The Voice of Accountable Physician Groups

September 8, 2015

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-1631-P, Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Acting Administrator Slavitt,

On behalf of CAPG, we appreciate the opportunity to comment on the Medicare Physician Fee Schedule Proposed Rule (Proposed Rule).

CAPG represents over 190 multi-specialty physician organizations across 39 states, Washington, DC and Puerto Rico. CAPG members participate in value-based payment models across all of Medicare, including in Medicare Part B. In fact, CAPG members have successfully operated under risk-based payment models in various contexts for over two decades.

Our members' preferred population-based payment approach avoids incentives for high utilization associated with fee-for-service and instead aligns incentives for physician to innovate and to provide the best care to improve the health of entire populations of seniors. Our members' value-based pay arrangements create incentives for (1) a team-based approach that emphasizes primary care; (2) physician 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 on specific elements of the Proposed Rule are provided below.

I. MACRA Implementation

The Medicare Access and CHIP Reauthorization Act (MACRA) repealed the Medicare sustainable growth rate (SGR) formula and strengthened Medicare access by stabilizing physician payments for the future. MACRA also creates two paths for the future of physician payment – the merit-

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based incentive payment system (MIPS) or an alternative payment model (APM) option. The Proposed Rule requests input on several issues related to MACRA implementation.

Briefly, under the MIPS path, physicians and physician groups are subject to a potential bonus or penalty depending on their MIPS performance. Total performance for the eligible professional will be assessed in four categories: quality, resource use, electronic health records, and clinical practice improvement activities. Under the MIPS, the eligible professional will receive a composite score that will determine whether there is a penalty or bonus for that professional for the year at issue. The amount of the bonus/penalty begins at positive or negative four percent in 2019 and increases to nine percent over time.

CMS is seeking comments in several areas related to MACRA implementation in this Proposed Rule.

a. Clinical practice improvement activities

One of the four categories of performance in the MIPS is "clinical practice improvement activities." The statute defines these activities as those that relevant eligible professional organizations identify as improving clinical practice or care delivery and are likely to result in improved outcomes.

The statute itself outlines several clinical practice improvement areas that Congress had in mind: expanded practice access; population management; care coordination; beneficiary engagement; patient safety; and participation in an alternative payment model. Based on the language of the statute, CAPG believes this category is intended to prepare physicians and groups of physicians for the move to APMs in the future.

This journey to transform into alternative payment models, or to prepare physician organizations to accept financial and clinical risk from payers is intimately familiar to CAPG members. CAPG members across the country are taking financial risk from payers in Medicare Advantage, Medicare ACOs, Medicaid, and commercial arrangements.

To prepare for and assist in this journey, the CAPG Board of Directors created the CAPG Standards of Excellence Survey. Beginning in 2006, CAPG established the Standards of Excellence (SOE) Survey as an annual, comprehensive survey of coordinated care infrastructure for accountable physician groups. The survey examines the attributes of a successful, financially and clinically accountable physician organization. CAPG member groups participating in the survey respond to questions in six domains:

- **Domain One: Care management practices** – measures high complexity case management, behavioral health integration, post-hospital discharge care continuity and coordination, and advanced illness management.
- **Domain Two: Information technology** – use of registries for prevention, screening, and chronic conditions, meaningful use, and pay-for-performance participation.

- **Domain Three: Accountability and transparency** – financial standards, patient satisfaction, clinical performance data, hospital liaison.
- **Domain Four: Patient-centered care** – timely access capabilities, after-hours access to PCP or urgent care; culture and language services, preventive screenings and reminders, home supports for seniors, shared decision making and patient advisory committee.
- **Domain Five: Group support of advanced primary care** – team-based care, community engagement and education, primary care practice coaching.
- **Domain Six: Administrative and Financial capability** – elements of readiness to assume financial risk from payers.

All of the domains are scored and publicly reported, with the exception of domain six. Physician organizations are scored on a five star system, with five stars being the highest and zero stars being the lowest. The ratings are publicly announced at CAPG's annual meeting and are posted on our website.

