August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: CMS-4203-NC; Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide input into the Medicare Advantage (MA) program, and for your leadership on this Administration's efforts to ensure Medicare beneficiaries receive more equitable, high quality, and whole-person care that is affordable and sustainable.

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, 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.

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. Too often, we hear that independent practices and physicians cannot or do not want to participate in value-based care models. While this may be true for some, it is certainly not true for all. Many physicians and physician-led groups are participating in value-based models, or preparing to do so. In many cases, these clinicians are working with private payers as well as government-led programs such as Medicare and Medicaid.

Below, we provide feedback on steps the Centers for Medicare & Medicaid Services (CMS) can take to promote innovation in MA payment and care delivery, increase access to accountable and coordinated care, and support affordability and sustainability in value-based care provided by independent physicians and practices, and share more information about steps that would be impactful in encouraging MA plans to enter into value-based care arrangements with independent physicians and vice versa.

Key themes from our comments include:

- Over the past decade, MA plans have made significant investment in value-based care through alternative payment models (APMs), with more shared savings and population-based payments than the commercial, Medicaid, or Medicare Fee-for-Service (FFS) markets. Despite this progress, there continue to be significant opportunities to increase partnerships with independent physicians and practices.

- Standardization, transparency, and aligned incentives are key factors driving success in value-based care arrangements between MA plans and independent physicians and practices.
- Other factors that provide a "starting" point for successful arrangements include creating a glide path to risk, identifying a relationship "quarterback," and delivering actionable information practices can use to begin to implement population health strategies.
- It is critical to get the foundational policies right. Because the majority of MA APMs are built off Medicare FFS payment and infrastructure, Medicare FFS policies directly impact MA APMs. Low reimbursement rates for high-value services and policies that favor one practice setting over another impact MA value-based care models just like they impact FFS value-based care models.
- In addition to ensuring the foundational FFS policies support MA value-based care models, CMS could consider implementing policies requiring MA plans to offer advance investment payments to physician-led models, harmonizing quality measures across programs, and testing more multi-payer models to double down on synergies across markets.

C. Drive Innovation to Promote Person Centered Care

We encourage CMS to prioritize physician-led APMs by building on models and model design concepts that have demonstrated proven results. Physician-led accountable care organizations (ACOs) have consistently generated more savings than hospital-led ACOs based on Medicare Shared Savings Program (MSSP) results, largely because financial incentives in physician-led ACOs are fully aligned with key components of value-based care. MSSP results from 2021 show that, across the health care system, ACOs led by physicians, often called "low revenue," typically create nearly twice the Medicare savings per beneficiary than hospital-led ACOs, often known as "high revenue." According to CMS data, in 2021, physician-led MSSP ACOs had gross per-beneficiary savings of $237 compared to $124 per beneficiary for hospital-led MSSP ACOs.

Comprehensive Primary Care+ is also an example of a model where physicians and physician practices demonstrated their ability to reduce emergency room and acute care visits through advanced primary care medical homes. Independent practices outperformed system-owned practices by 15 percent in PY2017 and 18 percent in PY2019, even though both practice types improved their performance on overall utilization.

Specific feedback on a number of the questions raised in the RFI are below.

Question 1:

What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?

Despite gains in value-based payment model adoption, FFS is still entrenched in health care payments, making it difficult to sway incentives. FFS remains the base for most APMs. Further, most MA payments

still flow to providers on a FFS basis, as they are often tied to reimbursement rates set in the Medicare Physician Fee Schedule.

According to the Health Care Payment Learning and Action Network, 58 percent of MA payments to providers were paid through APMs in 2020. Of this 58 percent, about 36 percent of payments were APMs built on FFS architecture, with 29 percent being one-sided risk models and 8 percent being two-sided risk APMs. An additional 22 percent of payments were population-based APMs. Nearly 30 percent of MA payments represented two-sided risk APMs, about double that of Medicaid and two-thirds greater than commercial payers. [1]

However, according to the same data, 38 percent of MA payments in 2020 were FFS with no links to quality and value. This suggests that there continues to be significant opportunity for MA plans to do more in working with providers, especially independent physicians and practices, to move greater proportionate of their provider payments into value-based care arrangements.

