PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

August 17, 2023

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

Re: **Request for Information: Episode-Based Payment Model**

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide feedback on the request for information (RFI) on an Episode-Based Payment Model.

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.

Physicians have demonstrated their ability to generate favorable results in a range of different payment models. Physician group practice participation in Bundled Payments for Care Improvement (BPCI) Initiative was associated with significant reductions in overall Medicare payments, with no negative impact on clinical outcomes or increased readmissions. Reductions in per-episode payments on surgical clinical episodes from physician group practices were more than double the reduction of hospital episode initiators. Further, in model year three, physician group practices reduced the unplanned readmission rate for all clinical episodes and were the primary driver of a small reduction in the mortality rate.

Physician-led ACOs are also creating a better experience for patients while lowering costs in the Medicare Shared Savings Program (MSSP). According to CMS data, in 2021, physician-led ACOs in the MSSP achieved net savings that were nearly double than hospital-led ACOs ($237 per capita in net savings versus $124 per capita net savings). ACOs comprised of 75 percent primary care clinicians or more, saw $281 per capita in net savings compared to $149 per capita in net savings for ACOs with fewer primary care clinicians.

Our comments focus on specific considerations for the CMS Innovation Center to ensure that it develops future episode-based payment models that leverage past physician-led in similar models and reflects the unique clinical and financial circumstances of independent physicians and practices. It is critical that a new model does not inadvertently incentivize further consolidation by favoring larger physician practices and systems. **We urge CMS to develop a model that is voluntary for all providers, including accountable care organizations (ACOs), and recognizes that every provider is unique and will require different tools to succeed.**

Considerations for a New Episode-Based Model

Independent physician practices have several advantages that lend to their success in value-based care models, including longer-term relationships with patients and better-aligned financial incentives than many hospitals or health systems. As episode-based models frequently generate savings by eliminating unnecessary services or proving care in lower acuity settings, financial entanglements and ownership of facilities can act as a perverse incentive to reducing wasteful utilization.

Voluntary Path to Adoption with Robust Physician Participation in Model Development

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. Different provider types have varied levels of readiness for accountable care, different patient populations, and different geographic considerations, which may make an episode-based payment model more or less appropriate for care delivery based on their unique circumstances. Some independent practices are primary care practices, but there are also significant numbers of independent practices in specialties such as gastroenterology and radiology. While some independent practices might want to participate in an episode-based payment model as a stepping stone into other accountable care arrangements, other practices may be participating in total cost of care arrangements and may wish to further experiment with bundled payments as an option for deepening and expanding their ability to generate better health outcomes and lower medical expenses for their aligned patient populations.

For this reason, we urge CMS to develop a model that is voluntary for all providers, including ACOs. Every provider and ACO is unique, and will require different tools to drive transformation in their patient populations. To be successful, an episode-based payment model much recognize this and be appropriately designed and tailored to engage the providers and patient journeys that it wishes to impact.

One idea for developing an episode-based payment model would be for the CMS Innovation Center to create a process whereby providers can submit episode model options. This would enable CMS to develop clear guidelines regarding care transformations, while maintaining a provider-driven model. We believe that providers are best equipped to identify the episodes, providers, and incentives necessary to improve outcomes and reduce costs. CMS could leverage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) or the Quality Payment Program (QPP) process for submitting “other APMs” to develop this approach.

It is crucial that CMS strikes an appropriate balance to ensure that it is promoting more payment models for specialty care without disrupting existing partnerships. We support CMS’ efforts to bring more specialists into alternative payment models and recognize that an ACO will not be the best fit for every provider. As such, a physician should feel compelled to enter an ACO to participate in an episode-based payment model. However, any episode-based model should be structured so that organizations that are already taking accountability for total cost of care, including ACOs, are not disadvantaged by the pricing of these episodes. Models that change the assignment of the beneficiary can disrupt existing partnerships, forcing ACOs to restructure and even leave partnerships. In the Medicare population in particular, a primary care provider may be managing several chronic conditions before, after, and throughout, the procedural episode timeframe. CMS must ensure that attribution in an episode-based model does not serve as a disincentive to collaborate and integrate across specialties. CMS should strive to align

benchmarking so that a beneficiary can be aligned to both an episode-based payment model and an ACO, without creating higher costs in the ACO's benchmark years.

Data Sharing to Support Real-Time Decision-Making

Real-time, actionable data is critical to the success of value-based care models, including physician-led models. Independent physicians and practices often face disproportionate barriers, including staff or financial limitations, that make it more difficult to integrate new technologies and maintain and update data infostructures over time. The perceived administrative burden associated with new payment and delivery system models, such as increased reporting requirements and increased data analysis and insight generation, serves as a barrier to greater adoption of value-based care models by independent physicians and practices. To this end, 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 would be an important step in reducing administrative burden for independent practices and physicians participating in an episode-based payment model.

Episode-based payment models must include accountabilities to ensure consistent data sharing between episode-based payment participants and primary care practices that have a longitudinal relationship with the patient. We believe CMS should help facilitate participation in a neutral patient-centered data utility or health information exchange.

CMS should start by making data available to providers so that they can determine whether and how participation in a bundled payment model makes sense for them. In addition, we urge CMS to consider the following consensus-based best practices when addressing data sharing in its new episode-based model and other future models[1]:

1. Create an Interoperable Data Ecosystem: Adopt consistent content and exchange standards to simplify and expand data sharing.
2. Share More Complete, Comprehensive Data: Empower value-based care participants with complete, accurate, and consistent data that paints a more comprehensive picture of a patient population.
3. Improve Data Collection and Use to Advance Health Equity: Collect and share data to identify and address health disparities as well as barriers to care beyond the clinical setting, while ensuring transparency, appropriate use, and confidentiality.
4. Share Timely, Relevant, and Actionable Data: Prioritize sharing focused insights and data early, often, and in accessible ways, to improve care.
5. Make Data Methodologies, Calculations, and Context Readily and Easily Available: Share detailed information on how and what data were derived from to foster trust among VBC participants in the data they receive, use, and by which performance is measured.

Payment Policies That Ensure Solid Financial Foundation for Innovation

[1] AHIP, AMA & NAACOS (2023), "The Future of Sustainable Value-Based Payment: Voluntary Best Practices to Advance Data Sharing."

CMS must ensure that there is appropriate payment in place for any episode-based payment model. 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 and achieving its laudable accountable care goals. FFS must provide a sustainable platform for providers to deliver care in a way that promotes clinical and financial accountability. Inadequate reimbursement reduces incentives for experimentation and innovation. As 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 also urge CMS to make bonuses available for physician-led models.

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. 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. We urge CMS to invest in the Medicare physician fee schedule to ensure that Medicare providers are appropriately reimbursed for their services and that reimbursement accounts for rising overhead costs and inflation.

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Thank you for the opportunity to provide input into this RFI. Please do not hesitate to let me know if you have questions or if we can be a resource.

Best,

Kristen McGovern
Executive Director