PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

Roundtable on the CMS Innovation Center Health Equity Strategy
Written Comments
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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 physician 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, California Medical Association, Florida Medical Association, and Medical Group Management Association. 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.

1. **What approaches or interventions should the CMS Innovation Center prioritize when building models to eliminate health inequities?**

Our members believe that independent physicians and practices are well-positioned to continue to lead the value-based care movement, achieving superior results in value-based care models through their commitment to improving outcomes and reducing costs. Independent practices and physicians are often integral parts of their communities. Identifying and addressing unmet needs is part of the longitudinal patient-physician relationship and is made possible through non-utilization-based reimbursement models that allow providers to spend time with their patients, assessing their needs and connecting them to services even when there isn't a specific code to bill for doing so.

Value-based care allows for more flexibility to make the needed upstream investments in social determinants of health and health disparities. Traditional fee-for-service payment methodologies do not pay for or support the needed care coordination and investment in community social needs needed to address the social determinants of health. Value-based care provides a critical opportunity to do this, as it creates the incentive structures for physicians to invest in upstream care and in increased care coordination with medical and non-medical providers. It also incentivizes payers and physicians to proactively identify the social risk factors and unmet social needs that pose a barrier or threat to an individual's health.

Federal policymakers should adopt more holistic evaluation of model success to include addressing health disparities. Including metrics related to quality, access, and equity would be beneficial in aligning metrics/incentives in multi-payer models tailored to underserved or vulnerable communities. Addressing social risk factors should also be incorporated as important factors for model success, even if improvements aren't linked to lower costs. Often, these types of interventions lead to preventive care and downstream savings, which may or may not be considered during formal model evaluations. We believe that policymakers should take a holistic approach in measuring the full range of benefits realized by payment and delivery system reform models.

2. **CMS is currently exploring options for expanding collection of self-reported demographic and social needs data. What could the CMS Innovation Center do to support collection of self-reported data? What are successful approaches for such collection?**

To effectively implement programs that address health disparities and social needs, physicians have to understand the needs of the communities they are serving. Some physicians – including many that participate in value-based care models --- are already screening for social needs indicators. However, it is often not physicians' primary area of expertise. Further, the process for identifying and assessing these needs can be burdensome and is not standardized across physicians. It can also be difficult for practices from a resource and staffing perspective.

Additionally, not all EHR platforms are equipped to screen for social needs data. Some have screening capabilities, but physicians report the questions may be insufficient. Other times EHR platforms may not be equipped at all for social determinants of health screening, forcing physicians to resort to paper collection methods or other digital platforms. This creates problems both from an administrative and privacy standpoint.

Federal policymakers should invest in comprehensive social needs data collection. Data elements used for race, ethnicity, primary language, gender identity, sexual orientation, income status, and other characteristics should be standardized to address disparities in a systematic way throughout the health care system. Physician practices should also be reimbursed to increase intake of these additional screenings which will be critical to addressing social determinants of health; this can be done through value-based payment mechanisms.

Once data has been collected and standardized, data should be used and leveraged to best serve beneficiaries. Web-based platforms that help link individuals to services can be key to making sure beneficiaries receive the services they need that physician practices cannot provide.

3. **What are the most significant obstacles for safety net providers who want to participate in a CMS Innovation Center or another value-based, accountable care model, and how do you recommend the CMS Innovation Center help these providers overcome these obstacles?**

CMS should consider the unique circumstances of all physicians when developing models, recognizing that models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all. We encourage CMS to design models that provide physicians upfront resources and a glide-path to full risk. For physicians who have never participated in an APM and who may have limited resources, the transition to value-based care may be daunting. However, CMS can take steps to encourage physicians to make the transition, with less risk to physician's livelihoods. We support models like the ACO Investment Model (AIM), and the Community Health Access and Rural Transformation (CHART) Model that provide upfront capital to ACOs who may not have otherwise been able to participate.

We encourage federal policymakers to more intentionally design models from the beginning for underserved communities. Traditionally, APMs have been tested in limited regions. CMS should expand testing all across the country to make sure that APMs work for all Americans. APMs have also historically been focused on Medicare, and changing some aspects to fit the needs of Medicaid and safety-net

providers can make the difference between someone accessing the care they need and delaying it indefinitely.

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Thank you for the opportunity to comment. Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org or 202-640-5942.

Sincerely,

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