PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

September 6, 2022

Submitted via regulations.gov

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

Re: **CMS–1770–P; Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts**

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the proposed CY 2023 Medicare Physician Fee Schedule rule. We appreciate your leadership in driving innovation to tackle our health system challenges and promote value-based, person-centered care.

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.

Because many value-based care models continue to be built on the fee-for-service (FFS) chassis, Medicare FFS payment rates and policies are integral to the success of CMS' value-based care models. FFS must provide a sustainable platform for providers to deliver care in a way that promotes clinical and financial accountability.

A key part of providing a sustainable platform for accountable care is ensuring that Medicare FFS reimbursement rates keep pace with inflation and rising costs. The services of doctors, nurses and other skilled clinicians have been systematically undervalued by the Medicare program, with the gap between actual costs and reimbursed costs widening over time as costs increase. Failure to update these pricing inputs over time has contributed to the increasingly difficult climate for independent practices to survive. It has led to an imbalance across practice settings with hospitals, skilled nursing facilities and other facilities receiving annual Medicare payment updates to account for increasing costs while physicians and other clinicians are forced to figure out how to do more with less.

Below are our comments on specific proposals in the CY 2023 Medicare Physician Fee Schedule proposed rule. Our comments reflect the perspective outlined above, and are framed with an eye toward ensuring that independent physicians and practices are well-positioned to move off the unsustainable FFS chassis and into value-based care models that reflect their unique practice and financial circumstances.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology

CMS notes that "[m]arket consolidation, and shifts in workforce alignment, as well as an evolution in the type of business entities predominant in health care markets, all suggest significant transformation in the composition and proportions of practice expenses required to furnish care." CMS states that comprehensive practice expense (PE) data inputs and a different PE calculation methodology would better account for indirect/overhead costs, current trends in the delivery of health care, the use of machine learning technology, and EHRs, and the cost differentials in independent versus facility-based practices.

CMS seeks comment on current and evolving trends in health care business arrangements, use of technology, or similar topics that might affect or factor into indirect PE calculations, and requests public comment on any concerns about beneficiaries' access to care, possible consolidation of group practices, or burden on small group or solo practitioners.

PEPC Comments

Consolidation is occurring across the provider market for many reasons. One reason is the crushing financial pressure that many independent physicians and practices face amid rising practice costs and insufficient FFS payment rates. Many physicians gave up independent practice during the COVID-19 pandemic not because they wanted to, but because it was no longer financially sustainable for them to remain independent.

To give independent practices and physicians a chance to remain independent if they choose to, reimbursement structures for federal programs such as Medicare must keep pace. This is true even as organizations like ours advocate for value-based care models as a path to sustainability for independent practices. Many value-based care models are built off the FFS chassis; as a result, it is imperative that the chassis appropriately compensate physicians for the clinical value of their services.

We cannot realize the vision for our health care system without ensuring appropriate payment as the underlying foundation. Despite rising costs and inflation, until proposals by CMS in 2022, Medicare clinical labor pricing had not been updated for almost 20 years. As a result, the services of doctors, nurses and other skilled clinicians were systematically undervalued by the Medicare program, with the gap between actual costs and reimbursed costs widening over time as costs increased.

Failure to update these pricing inputs has contributed to the increasingly difficult climate for independent practices to survive. It has led to an imbalance across practice settings with hospitals, skilled nursing facilities and other facilities receiving annual Medicare payment updates to account for increasing costs while physicians and other clinicians are forced to figure out how to do more with less.

Under these circumstances, consolidation has become almost inevitable to the great detriment of patients across the health care system. Time and time again, studies have shown that hospital acquisition of physician practices increases prices without any improvement in patient outcomes. The higher prices are then passed on to patients in the form of higher insurance premiums. One study from California found

that an increase in vertical integration in highly concentrated hospital markets led to a 12% increase in Marketplace premiums.

We were pleased to see that CMS finalized its proposal to increase Medicare clinical labor pricing, starting in 2022. Clinical practice data is used to inform staff salary and benefit levels – some of the most significant overhead costs borne by an independent practice. We strongly recommend that CMS continue to implement its clinical pricing update finalized in CY 2022. This update is a critical lifeline for independent practices and physicians, and is a mechanism for attempting to stave off additional provider market consolidation. PE inputs should reflect the additional overhead costs borne by independent practices and physicians compared to group practices affiliated with larger hospitals or health systems.

Valuation of Specific Codes (section II.E.)