In the survey's most recent year, 98 medical groups and independent practice associations participated in the assessment covering 11.3 million people in commercial insurance, including Medicare Advantage. 65 physician organizations achieved five star status in 2015.

CAPG recommends that CMS rely heavily on the SOE survey to develop the clinical practice improvement category of the MIPS. We believe that this survey best reflects the capabilities of practices ready to take the next step into APMs because it was developed in part by physician groups currently taking financial risk from payers. With the exception of Domain Two, which is likely covered by the meaningful use MIPS category, we believe that all of the Domains on the survey are appropriate areas for measurement of clinical practice improvement.

b. Implementing the Alternative Payment Model (APM) Path

Beginning in 2019, the statute also makes available as an alternative to the MIPS, an APM pathway. In this path, qualifying APMs can receive a five percent bonus for participating in an APM that takes "more than nominal" financial risk. CMS indicates in the Proposed Rule that a forthcoming Request for Information (RFI) will examine various issues relating to implementation of the APM pathway.

In the Proposed Rule, CMS indicates that one area where it is looking for feedback is around what constitutes nominal financial risk. CAPG has repeatedly called on the agency to encourage the transition to risk-bearing financial models. CAPG agrees with CMS that financial risk is necessary to induce meaningful change in the healthcare delivery system. We specifically have called on CMS to make more capitated payment models available in Traditional Medicare and are pleased that CMS announced it will be testing capitation through the Next Generation ACO model.

To continue to drive toward meaningful delivery system reform and risk-bearing payment arrangements, we encourage CMS to carefully consider the arrangements that quality as "more than nominal financial risk." We believe that the incentives in MACRA have tremendous

potential to shape the delivery system and further encourage experience with risk-bearing models, including capitation. Therefore, we believe that more than nominal financial risk should require some accountability for downside risk in the APM payment methodology, for example those contained in Track 2 and 3 Medicare Shared Savings Program (MSSP) ACOs, Pioneer ACOs and Next Generation ACOs. We look forward to working with CMS to further define the APM pathway.

II. Physician Compare Omits Quality Data for 30% of Medicare by Omitting MA Physician Organization Quality Information.

In the Proposed Rule, CMS indicates it is seeking comment on adding Medicare Advantage information to Physician Compare. Physician Compare is a website with information on Medicare physicians and other eligible professionals that participate in the Physician Quality Reporting System (PQRS). CMS launched the first phase of Physician Compare at the end of 2010. Since then, CMS has increased the amount of information it includes about physicians. In the Proposed Rule, CMS proposes to continue to add new information for public disclosure on Physician Compare, including information related to the value-based payment modifier, PQRS GPRO and ACO reporting; and individual PQRS reporting.[1]

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 pertaining to the Medicare Advantage program. Today, nearly 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 organization 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 creates an incomplete picture of physician performance for those physician organizations that participate in MA.

CMS is seeking comments on adding Medicare Advantage information to Physician Compare individual eligible practitioner and group practice profile pages. Specifically, CMS seeks comments on adding information about which health plans the eligible practitioner or group accepts and making this information available via a link to the Medicare.gov Plan Finder website.[2]

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[1] CY 2016 Medicare Physician Fee Schedule Proposed Rule, 80 Fed. Reg. at 41,814.
[2] 80 Fed. Reg. at 41,815.

CAPG appreciates that the agency is considering solutions to address the omission of Medicare Advantage data on the Physician Compare website. However, we do not believe that linking to Plan Finder will fully address the data gap.

Instead, 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. CAPG has been working with other industry stakeholders to develop a core measures set that could achieve this result. We look forward to continuing to work with the agency to accomplish this important goal.

III. Improving Payment Accuracy for Primary Care And Care Management Services

CMS is proposing to make potential refinements to its payments for care management services including transitional care management (TCM) and chronic care management (CCM).[3] CMS indicates that it is responding to stakeholders who have asserted that these new care management codes do not accurately reflect the work primary care physicians and other practitioners perform in managing the complex care needs of chronically ill Medicare beneficiaries. Stakeholders have called on CMS to revisit current codes to account for the time and intensity of the work, including medication reconciliation, assessment and integration of data, coordination among clinicians, collaboration with the team, development and modification of care plans, patient and caregiver communication, and communication of test results. CMS is seeking feedback on the kinds of services that involve cognitive work and whether the creation of particular codes might improve the accuracy of the relative values used for such services on the fee schedule.