Factors Informing Decisions by MA Plans and Providers to Participate in Value-Based Contracting in MA

There are a number of factors that inform decisions by providers to participate in value-based contracting within MA. While models vary in terms of architecture, independent practices and physicians benefit when MA plans are consistent in their approach to contracting terms and model implementation. To incent and assist plans as they transition away from FFS, CMS may need to do more to encourage the use of prospective payments. For primary care, predictable prospective payments that are adequately funded to support comprehensive care can drive participation in value-based contracting.

One of our members, MGMA, developed the following set of value-based contracting principles. These principles are informative as CMS considers factors that physician practices consider when deciding whether and how to adopt new payment and delivery models in MA, but also in other markets:[2]

- Clearly define practice roles and responsibilities for contracting activities.
- Analyze contract performance thoroughly, establish proformas for value-based care arrangements.
- Establish baseline performance and review data before entering into contractual arrangements.
- Routinely monitor contract performance to proactively identify challenges.
- Focus on creating a collaborative relationship with payer partners and understand it will not be perfect for everyone.
- Focus on short- and long-term goals for the practice and the payer.
- Define routine communications pathways and stick to the plan.
- Celebrate success and continue to look for the next opportunity to build upon successes.
- Consider steps that will assist the practice in successfully participating in value-based arrangements.

[1] https://hcp-lan.org/workproducts/APM_Infographic_2021.pdf
[2] https://www.mgma.com/data/data-stories/most-practices-adding-value-based-contracts-but-in

Other principles that may be used to help inform successful value-based contracting between MA plans and independent physicians and practices are outlined in the 2018 Health Affairs article, "A Principle-Driven Approach to Gain-Share Contracts[3]":

- *Payer and provider interests should be aligned as much as possible*. Model terms limiting shared savings, such as caps on gain-share or minimum savings, or resetting benchmarks annually, tip the scales to the payer thus creating a misalignment that should be avoided.
- *Savings should be shared equitably between payers and providers based on their relative contributions to generating the results.* Arbitrary caps on shared savings decrease providers' return on investment and may lower provider effort related to the value-based arrangement.
- *Long-term sustainability should be a key goal for both the payer and the provider.*
- *Any risk should be great enough to motivate real change but not so large as to threaten the financial viability of a physician practice.*
- *All aspects of the contract should be transparent and claims data and quality results should be shared in a timely manner*.
- *Administrative burdens for providers should be minimized.* Payers should consider taking steps such as harmonizing quality measures, reducing burden associated with reporting, and standardizing contracting terms and reports where possible.

Alignment Across MA, MSSP, CMMI Models, Commercial Payer and Medicaid

We applaud this Administration's recognition that, from the provider perspective, alignment of value-based payment arrangements within Medicare and across payers, including Medicaid, is essential to improve participation and success in value-based models.[4] Alignment across programs is especially important to independent physicians and practices because the investment needed to participate in value-based care makes is much easier if providers can make changes that apply to a broader group of patients in the patient panel.

Alignment, or misalignment, across markets directly impacts MA value-based care arrangements in several ways. First, as MA rates paid by plans to physicians participating in APMs are often based on FFS, the underlying FFS payment continues to be impactful in the MA market. Low FFS reimbursement for high-value services translate to low MA payment for high-value services. Differences in payment rates across practice setting (i.e., facility fees) persist even in MA. These types of policies create financial incentives that can make it difficult for providers to be successful in MA models.

MA plans have flexibility to offer non-covered services to beneficiaries aligned to value-based models since MA plans are allowed to offer supplemental benefits that are not available in FFS. FFS models try to add in some flexibility through waivers and other model design options such as voluntary beneficiary incentives and enhancements. These additional flexibilities are leveraged by physician practices to improve care for patients. To close remaining gaps, we recommend CMS consider removing cost barriers around supplemental benefits, which continue to limit access for low-income patients, documenting how

[3] https://www.healthaffairs.org/do/10.1377/forefront.20180531.820294
[4] https://www.healthaffairs.org/content/forefront/medicare-value-based-care-strategy-alignment-growth-and-equity

MA plans are using supplemental benefits, and providing network maps for providers of these benefits to make them more accessible to MA beneficiaries.

