PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

September 11, 2023

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: **CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program**

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the proposed Calendar Year (CY) 2024 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.

Now more than ever, the Administration must ensure that physicians are able to realize the benefits of the investments they have made in population health while simultaneously creating a platform for others to make new investments as their financial situation allows. This is especially critical to the survival of independent practices. In recent years, there has been a historic pendulum swing between employed physicians and private practice. The American Medical Association's recently released Physician Practice Benchmark Survey found that only 46.7% of physicians worked in physician-owned practices in 2022, a decrease from over 60% in 2012. This troubling trend of provider consolidation is leading to indisputable increases in health care prices without corresponding gains in quality - and some evidence that quality may actually diminish post-merger or acquisition.

Yet, physician-led models generate cost savings and higher quality than unsustainable fee-for-service (FFS) and other value-based care models led by other providers. We urge CMS to make value-based care participation as accessible as possible to independent physicians and practices. This includes not only ensuring that the financial structure of models is appropriate to accommodate the unique financial circumstances of independent practices, but also ensuring that the other requirements associated with model participation are streamlined as appropriate while still ensuring patients are protected.

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Below are our comments on specific proposals in the CY 2024 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.

Overarching Payment Policies

Physician Payment
For CY2024, CMS proposes a PFS conversion factor of $32.75, a decrease of $1.14 (or 3.34%) from the CY2023 conversation factor of $33.89.

PEPC has deep concerns with CMS' proposed decrease in the PFS conversion factor. Because many value-based care models continue to be built on the 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. We urge CMS to work with Congress to develop a more permanent fix to Medicare physician pay, such as indexing physician pay off the Medicare Economic Index, a measure of inflation faced by physicians with respect to their practice costs and general wage levels.

Complex Chronic Add-On Payment
CMS proposed to implement the office/outpatient (O/O) evaluation and management (E/M) visit complexity add-on code (HCPCS code G2211) beginning January 1, 2024. When fully adopted, CMS estimates HCPCS code G2211 will be billed with 54% of all O/O E/M visits.

PEPC appreciates CMS' recognition of the resources required to provide comprehensive, patient-centered primary care. We urge CMS to finalize this proposal, which will provide a crucial lifeline to independent physicians - who do this work best and have been historically undervalued by Medicare - and support the broader value-based care infrastructure.

Reimbursement for Auxiliary Services
CMS proposed coding and payment changes intended to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel.

We agree with CMS that paying separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services will better account for added

resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. These services and care team members are integral components of providing patient-centered, value-based care and many accountable care organizations (ACOs) are providing these services today without compensation.

SDOH Risk Assessment as Part of AWV
CMS proposed to add a SDOH Risk Assessment as an optional add-on service and payment, furnished as part of the annual wellness visit (AWV) with no cost sharing on the part of the beneficiary.

For many practices and physicians, a key part of value-based care is addressing SDOH. 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 by value-based care models that allow providers to spend time with their patients, assessing their needs and connecting them to services. We urge CMS to finalize this add-on service and payment, which we believe will enable physicians to be reimbursed for the important work they are already doing.

Medicare Shared Savings Program

CMS proposed several important changes to the Medicare Shared Savings Program (MSSP) with the intention of advancing its overall value-based care strategy of growth, alignment, and equity; as well as addressing concerns raised by ACOs and other stakeholders.

Advance Incentive Payments
In the CY 2023 PFS final rule, CMS finalized a new payment option for eligible MSSP ACOs entering agreement periods to receive advance incentive payments (AIPs). In this rule, CMS proposed a series of technical modifications to refine AIP policies intended to better prepare for initial implementation of AIP.

Access to capital can be a barrier in taking on financial risk and participating in value-based models for many independent providers and practices. PEPC has long supported models like the CMS ACO Investment model (AIM) to provide upfront capital for ACOs to make investments they may not have otherwise been able to make. We believe these modifications and flexibilities will make it easier for more providers to benefit from AIPs.

However, we urge CMS to modify this proposal by expanding AIP eligibility to existing ACOs and those participating in the MSSP ENHANCED track. As physicians take on downside risk, capital is more important than ever to make investments needed to keep their patients healthy, including more robust care coordination, screening tools, and technology services. Supporting independent physicians as they move into two-sided risk is crucial to encouraging progression along the risk spectrum.

