Medicare population. We support the agency's efforts to improve care for this population. Accordingly, we support the proposed expansion of diabetes prevention services to the traditional Medicare population.

We are concerned that the proposed rule makes no mention of whether or how this new service would integrate with the Medicare Advantage program. Today, Medicare Advantage enrollment makes up nearly a third of Medicare enrollment. Medicare Advantage offers the best opportunity for a coordinated care delivery system and a health plan to intervene to prevent and slow the progression of chronic diseases. We call on CMS to provide greater clarity about how this benefit might interact with the Medicare Advantage program.

Improving Payment Accuracy for Primary Care, Care Management and Patient-Centered Services

CMS is proposing to make refinements to its payments for primary care and patient-centered care management. These changes are in addition to new codes to pay for transitional care management (TCM) and chronic care management (CCM). For example, CMS proposes making separate payments for existing codes for non-face-to-face prolonged evaluation and management services and establishing separate payment for behavioral health integration.

CAPG Comments:

We support the agency's efforts to improve payment for primary care and patient-centered care management services and we generally support the proposals in the rule. However, while we support the improvement of fee-for-service payment, we point out that there is broad agreement in the health policy community that the dominant fee-for-service payment system provides the wrong incentives for healthcare delivery. While we believe that there is a role for fee-for-service, its prominence in Traditional Medicare does nothing to encourage providers to work together to ensure the best care and best outcomes for patients. We believe that new payment models outside of fee-for-service have significantly greater potential to improve care for all patients, including those with multiple chronic conditions. We encourage CMS to continue to test and evaluate new models that move away from fee-for-service as a dominant payment model and move toward population-based payments to physician organizations.

CAPG supports expanding Medicare-covered telehealth services

Consistent with the annual rulemaking process, CMS is proposing to add specific telehealth services to the list of covered services to include end-stage renal disease-related services, advanced care planning services, and telehealth critical care consultations.

CAPG Comments:

We support the proposed expansion of telehealth services. While we agree that the list of services needs to be expanded and updated, we believe that this approach to expanding telehealth-covered services within the Medicare program is failing to keep pace with technological developments and the needs of accountable physician organizations.

We support broad use of appropriate telehealth technology. Specifically, we believe that CMS should explore its authority to establish a separate regulatory pathway for risk-bearing physician organizations to test more robust approaches to telehealth technologies. We believe that telehealth has significant potential to improve care and lower costs for Medicare beneficiaries and that more can and should be done in this arena.

We note that the CMS Innovation Center is proposing to waive certain restrictions on coverage of telehealth services in certain innovation center models. We support this experimentation for models in traditional Medicare because we believe it will benefit patients in the short and long term.

However, CMS has often stated in the context of Medicare Advantage that the agency is confined to the statutory parameters for telehealth services covered by fee-for-service

Medicare for purposes of the basic benefit package. As a result of this limitation in Medicare Advantage, plans use their rebate dollars to cover telehealth as a supplemental benefit. As CMS explores expanding telehealth coverage in ACO programs, we encourage the agency to continue to pursue strategies to create greater and parallel flexibility around telehealth services for coordinated care physician groups in Medicare Advantage.

Medicare Advantage Provider Enrollment

The proposed rule would require that MA providers and suppliers be enrolled in Medicare in an approved status. CMS is proposing that this requirement would become effective in 2019. Under current guidance, health plans may include providers that are not enrolled in Medicare. CMS states that it is pursuing this proposal to shield Medicare beneficiaries against potentially unqualified or fraudulent providers and to align protections with those in the fee-for-service and Part D program.

CAPG Comments:

Our members are active participants in the Medicare Advantage program. In fact, several CAPG members participate mostly or exclusively in Medicare Advantage as opposed to traditional Medicare.

We support the agency's efforts to protect Medicare Advantage beneficiaries, affording them the same protections as those afforded to beneficiaries in other Medicare parts. However, we encourage CMS to administer these requirements in a way that reduces burden on physician practices to the greatest extent possible.

As we understand it, the current Medicare provider enrollment process is overly burdensome on physicians who predominantly provide services to Medicare Advantage beneficiaries. Specifically, CMS currently deactivates a provider or supplier if no traditional Medicare claim has been submitted for 12 consecutive months. This means that physicians who have a low volume of Part B claims, or no Part B claims, would be subject to regular deactivations, which would now potentially make these physicians non-compliant with the proposed requirement, having additional consequences for physicians, health plans and beneficiaries.

As you know, Medicare Advantage has seen explosive program growth over the past several years. One key reason for that growth is the superior care coordination and quality available for seniors in a coordinated care model as opposed to a fragmented, fee-for-service model. The benefits of this model are well documented and include lower preventable readmission rates and superior performance on quality metrics. Our

members have seen tremendous quality improvement in risk-bearing relationships with health plans in Medicare Advantage, particularly when compared to fee-for-service Medicare. In some instances, the difference between Medicare Advantage and fee-for-service is truly striking – for example, our members in Medicare Advantage have readmission rates of around 7-8% (compared to a fee-for-service average around 15%). The superior quality in MA has led more patients to enroll in that option. In some areas where our members provide healthcare services, more than half of seniors are enrolled in MA. Many of our members are therefore treating increasing proportions of seniors in MA as compared to traditional Medicare. We expect the MA enrollment trend to continue as more patients become familiar with the benefits of coordinated care available in that program.

Due to the increasing popularity of MA, we believe that an increasing number of physician practices may find themselves in the position of providing most or all of their Medicare services to MA patients. This is good thing for those patients and for the delivery system because of the high quality and high value patient experience available in MA. To ensure that these physicians are not unfairly burdened in the new provider enrollment system, we encourage CMS to develop a methodology that allows physicians who participate mostly or exclusively in Medicare Advantage relationships to maintain their enrollment without having to submit Part B claims.

Conclusion

We appreciate the opportunity to comment on these proposals. For questions about these comments, please contact Mara McDermott, Vice President of Federal Affairs (mmcdermott@capg.org). We look forward to working with you to advance a stronger Medicare delivery system for the future.

Sincerely,

Donald H. Crane
President & CEO
CAPG