Request for Information: Medicare Potentially Underutilized Services

CMS seeks comment on how to best define and identify high value, potentially underutilized health services. CMS asks for information about obstacles to accessing these services and how specific potential policy, payment or procedural changes could reduce potential obstacles and facilitate better access to high value health services. CMS is also interested in learning about how CMS might best promote high value care and health equity, address concerns regarding health disparities, and increase access to high value services, which could improve the health of Medicare beneficiaries.

PEPC Comments

CMS could identify high-value underutilized services by cultivating a deeper understanding of the services that providers participating in value-based care models spend their own money on. High-performing accountable care organizations (ACOs) and/or providers receiving care management funds through programs such as Primary Care First may reinvest their funds into patient services that are not reimbursable by Medicare, or that are reimbursed at low rates. CMS could also examine which waivers are used by providers participating in CMS Innovation Center models, and which beneficiary enhancements they are offering to their patients. These bread crumbs should give CMS insight into the high-value services that support quality care and improve patient outcomes.

Comment Solicitation on Payment for Behavioral Health Services Under the PFS

CMS is soliciting comment on how it can best ensure beneficiary access to behavioral health services, including any potential adjustments to the PFS rate setting methodology, for example, any adjustments to systematically address the impact on behavioral health services paid under the PFS.

PEPC Comments:

Value-based care models support providers in meeting their patients' needs, whether those needs are medical, social, or behavioral health needs. Payment models that incorporate prospective payments or capitation, as well as models that share savings with successful model participants, provide capital needed to make investments in more robust care coordination, screening tools, and technology services such as telehealth that have proven to be an effective forum for delivering behavioral health services. As such, one solution to increasing beneficiary access is to align provider incentives through accountable care relationships.

Increased participation in value-based care models, and provider movement off the FFS chassis will result in increased access to behavioral health services, provided that payments made through value-based care models support these investments. Risk adjustment is incredibly important to ensuring that the payments made to physicians and practices participating in integrated delivery models reflects the clinical and social complexity of the patient population.

When independent practices and physicians are supported by a predictable, prospective revenue stream that is risk-adjusted for the clinical and social complexity of their patients, independent practices and physicians thrive, and patients have better outcomes.

Medicare Shared Savings Program (section III.G.)

CMS proposes a number of changes to the Medicare Shared Savings Program (MSSP) to advance its overall value-based care strategy of growth, alignment, and equity.

Advance Investment Payments

CMS proposes to incorporate an option into MSSP to make advance investment payments (AIPs) to certain ACOs. CMS believes these proposals, if finalized, will encourage many providers in rural and other underserved areas to join together as ACOs, building the infrastructure needed to succeed in the program, and promote equity by holistically addressing patient needs. Under the proposed approach, an eligible ACO new to the MSSP and identified as being low revenue and inexperienced with Medicare performance-based risk ACO initiatives, may receive a one-time fixed payment of $250,000 and quarterly payments for the first two years of the five-year agreement period. Quarterly payments would be based on a score set to 100 if the beneficiary is dually eligible for Medicare and Medicaid or set to the area deprivation index (ADI) national percentile rank of the census block group in which the beneficiary resides if the beneficiary is not dually eligible, with higher payment amounts for assigned beneficiaries with a higher risk factors-based score. Payments would be capped at 10,000 assigned beneficiaries. ACOs must use advance investment payments to improve health care provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries, which may include addressing social needs. CMS proposes the initial application cycle to apply for advance investment payments will occur during CY 2023 for a January 1, 2024, start date.

PEPC Comments

Access to capital can be a barrier in taking on financial risk and participating in value-based models for many independent providers and practices. We have long supported models like the CMS ACO Investment (AIM) model to provide upfront capital for ACOs to make investments they may not have otherwise been able to make. We strongly encourage CMS to finalize its proposals to expand the AIM model to MSSP through the AIP program outlined in the proposed rule, offering the following additional thoughts on specific components of the proposal:

- Eligibility Criteria – PEPC generally supports the eligibility criteria outlined in the proposed rule. We believe it is important for "inexperience" to be measured at the organization level rather than the individual level to avoid discouraging experienced clinicians from leveraging their expertise to support organizations that are new to the value movement.
- Use and Management of Payments – PEPC generally supports these proposals. However, we encourage CMS to consider allowing physician-led ACOs to use AIPs on provider/staff retention

bonuses. Independent practices must compete for talent with larger, more resourced providers, which often proves very difficult. Allowing physician-led ACOs to use AIPs on retention bonuses would help level the playing field, and give independent physicians and practices more resources to attract clinician leaders who can lead value-based care models in these care settings.