Finally, while the Medicaid program has relatively few value-based payment models as compared to Medicare, both markets face similar challenges, to varying degrees, and share policy goals. While risk-adjustment is an important component of all value-based care models, this will be particularly vital for models that incorporate Medicaid beneficiaries, who are more likely to face social needs and a variety of other risk factors. Further, models that are designed with "on ramps" to assist with making needed investments before taking on risk will be particularly important to practices caring for a high proportion of Medicaid beneficiaries, who are more likely to operate on slim margins.[5]

Question 2:

What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?

Experiences of Providers and MA Plans in Value-Based Contracting

Engaging with independent physicians presents some challenges to payers, but if both parties start by agreeing upon a set of principles to guide these arrangements, we believe independent physician practices can be a major force for positive change in American health care.

Best practice – Move away from one size fits all approach.

Recognizing that every provider population is different, a scalable framework that is adaptable to meet the needs of every unique physician practice is important to the success of a value-based care model. One way to approach this type of contracting is to present physicians with a range of options to choose from, allowing physicians to select which model components they believe best fit their patient population and workflow needs.

Best practice – Culture and Leadership Matters.

Success on the provider side requires a large amount of work and investment. There are many operational changes that have to happen to transition to value-based arrangements. Physicians have to change their workflows and the way they manage their patients and panels. Even without financial downside risk, the shift to value-based care is still an investment. Payers play a major role in the success of physician practices, as their investment allows practices to transition to value-based models. This investment includes streamlining contracting processes, using consistent terms across contracts, investing in infrastructure that enables the payer to send actionable data to the practice, establishing a point of contact for the practice, and aligning financial incentives across practice and payers. Leadership, both on

[5] https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicaid/LT-CMS-DirectorDanielTsaiIntro-070721.pdf

the payer and provider sides, matters as the success of the partnership hinges on mutual communication and support. Furthermore, the culture of value-based arrangements ideally focuses on the collaboration and cooperation of providers and payers to do what is best in the interest of the patient.

Opportunities to Better Align MA and Medicare FFS Value-Based Arrangements

For value-based contracting to be successful, alignment across payers is important. This is especially true for independent physicians, as the investment needed to participate in value-based care is more worthwhile if the changes made can be applied to a broader group of patients. Thus, multi-payer pilots may increase competition and reduce FFS entrenchment, especially among independent physicians and practices.

<u>Require MA plans to offer advance payments to physician-led value-based care groups, similar to what is being proposed and has been tested in FFS.</u>

While there has been great momentum in supporting value-based care at the federal level, barriers still exist, particularly for independent physicians and practices. Access to capital continues to be significant barrier to independent physicians and practices entering value-based care models. Unlike physicians employed by large hospitals or health systems or physicians working in medical groups with access to investment dollars, many small, rural, and independent practices and physicians are resource-constrained in their ability to make the investments needed to transition off the FFS chassis. Given the time lag between when practices begin making investments and when they can realistically expect to receive sufficient savings to recoup their investments, organizations with less access to capital may be less likely to enter or sustain participation in shared savings initiatives. CMS has proposed to make advance payments available to certain ACOs participating in MSSP, but there is no comparable investment requirement or plan on the MA side.

<u>Focus on "low hanging fruit" including a small set of quality metrics.</u>

Quality metrics and data are integral components of value-based care models, allowing for population health management and appropriate care coordination. With respect to quality metrics, CMS has over 2,000 quality measures, with over 500 currently active, in addition to NCQA, HEDIS, and Star measures. Quality measures should be harmonized across new and existing models to the extent possible and CMS should use a parsimonious list of meaningful measures that reduce the burden of reporting. With respect to the MA program in particular, small practices report that the documentation burden associated with Star measure reporting can be significant. We urge CMS to harmonize measures across new and existing models, focusing on those measures that have the greatest impact on patient care. It is also important to recognize that practices value different qualities and CMS must present a sustainable business case so physicians feel supported and understand that their investment will pay off.

