PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

September 13, 2021

*Submitted electronically via: http://regulations.gov/*

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

**RE: CMS-1751-P; Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc.**

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide input on the proposed Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS) rule. As outlined below, we appreciate the steps taken by the Centers for Medicare & Medicaid Services (CMS) to reduce physician burden in impactful ways, and encourage CMS to consider additional steps it may take to further encourage physicians to move away from fee-for-service delivery models.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, Florida Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

With the PFS rule, we encourage the Administration to use all available levers to ensure that physicians have an opportunity to move off the fee-for-service (FFS) chassis, regardless of their practice setting. Greater adoption of value-based care models has long been a goal for our health care system as a result of the benefits of quality improvement and cost reduction. The COVID-19 experience highlighted the flaws of the FFS system, as practices heavily reliant on utilization-based payment methods were hit hard when practice visits dropped at the beginning of the pandemic. In contrast, practices that relied on value-based payments for at least a portion of their income were somewhat insulated or at least had resources that could be repurposed to help generate income from virtual visits.

Now more than ever, the Administration must ensure that physicians are able to realize the benefits of the investments they have made in population health while simultaneously creating a platform for others to make new investments as their financial situation allows. This is especially critical to the survival of independent practices. In recent years, there has been a historic pendulum swing between employed physicians and private practice. At the time the survey was fielded in September to October 2020, the American Medical Association's 2020 Physician Practice Benchmark Survey found that 49.1 percent of

physicians worked in physician-owned practices, 38 percent were practice owners, 8.2 percent were employed by physician-owned practices, and 2.5 percent were independent contractors working for physician-owned practices.[1]

Yet, physician-led models generate cost savings and higher quality than FFS and other value-based care models led by other providers. We urge CMS to make value-based care participation as accessible as possible to independent physicians and practices. This includes not only ensuring that the financial structure of models is appropriate to accommodate the unique financial circumstances of independent practices, but also ensuring that the other requirements associated with model participation are streamlined as appropriate while still ensuring patients are protected.

With this in mind, we would like to comment on a few aspects of the CY2022 Physician Fee Schedule. As outlined in more detail below, PEPC is supportive of the proposed MIPS Value Pathways (MVPs) and encourages CMS to leverage MVPs as an optional, voluntary platform to facilitate the transition of more physicians and physician-led practices to value-based care. While PEPC supports CMS' proposal to delay implementation of the eCQM requirements to allow Accountable Care Organizations (ACOs) additional time, we urge CMS to consider whether the framework for aligning Medicare Shared Savings Program (MSSP) and Merit-based Incentive Payment System (MIPS) program quality measures continue to incentivize and reward high-quality care. Finally, we strongly urge CMS to immediately adopt policies to address the MSSP "rural glitch," thus fixing a technical issue that disincentivizes adoption of ACOs by providers in rural areas. As a result of this methodology flaw, Medicare beneficiaries in rural areas have less access to providers participating in delivery system models that incentivize cost-effective, high-quality care compared to their urban counterparts.

Our specific comments on each of these issues are outlined in more detail below.

**MIPS Value Pathways (MVPs)**

In the CY2022 Proposed PFS, CMS proposed reporting requirements for MVPs and discussed the allowance of clinician choice in selecting which quality measures and improvement activities to report. CMS proposed seven different MVPs, but recognized that many other MVPs will need to be developed and that the traditional MIPS framework will be needed until there are a sufficient number of MVPs available. Through the MVP development work, CMS will gradually implement MVPs for more specialties and subspecialties participating in the program. CMS proposed to begin transitioning to MVPs in the 2023 MIPS performance year, and its intent is to provide practices the time needed to review requirements, update workflows, and prepare systems to report MVPs.

Overall, PEPC supports using MVPs as an optional, voluntary platform to encourage providers to move into value-based care. We encourage CMS to leverage MVPs as a way to make the transition from FFS to alternative payment model (APM) participation as smooth as possible. If designed correctly, we are hopeful that the MVP pathway will prepare practices, especially small and independent ones, to make the transition to value based care.

[1] American Medical Association, Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020.