- Payment Methodology – PEPC generally supports these proposals. Independent physicians and practices need consistent, predictable revenue streams to create a platform for increased investment in value-based care. We encourage CMS to adopt proposals that give ACOs as much predictability as possible, and applaud CMS for recognizing the importance of risk-adjusting advance payments to accurately capture the level of investment needed to accommodate specific patient need.

Smoothing the Transition to Performance-Based Risk

CMS proposes to allow ACOs applying to the program that are inexperienced with performance-based risk to participate in one five-year agreement under a one-sided shared savings model by entering the BASIC track's glide path and remaining in Level A for all five years. These ACOs may be eligible for a second agreement period within the BASIC tack's glide path, with two additional years under a one-sided model for a total of seven years before transitioning to two-sided risk. For performance years beginning January 1, 2023, and in subsequent years, CMS proposes to allow ACOs currently participating in Level A or B the option to elect to continue in their current level of the BASIC track glide path for the remainder of their agreement. For agreement periods beginning on January 1, 2024, and in subsequent years, CMS proposes to remove the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track; participation in the ENHANCED track would be optional.

PEPC Comments

We support policies that allow independent practices and physicians to choose a path to value-based care that is right for them and their patients. Taking on full risk at the start can be difficult for independent practices, and full downside risk is not always needed to get results. We agree that having an entry into shared savings and gradually moving into a more aggressive risk profile has been helpful for physicians, as has starting in models that enable care transformation but do not require shared risk.

We encourage CMS to ensure its policies strike a balance between creating an appropriate entry point to value-based care for providers with the urgency required by the ambitious goals set by CMS of getting all Medicare patients into accountable care relationships by 2030.

Strengthening Program Participation by Reducing the Effect of ACO Performance on Historical Benchmarks, Addressing Market Penetration, Strengthening Incentives for ACOs Serving Medically Complex and High Cost of Care Populations

Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark

CMS proposes a combination of policies aimed at achieving the goals of ensuring a robust benchmarking methodology to reduce the effect of ACO performance on ACO historical benchmarks and increasing options for ACOs caring for high-risk population. CMS specifically proposes to 1) modify the methodology for updating the historical benchmark to incorporate a prospective, external factor, 2) incorporate a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs, and 3) reduce the impact of the negative regional adjustment. CMS believes these proposed modifications could serve as "stepping

stones" to a longer-term approach to the benchmarking methodology. These proposed changes, and the other proposed changes to MSSP's benchmarking methodology would be applicable for agreement periods beginning on January 1, 2024, and in subsequent years.

PEPC Comments

One of PEPC's fundamental value-based care principles is that new payment and delivery system models should allow physician practices to assume appropriate financial risk for reducing costs proportional to their finances while offering greater reward over time for practices agreeing to take on more risk. Risk should not be required and should not be so large as to favor consolidation of practices or deter program participation. Additionally, risk adjustment and benchmarking methodologies should be accurate and predictable, and should work for a range of different types of physician practices.

With these principles in mind, we offer our feedback on CMS' specific benchmarking proposals:

- Incorporating a Prospective External Factor in Growth Rates Used to Update the Historical Benchmark: PEPC supports clear, consistent benchmarks. While we appreciate and support CMS' focus on mitigating the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor, we believe that the proposed Accountable Care Prospective Trend (ACPT) policy swings the pendulum too fast, too far in the other direction, creating stark winners and losers based on geography. PEPC supports opportunities for independent practices and physicians across the country to participate in value-based care models such as MSSP. We believe that this policy would create a significant financial disincentive for independent practices and physicians in certain regions to move into and stay in MSSP. We urge CMS to not finalize this proposal, but to instead work with stakeholders to assess benchmarking changes that will achieve CMS' goals and may be more equitably applied.
- Adjusting ACO Benchmarks to Account for Prior Savings: PEPC supports policies that reduce the "ratchet effect," which serves to penalize high performing ACOs. We agree the proposed policies create an incentive for remain in the program long-term.
- Addressing the Rural Glitch: PEPC strongly encourages CMS to take action to address the MSSP "rural glitch," and we were pleased that CMS included a proposal for fixing this important issue in the proposed rule. We cannot support the proposal as written, however, because it only partially addresses the financial headwind facing rural practices as a result of policies that continue to include the ACO's own beneficiaries in the benchmark calculation. 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. This will continue to be true even if the proposed change is finalized. As a result, we urge CMS to instead fully address the "rural glitch" and remove an ACO's own beneficiaries from benchmark calculations.
- Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High Cost Beneficiaries and Guard Against Coding Initiatives: PEPC supports accurate and predictable risk adjustments that appropriately reflects the medical complexity of a provider's patient population.
- Increased Opportunities for Low Revenue ACOs to Share in Savings: We support CMS' proposals to expand the eligibility criteria to qualify for shared savings for agreement periods beginning on January 1, 2024, and in subsequent years, to enable certain low revenue ACOs participating in

the BASIC track to share in savings even if the ACO does not meet the minimum savings rate requirement.