What steps within CMS's statutory or administrative authority could CMS take to support more value-based contracting in the MA market? How should CMS support more MA accountable care arrangements in rural areas?

Steps to Support More Value-Based Contracting in MA

Incentivize MA plans to work with independent physicians and practices in value-based care models.

Models should be accessible to a wide range of physicians, including physicians choosing to remain independent. As you know, the physician workforce is not homogenous. Instead, there are physicians in large practices and small practices, in rural and urban settings, in a variety of different employment arrangements. CMS should consider the unique circumstances of physicians in independent practice when developing models, ensuring that there are options available for this cohort of the workforce and recognizing that models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all.

Supporting MA Accountable Care in Rural Areas

Current policy may disincentivize rural providers from entering MSSP. When ACOs with a large market share (often in rural areas) succeed in lowering costs, they lower costs for the entire region. This phenomenon, otherwise known as the “rural glitch,” has the unintended consequence of essentially penalizing an ACO for lowering costs and causes ACOs to be paid differently for the same performance based on where they are located.[6] CMS should take an across-the-board approach to accountable care in rural areas, fixing the rural glitch to incent more participation by rural providers in value-based arrangements such as MSSP. By increasing FFS models, CMS will create a platform that providers can use to expand into other markets such as MA.

Do certain value-based arrangements serve as a “starting point” for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost?

Best practice – Create a glide path to risk, starting with no risk.

We recognize that value-based care is essential to improve quality, empower patients and physicians, and promote person-centered care and encourage HHS to increase APM participation opportunities. These models should include a glidepath to risk, starting with no risk. A Health Affairs study found that ACOs need at least three years to prepare for downside risk.[7] Importantly, value-based models with no risk such as the Comprehensive Primary Care Initiative, have been successful, highlighting that predictable, prospective payments enable practices to drive quality and outcome improvements. This glidepath is particularly important for independent physicians and practices, as well as providers practicing in underserved or rural areas. In assessing different payment arrangements, CMS must consider what products and tools are needed to give providers a feeling of control and support that they need to be successful. As a starting point, providers should be offered incentives through a framework that recognizes the investment practices must make to close quality gaps.

[6] https://resources.aledade.com/blogs/proposed-2023-physician-fee-schedule-big-changes-to-mssp-are-on-the-horizon
[7] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01819

Best practice – Identify a relationship "quarterback"

Practices need a single point of contact to help them navigate quality measures, data, and clinical workflows. In addition to the point of contact, another key issue is the understanding that practices value different qualities in a payer partner and payment model. Some practices value predictability or prospective or retroactive attribution, but ultimately, it is important for payers to present a sustainable business case so practices will feel supported and understand that their investment will pay off. Payers should not only be rewarding their MVPs, but also their most improved practices as well. The relationship should not be a duplication of efforts. Efficient and effective communication should lead to the plan to work synergistically with providers to ensure continuity of care.

Best practice – Deliver information, not just data, while being flexible on approach to technology.

One way to improve value is to look at the increasing amount of outcomes and claims data. Providing all the data, however, is not helpful information, and there is a lack of consistency in what data MA plans share with providers. Health plans need to ensure that they can provide access to actionable data that helps give insights on the provider's clinical populations, workflows, and claims data. Giving providers all of the information without analysis only creates more administrative work for physicians and their staff. Payers have reported that physicians want options when it comes to delivering data; some want to use their plan's dashboards, others want to export into the tool of their choice and combine with data from other plans, but all physicians want this data in an active, timely and predictable manner. CMS should encourage MA organizations to partner with physician practices and community-based organizations to provide them with actionable data that is customized to their practice size, patient population, and workflow.

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Thank you in advance for your consideration of these comments. Please do not hesitate to reach out to me at kristen@physiciansforvalue.org or 202-640-5942 if you have questions.

Sincerely,

Kristen McGovern
Executive Director