However, we continue to be concerned by the limited number of APMs available to small and independent practices and believe that this is likely to be a limiting factor impacting the goal of using MVPs as a platform to move a wide range of providers into APMs. We strongly urge CMS to develop additional models that span the risk spectrum. We encourage CMS to design models that provide physicians a glide-path to full risk to make the transition to value based care more enticing to physicians as physicians may be concerned about accepting full downside risk at the onset. PEPC also urges CMS to ensure MVPs include the measures and activities that will adequately prepare participants for an APM. Increasing alignment between MVPS and APMs will create a clearer on-ramp for practices to move into APMs.

PEPC also supports CMS's decision to delay implementation of the MVPs. We believe that this additional time will allow physicians to evaluate the current seven proposed MVPs and decide whether to participate in the first year. As MVPs are designed to create more clinically appropriate reporting pathways for practices, we also believe a longer transition will allow for the needed time to develop specialty MVPs. PEPC encourages CMS to ensure that there are adequate MVPs to reflect the diverse needs of different specialties and physician types.

Next, PEPC encourages CMS to make the transition to MVPs as seamless as possible for physicians. Currently, as there are only seven available pathways, there will be a limited number of practice types for which they will be relevant. CMS should hold physicians harmless from a payment penalty for the first two years that MVPs are introduced into the program and apply this policy to new MVPs as they are introduced. This will ensure that a practice type who does not have relevant MVP until three years in to the program will receive the same transition period as those starting in year one of the program.

Additionally, we believe traditional MIPS should remain available to reflect the diverse needs of different physician groups. In the CY2021 Medicare PFS, CMS wrote that they "envision that MVPs will be optional"[2] and physicians will be able to choose whether to report with MVPs or traditional MIPS based on which makes the most sense for their practice. PEPC would recommend that CMS leave MVPs as optional to allow physicians to choose what reporting system aligns best to their practice needs and limits their reporting burden.

Finally, PEPC urges CMS to ensure MVPs will meaningfully reduce the burden of reporting to MIPS by finding ways to offer cross-category credit within MVPs. Cross-category credit would also incentivize participation in MVPs and more clearly differentiate them from traditional MIPS. Absent a reduction in burden and complexity, there will be little incentive to report an MVP.

**Alignment Between MSSP and MIPS Quality Reporting**

Over the past several years, CMS adopted policies purporting to align quality reporting requirements for MSSP and MIPS, recognizing that many providers participating in MSSP ACOs also continue to report through MIPS either because they are in a one-sided ACO or because they do not meet revenue thresholds needed to report through the AAPM track. A goal behind this alignment was to alleviate provider burden by streamlining quality reporting requirements where possible.

[2] The Centers for Medicare & Medicaid Services CY 2021 Medicare Physician Fee Schedule Proposed Rule, CMS-1734-P. (85 Fed. Reg. 50279).

In this rule, CMS proposes a longer transition for ACOs reporting electronic clinical quality measure/Merit-based Incentive Payment System clinical quality measure (eCQM/MIPS CQM) all-payer quality measures under the Alternative Payment Model (APM) Performance Pathway (APP), by extending the availability of the CMS Web Interface collection type for two years, through performance year (PY) 2023. CMS also proposes to freeze the quality performance standard for PY 2023, by providing an additional one-year before increasing the quality performance standard ACOs must meet to be eligible to share in savings, and additional revisions to the quality performance standard to encourage ACOs to report all-payer measures. CMS notes that these three proposals, in addition to existing policies, provide three years for ACOs to transition to reporting the three eCQM/MIPS CQM all-payer measures under the APP.

PEPC offers the following comments on these proposals:

First, while we understand and support the original goal of streamlining requirements for providers participating in both MSSP and MIPS, we are concerned that the method for measuring success under the programs are not aligned and that even high scoring ACOs with exemplary quality of care could be penalized under the MIPS APP quality framework. We believe that this could occur because of two reasons. First, ACOs have three measures that are not included in the comparison group of other MIPS eCQM quality scores. Second, ACOs would not know what is necessary to achieve savings in a performance year until after the fact because the quality requirements serve as a "gateway." MSSP has always operated on a prospective scoring system where an ACO knows what they need to do to achieve savings. We thus urge CMS to further consider how it defines and rewards high-quality care under a combined MSSP/MIPS APP framework, and as needed, to de-link MSSP and MIPS reporting requirements if alignment jeopardizes program success for high performers.