Separately, CMS is seeking comment on how it can reduce the burdens associated with the CCM and TCM codes such that Medicare beneficiaries can receive the full benefit of these services.

CAPG agrees with stakeholders that point out the substantial cognitive and time-intensive work associated with care management, particularly for Medicare patients with multiple chronic

[3] 80 Fed. Reg 41,708 (July 15, 2015).

conditions. Appropriate care management for these populations often includes substantial physician time and cognitive work, including the tasks that CMS outlines in the Proposed Rule. As an example, in other contexts, CAPG physicians participate in weekly case management meetings, led by primary care physicians and attended by the key stakeholders in patient care.

The multidisciplinary team is led by the physicians of the clinical care team and specialists, pharmacists, social workers, behavioral health providers, and health plan case managers. The case managers cover complex and high risk care; disease management; care transitions; and inpatient hospital care. Further, our physicians perform risk stratification of the target patient population to identify patients appropriate for high risk and complex case management interventions and subsequently, dedicate appropriate level of resources for care management and coordination.

Patients are also offered the opportunity to call into the case conference to provide their perspectives on their own care and conditions and are provided real-time access to their physicians, pharmacists, social workers and utilization nurse managers through phone calls and/or emails. In the event that the patients are unable to attend, our physicians go to meet the patients in their homes with the care team for a face-to-face visit to best manage their care and facilitate achievement of their care management goals. Our physicians take the time and resources to review thoughtful personalized care for the patient and conduct shared decision making with benefit coordination with appropriate stakeholders so that the triple aim is fulfilled. This intensive investment in care management requires a substantial and worthwhile time investment on behalf of all members of the care team. We believe that this time and work could be better reflected in the physician fee schedule.

CAPG recommends that CMS reduce the administrative burden associated with TCM and CCM codes. Our physician organization members have reported that the technical requirements associated with these codes are serving as a barrier to access for beneficiaries. As an example, our members point to requirements specifying which practitioners' time and services are required in order to bill the code. Our members find that these specifications associated with the codes do not align with their care teams and work flows put in place for other payer arrangements. Therefore, the Medicare Part B procedures are difficult to implement and thus are not being used as frequently possible.

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. CAPG believes 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.

IV. Establishing Separate Payment for Collaborative Care

CMS is considering establishing separate payment for collaborative care.[4] Specifically, CMS is seeking stakeholder input on how Medicare might account for the resource costs of a more robust inter-professional consultation for behavioral health services for Medicare beneficiaries. CMS is seeking input on the resources involved in collaborations between a specialist and a primary care physician; how these collaborations can be distinguished from evaluation and management services; and how such services should be valued on the physician fee schedule.

CAPG supports the development of a separate payment for collaborative care. CAPG believes that these services certainly have the potential to improve care and quality of life for Medicare beneficiaries. We encourage CMS to apply the lessons learned from the CCM and TCM codes when developing the technical specifications for this code. For example, there is a broad spectrum of professionals offering behavioral health services as part of the care team already in place. CMS should work with physician organizations to understand the full complement of professionals providing these services and any payment should reflect the on-the-ground practices of these existing care management teams.

V. CAPG supports expanding Medicare-covered telehealth services. We recommend that CMS consider ways in which to test additional coverage of telehealth services.

Consistent with the annual rulemaking process, CMS is proposing to add specific telehealth services to the list of covered 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.

CAPG supports broad use of appropriate telehealth technology. Specifically, we believe that CMS should explore its authority to establish a separate regulatory pathway for clinically integrated organizations to test more robust approaches to telehealth technologies. We encourage CMS to engage physician organizations in determining an appropriate definition for "clinically integrated physician organizations" and to allow these organizations to deploy more robust telehealth technologies for Medicare patients. 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 the Next Generation ACO program.[5] CAPG supports this proposed waiver and believes it can have a positive impact on patient care in the ACO program.