Transitioning ACOs to All Payer Quality Measure Reporting, Adjusting for Health Equity and Addressing Social Determinants of Health

Proposal to Use a Sliding Scale Approach for Determining Shared Savings and Scaled Losses Beginning in PY 2023 and Extend the Incentive for Reporting eCQMs/MIPS CQMs for PY 2024

Beginning on January 1, 2023, CMS proposes to change the all-or-nothing approach for determining an ACO's eligibility for shared savings based on quality performance to allow for scaling of shared savings rates for ACOs that fall below the 30th/40th percentile quality standard threshold required to share in savings at the maximum share rate, but who meet minimum quality reporting and performance requirements. CMS also proposes to extend the incentive for reporting eCQMs/MIPS CQMs through performance year 2024.

PEPC Comments

PEPC supports CMS' proposed transition from the existing "all or nothing" approach back to a sliding scale approach for quality performance. Providing high-quality care is of the utmost importance to physician-led ACOs, but we agree that additional flexibility with respect to the scoring system would be beneficial in removing a perceived barrier to program participation with resulting in a marked decrease in the quality of care provided by ACOs participating in MSSP.

Proposal to Implement a Health Equity Adjustment

CMS proposes to implement a health equity adjustment of up to 10 bonus points to an ACO's Merit-based Incentive Payment System (MIPS) quality performance category score when reporting all-payer eCQMs/MIPS CQMs and based on 1) high quality measure performance; and 2) providing care for a higher proportion of underserved or dually eligible beneficiaries. CMS proposes to use the ADI score and Medicare and Medicaid dually eligible status to assess underserved populations. CMS proposes to add bonus points to the ACO's MIPS quality performance category score if the ACO scores in the top third or middle third of performance for each quality measure. CMS notes that it proposes this incentive for two reasons: 1) to encourage ACOs to go into underserved communities; and 2) to correct for potentially skewed quality scores resulting from the shift from the CMS Web Interface (Medicare only measures) to eCQMs/CQMs (all payer, all patient measures).

PEPC Comments

A comprehensive view of the metrics of model success – particularly metrics related to quality, access and equity – will be beneficial in encouraging accountable care relationships in underserved or vulnerable communities, and we were pleased that the 2021 MSSP results recently released included an assessment of the model's impact on health equity.

While we support a health equity incentive in concept, we are concerned the proposed incentive will not drive meaningful behavior change as designed. Adding an additional 10 points to a practice's MIPS quality score is not the kind of tangible, quantifiable incentive that drives smaller, independent practices to prioritize and make investments. There will be a significant lag time in between the time of an investment and the time at which the practice realizes any financial return. Finally, it is unclear that the return would

cover the cost of the investment in these communities, particularly given the medical complexity of patients in many underserved areas, or that it would appropriately adjust for the quality score differential that will occur when a practice shifts from reporting Medicare-only measures through the CMS Web Interface to reporting all-payer, all-patient measures through eCQM/CQM. We encourage CMS to consider how to restructure the incentive to achieve the intended goal of getting more patients in underserved communities into accountable care relationships, which we agree is critical for MSSP and value-based care overall.

Social Determinants of Health Measure and Addition of New Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System Survey Questions Requests for Information

The proposed rule includes two RFIs: one on the use of an eCQM/MIPS CQM outcome-oriented measure for ACOs, to assess providers on the percentage of individuals screened for social needs; and two, one inclusion of CAHPS for MIPS survey questions specific to discrimination and price transparency.

PEPC Comments on Use of an eCQM/MIPS CQM Measure Assessing Providers on the Percentage of Individuals Screened for Social Needs

For many practices and physicians, a key part of value-based care is addressing social determinants of health. 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.

To address social determinants of health through new payment and delivery system models, federal and state policymakers must: 1) standardize data collection for social determinants of health indicators; 2) encourage physicians and practices to adopt value-based care models which inherently give more incentives for physicians to evaluate and address social determinants of health; 3) adopt more holistic measures of model success that incorporate the social determinants of health; and 4) develop value-based care models that meet the needs of small practices and underserved groups.

