PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

March 6, 2023

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

Re: Calendar Year (CY) 2024 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear CMS Administrator Brooks-LaSure,

Thank you for the opportunity to provide input into the Calendar Year (CY) 2024 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Advance Notice). We appreciate 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. 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 comments below focus on how the proposed policies in the MA Advance Notice will impact independent physicians and practices participating in, or considering participating in, value-based care models in MA as well as Medicare fee-for-service (FFS).**

Value-Based Care in Medicare Advantage

One of our core principles is to support more value-based care models in MA among independent practices. Despite gains in value-based payment model adoption, FFS is still entrenched in health care payments, making it difficult to sway incentives. **We continue to support efforts to encourage further value-based payment adoption in MA, including through incorporating a value-based care Star measure and harmonizing existing measures to reduce burden on small and independent practices.**

CMS has previously expressed interest in developing a measure to capture the value-based care arrangements MA organizations have with providers based on health outcomes and quality of services provided to their patients. We support the development and implementation of a value-based care measure to capture the arrangements MA organizations have with physician practices, and urge CMS to incorporate this measure into the Star ratings. This measure should be designed to require MA organizations to report various characteristics of value-based care arrangements with physician practices. The measure should not create problematic incentives for MA organizations to increase the proportion of value-based arrangements, as such a measure could negatively impact physician practices and result in

narrowing of MA networks. We believe that this addition should occur alongside other Star measure reforms to streamline measures and reduce burden for independent practices and physicians.

Impact of Proposed MA HCC Model Changes on Value-Based Care

The Advance Notice includes many changes to the CMS-Hierarchical Condition Categories (HCC) model used to risk adjust payments to Medicare Advantage Organizations (MAOs), including updating the plan year and denominator, mapping the HCC model to ICD-10 diagnosis codes, and eliminating and/or collapsing a number of codes identified as "Principle 10 codes," e.g., codes that are billed more often in MA compared to FFS.

The proposed changes will impact value-based care arrangements in MA, as well as Medicare FFS. First, almost all the partial and fully at-risk arrangements deployed in MA incorporate risk adjusted payments into their capitated arrangements. The extent of the impact, including the impact on alternative payment models (APMs) being tested by independent practices and physicians, is still unclear as the changes are complicated and MAOs have some discretion in determining how to implement them. We do have some concern, however, that MAOs will pass along any perceived payment cuts to providers, and that it could discourage plans from entering value-based care arrangements in the future. These unintended consequences would be counter to our shared goal of more accountable care arrangements, and specifically more value-based payment model tests led by independent physicians and practices. We urge CMS to consider engaging stakeholders on these proposed changes to better understand the full extent of the implications.

Second, the HCC model underpins the Medicare Shared Savings Program (MSSP) and the ACO REACH model – Traditional Medicare's two largest accountable care organization (ACO) programs with approximately 600 ACO participants. We urge CMS to consider how these proposals might impact those programs given differences in patient population, geographic footprint, program design, and more. We note that, unlike MA, the MSSP and ACO REACH model have guardrails in place to prevent gaming. Risk score growth in MSSP and ACO REACH is capped at three percent, and both models incorporate regional benchmarking. HCC scores are also used in other value-based care models, like CMMI's Primary Care First model.

Milliman used the V24 model to calculate risk scores for payment year 2023 and the V28 model to calculate proposed risk scores for the 2024 payment year for both FFS and MA populations. The estimated national impact of the proposed changes would result in a 2.8 percent increase in risk scores for Traditional Medicare beneficiaries. CMS needs to make sure this change in measurement, which doesn't reflect a true change in morbidity or coding behavior in Traditional Medicare, does not inadvertently penalize MSSP ACOs. Therefore, we strongly recommend that CMS either increase the MSSP risk cap (in recognition that the new V28 provides significant protection against discretionary risk coding) or apply the three percent cap to the difference between the ACO's risk growth and the county's risk growth (to prevent the change in risk measurement methodology from unfairly penalizing ACOs).

The CMS-HCC model impacts APMs and value-based care efforts in Traditional Medicare. We urge CMS to consider the far-reaching impact of model changes in their analysis when considering finalizing any changes, including applying CMS-HCC model updates to value-based care models. Given that these updates are specifically designed for risk-adjusting capitated payments to MA organizations, they may be inappropriate for use in other areas.

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Ensuring Adequate Physician Payment

As you know, FFS remains the base for most APMs and 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. Thus, we cannot realize the vision for our health care system to deliver accountable, whole-person care without ensuring appropriate payment as the underlying foundation.

As many independent practices continue to operate on very low margins and at a competitive disadvantage compared to other practice settings that receive higher payments for the same services, it is critical to ensure that physician payment is not impacted by proposals in the Advance Notice. We also continue to advocate for CMS to provide a sustainable platform for accountable care by ensuring Medicare FFS reimbursement rates keep pace with inflation and rising costs and to implement policies that level the playing the field across practice settings. This includes:

- Provide certainty surrounding provider reimbursement to ensure patients continue to have access to the services and care they need. This includes investing in the Medicare Physician Fee Schedule to ensure that Medicare providers are appropriately reimbursed for their services and to ensure that reimbursement accounts for rising overhead costs and inflation.
- Build upon existing site-neutrality rules and create more fairness in the payment system by passing legislation to ensure CMS pays the same Medicare rates for drugs and clinic visits at physician offices and hospitals. In certain cases, this may involve setting an appropriate midpoint between current physician and hospital outpatient payment rates, rather than simply bringing hospital payments down to Medicare physician rates that have not kept up with inflation for over a decade.

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Thank you in advance for your consideration of these comments. Please do not hesitate to reach out to me if you have questions or the Partnership to Empower Physician-Led Care (PEPC) can be a resource to you. I can be reached at kmcgovern@sironastrategies.com or 202-640-5942.

Sincerely,

Kristen McGovern
Executive Director