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[4] Proposed Rule at 41,710.
[5] 79 Fed. Reg. 72,820-22.

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 the 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 as well.

VI. Medicare Shared Savings Program (MSSP)

CMS states that it has encountered circumstances where changes in clinical guidelines result in quality measures within the MSSP that no longer align with best clinical practice. For example, CMS says that in CY 2015, it retired measures that were no longer consistent with clinical guidelines around cholesterol targets, but were unable to finalize retirement of the measures for the 2014 reporting year due to the timing of the rulemaking cycle. To deal with this challenge, CMS is proposing that measures that are no longer clinically appropriate will revert to pay-for-reporting, rather than pay-for-performance. CMS is requesting the flexibility to do this if the measures owner determines the measure no longer meets best clinical practices due to clinical guideline updates or when clinical evidence suggests that the measure might result in harm to patients. This flexibility will enable CMS to respond more quickly to clinical guideline updates that affect measures without waiting until a future rulemaking cycle to retire a measure or revert to pay-for-reporting. CAPG supports this proposal and believes it will lead to better and more accurate quality information in the MSSP.

VII. Encouraging and Facilitating New Financial Relationships in Alternative Delivery and Payment Systems

CMS indicates that it has received stakeholder feedback expressing concern that outside of the Medicare Shared Savings Program or certain CMMI sponsored care delivery models (which have specific waivers on physician self-referral prohibitions), physician self-referral law prohibits the financial relationships necessary to achieve the clinical and financial integration required for successful health care delivery and payment reform.

Our members indicate that physician-self referral prohibitions continue to serve as a barrier to adopting alternative payment models. We encourage CMS to continue to engage with physician groups to better understand the existing barriers and to take swift action to remedy regulations that stand in the way of the adoption of new alternative payment models. We believe that action on physician self-referral prohibitions is integral to achieving the goals of delivery system reform. We encourage the agency to take a comprehensive approach to resolving these barriers rather than a piecemeal approach that looks at individual demonstrations and specific exceptions.

VIII. Expanding the Comprehensive Primary Care Initiative (CPCI)

CPCI is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. The initiative is currently being tested in Arkansas, Colorado, New Jersey, and Oregon, and regionally in New York, Ohio/Kentucky, and Oklahoma. In the CPCI, CMS is collaborating with commercial payers and state Medicaid offices to test a payment model consisting of non-visit based per beneficiary per month care management payments and shared savings opportunities. The per-beneficiary care management fee is in addition to the usual fee-for-service payment that Medicare practitioners receive. Participants are expected to combine CPC revenues across payers to support while-practice care delivery transformation.

The payment model is designed to support the provision of five comprehensive primary care functions: (1) risk-stratified care management; (2) access and continuity; (3) planned care for chronic conditions and preventive care; (4) patient and caregiver engagement; and (5) coordination of care across the Medical Neighborhood.

CMS is seeking public comments on a variety of issues related to the CPCI, including potential expansion of the model. Specific to CPCI, CAPG supports the multi-payer approach and believes that this broad engagement will strengthen the model.

CAPG is engaged in practice transformation programs designed to assist our members in moving from volume to value-based care delivery. CAPG has partnered with 2.0 Healthcare, LLC to make available a highly focused, expert-led process of primary care transformation for our members. We have already seen the tremendous impact that practice transformation can have in terms of improving quality. We encourage CMS to consider how any expansion of the CPCI interacts with and incorporates best practices from ongoing practice transformation efforts. We also encourage the agency to continue to assess how initiatives like CPCI can work together with Medicare ACOs and, more broadly, how medical home models will co-exist with ACO models.

Conclusion

We appreciate the opportunity to comment on these proposals. We are pleased to discuss any of this further. Please do not hesitate to contact us with any questions.

Sincerely,

Donald H. Crane
President & CEO
CAPG