To effectively implement programs that address social determinants of health, providers 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 determinants of health 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 providers. 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 providers report the questions may be insufficient. Other times EHR platforms may not be equipped at all for social determinants of health screening, forcing providers to resort to paper collection methods or other digital platforms. This creates problems both from an administrative and privacy standpoint.

CMS should invest in comprehensive social determinants of health 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 care 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.

PEPC Comments on the RFI on New CAHPS Questions Related to Discrimination and Price Transparency

We support the addition of a CAHPS question related to patient experiences within discrimination in accessing health care. However, we are concerned with the scope of the proposed question, and note that it would measure patient experiences across the health care system, not just experiences with treatment provided by the ACO.

We also support the addition of a CAHPS question related to price transparency. PEPC has long supported site neutral payments as a way to level the playing field between independent practices and physicians. Absent policy that removes financial incentives to shift services to higher cost settings, encouraging providers to have conversations with their patients about the cost of the services rendered could be a mechanism for more informed decision-making by the patient. We agree that prescription drug pricing is only one piece of the puzzle, and that broader conversations about costs would be helpful to ensure that patients have the opportunity to make decisions aligned with their preferences and values.

Reducing Administrative Burden for ACOs

CMS proposes to remove the requirement for ACOs to submit marketing materials for CMS review prior to use, effective for PYs beginning January 1, 2023, and for subsequent years. CMS also proposes to modify the requirement for ACOs to provide a beneficiary notice prior to or at the first primary care service visit annually to providing the notice prior to or at the first primary care service visit once per agreement period, with a follow-up beneficiary communication taking place within 180 days after the beneficiary notice is provided, effective for PYs beginning January 1, 2023, and for subsequent years.

PEPC Comments

One barrier to greater adoption of value-based care models by independent physicians and practices is the perceived administrative burden associated with population health and new payment and delivery system models, whether it is increased reporting requirements, increased data analysis and insight generation, new beneficiary notice/communications requirements, and/or increased accounting requirements. We support CMS' proposals to address some of this burden by relaxing some of the restrictions on beneficiary communications and marketing.

Another way to reduce administrative burden for independent practices and physicians participating in value-based care models would be to improve information sharing from hospitals, specialists and other care team members to equip primary care physicians with the data they need to provide comprehensive, whole-person care. We were pleased to see CMS implement a new Condition of Participation requiring hospitals to share admission/discharge/transfer notifications with community providers in some instances, but the implementation of this requirement has created additional burden for physicians. To address this, CMS should consider requiring hospitals to accommodate a roster-based approach to event

notifications, so that independent practices and physicians could simply provide a roster of patients to the hospital and receive notifications any time there is an admission, discharge, or transfer for any of the patients on the roster.

Updates to the Quality Payment Program (section IV.)

MIPS Value Pathways (MVPs)

CMS proposes to broaden the opportunities for the public to provide feedback on viable MVP candidates by posting draft versions of MVP candidates on the QPP website to solicit feedback for a 30- day period. CMS also clarifies how MVPs can be developed to reflect team-based care and the patient journey by describing how MVPs can involve multiple clinician types that engage with the patient. CMS proposes to expand opportunities for interested parties to participate in MVP maintenance to include an annual public webinar to discuss potential MVP revisions that have been identified, as feasible. In addition to the existing 7 MVPs, CMS proposes 5 new MVPs for PY 2023: Advancing Cancer Care; Optimal Care for Kidney Health; Optimal Care for Patients with Episodic Neurological Conditions; Supportive Care for Neurodegenerative Conditions; and Promoting Wellness.

PEPC Comments

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 practices, to make the transition to value based care.

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.

Payment Gap for QPs and Subsequent Transition to Enhanced Conversion Factor Updates RFI

CMS requests information from interested parties about what, if anything, they would like to see CMS do in response to the transition from having a 5% lump sum APM Incentive Payment awarded to Qualifying APM Participants (QPs) in payment years 2019-2024 to having a 0.75% Conversion Factor update available to them in payment years 2026 onward.

PEPC Comments

The 5% APM Incentive Payment has been an important tool for ACOs to use to encourage providers, including independent practices and physicians, to adopt alternative payment models with increasing amounts of risk. We urge CMS to work with Congress to extend the authority for this bonus payment beyond 2024.

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Thank you for the opportunity to provide comment on these proposals. Please do not hesitate to contact me if PEPC can be a resource to you as you consider how Medicare FFS policies impact independent practices and physicians seeking to move into new payment and deliver models.

Best,

Kristen McGovern
Executive Director