With respect to reporting eCQMs though the CMS Web Interface, PEPC appreciates CMS' delay to sunset the CMS Web Interface but remains concerned that the updated timeline remains a significant issue for ACOs and their participants. ACOs will still need to ensure their entire system is able to report an eCQM/MIPS CQM – regardless of whether an ACO is reporting one or all eCQM/MIPS CQMs. Thus, the work and resources required to report one is the same as reporting all. Since ACOs will be required to report at least one eCQM/MIPS CQM beginning in 2023, they essentially have a year to update their systems and workflows. The changes ACOs will need to make to be ready to report the APP eCQM/MIPS CQM set are extensive, burdensome, and costly. We believe a longer timeline is needed, and urge CMS to further delay sunsetting of the CMS Web Interface by an additional period of time.

Third, like many other groups, we believe that the specific measures used to measure physician/practice performance are incredibly important, particularly for those measures that serve as a quality "gateway" to shared savings. Issues that have been pointed out in the past include the lack of clinically-relevant measures to many specialty-specific Advanced APMs, the additional administrative burden of having to report through the APP in addition to APM-specific reporting, and the fact that moving APM participants back into MIPS when they fall short of QP thresholds does not further the goals of value-based care nor live up to the statutory intent of MACRA. We also believe that ACOs' savings should not be dependent on performance related to non-ACO and non-Medicare beneficiaries; these are issues that come up with respect to all-payer measures.

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**MSSP "Rural Glitch" Methodology Flaw**

In the CY2022 PFS, CMS discussed several approaches for addressing the MSSP "rural glitch" – that is, for removing an ACO's assigned beneficiaries from the assignable beneficiary population used in regional expenditure calculations for an ACOs benchmark. The current methodology includes an ACO's assigned beneficiaries in the regional expenditure calculation, creating a savings "headwind" that rural ACOs with significant market penetration must overcome before sharing in savings. Urban ACOs, which generally have significantly less market penetration as one among many providers in a defined area, do not experience this same headwind and thus start accruing shared savings earlier than urban ACOs. The result is that urban ACOs generally achieve greater savings than rural ACOs for the same cost and quality improvements, disincentivizing providers in rural areas from adopting ACOs.

CMS noted in the proposed rule that it has considered several options from addressing this methodological flaw in a manner that would impose relatively limited operational burden while leveraging data elements already computed under the current benchmarking methodology.

PEPC strongly encourages CMS to take action to immediately address the MSSP "rural glitch." The full potential of ACOs can only be realized if ACOs are rewarded appropriately for their efforts to reduce costs and improve quality. This flaw in the scoring methodology systematically disadvantages ACOs in rural areas and makes it harder for them to achieve savings even when they improve quality and reduce costs on par with their counterparts in urban areas. PEPC strongly believes that no ACO should be placed in a less favorable position due to their geography alone. It is crucial that ACOs in rural areas have the same opportunity as ACOs in urban areas to be rewarded for delivering better care at lower costs, and that Medicare patients in rural areas have the ability to access providers participating in innovative delivery system models at the same or similar rates to Medicare patients in urban areas. This is an important value-based care equity issue.

**Adopt More Holistic View of Model Success To Address Health Equity**

PEPC applauds CMS's commitment to health equity and is pleased to see that CMS is seeking comment on the collection of data, and on how CMS can advance health equity for people with Medicare (while protecting individual privacy). PEPC suggests that CMS adopt a more holistic view of the metrics of model success – particularly metrics related to quality, access, and equity – which would be beneficial in aligning metrics/incentives in multi-payer models tailored to underserved or vulnerable communities.

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Thank you again for the opportunity to share our perspective. Please do not hesitate if we can be a resource to you. I can be reached at kristen@physiciansforvalue.org.

Best,
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Executive Director