Proposals to Improve ACO Risk Adjustment, Alignment and Benchmarking
CMS proposed several policies intended to improve benchmarking, risk adjustment, and alignment, including:
- CMS proposed to eliminate the negative regional adjustment on the benchmark.
- CMS proposed to cap the prospective Hierarchical condition category (HCC) risk score growth in an ACO's regional service area between the benchmark year three and the performance year (PY).

- CMS proposed to implement the revised 2024 CMS-HCC model (Version 28) using the same three-year phase in as Medicare Advantage; for PY 2024, the underlying model will be 67% of the current 2020 CMS-HCC risk adjustment model and 33% of the CMS-HCC risk adjustment model. CMS will apply the same CMS-HCC risk adjustment model used in the PY for all benchmark years.

PEPC supports clear, consistent benchmarks and risk adjustment policy; and appreciates CMS' efforts to ensure its policies are not creating a disincentive for independent practices and physicians in certain regions to move into and/or remain in MSSP. We thank CMS for ensuring physicians in certain geographies are not disincentivized from participating in the MSSP by eliminating the negative regional risk adjustment and capping HCC risk score growth.

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.

Medicare CQMs
CMS proposes to establish the Medicare clinical quality measures (CQMs) for ACOs participating in the MSSP as a new collection type for Shared Saving Program ACOs under the alternative payment model (APM) Performance Pathway (APP). Medicare CQMs would serve as a transition collection type to help ACOs build the infrastructure, skills, knowledge, and expertise necessary to report the all payer/all patient MIPS CQMs and electronic CQMs.

PEPC is pleased that CMS is introducing an additional reporting option to ease the transition to electronic clinical quality measures (eCQMs) and MIPS CQMs reporting for ACOs. We applaud CMS for this proposed new reporting option for MSSP ACOs. We believe that limiting reporting to Medicare patients, versus all-payer data, will be an important step towards reducing burden for providers in ACOs and encouraging specialist participation. We urge CMS to maintain the Medicare CQM reporting option for ACOs until digital quality measurement and reporting is feasible for all ACO participants, especially small and independent providers who will need more technical assistance, resources, and support during this transition.

Determining Beneficiary Assignment Under the Shared Savings Program
Starting in PY 2025, CMS proposes to revise the step-wise beneficiary assignment methodology used by ACOs to include a new step three, which would utilize an expanded window for assignment (a 24-month period that would include the applicable 12-month assignment window and the preceding 12 months) to identify additional beneficiaries for assignment.

CMS' also proposes to revise the definition of primary care services used for assignment in the Shared Savings Program regulations to include Smoking and Tobacco-use Cessation Counseling; Remote Physiologic Monitoring; Cervical or Vaginal Cancer Screening; Office-Based Opioid Use Disorder Services; Complex Evaluation and Management Services; Community Health Integration services; Principal Illness Navigation (PIN) services; SDOH Risk Assessment; Caregiver Behavior Management Training; and Caregiver Training Services.

PEPC supports CMS' proposed changes to MSSP beneficiary assignment, which will be an important step in enabling ACO participants to address beneficiaries' SDOH, improving health equity, and bringing more beneficiaries into accountable care arrangements.

However, we urge CMS make this assignment methodology available in 2024 to ACOs in current agreement periods. The contradiction between making improvements that are unavailable to ACOs unless they enter a new agreement period is counterproductive to achieving our shared goals of bringing more Medicare beneficiaries into accountable care relationships.

Future of the Shared Savings Program
CMS seeks comment on incorporating a higher risk track than the ENHANCED Track in the MSSP. CMS seeks comment on (1) policies/model design elements that could be implemented so that a higher risk track could be offered without increasing program expenditures; (2) ways to protect ACOs serving high-risk beneficiaries from expenditure outliers and reduce incentives for ACOs to avoid high-risk beneficiaries; and (3) the impact that higher sharing rates could have on care delivery redesign, specialty integration, and ACO investment in health care providers and practices.

CMS also notes it has continued to receive significant input from interested parties regarding opportunities to increase participation in ACO initiatives, including leveraging MSSP to provide prospective payments for primary care that would reduce reliance on FFS and support innovations in care delivery.

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.

As highlighted in the recently released 2022 MSSP results, physician-led ACOs consistently achieve superior savings in ACO models. Physician-led ACOs comprised of at least 75% primary care clinicians achieved savings that were twice as great as other ACOs, demonstrating the opportunity for improved outcomes and lower costs if CMS leverages primary care capitation as the backbone of a new MSSP track. To that end**,** we urge CMS to develop a full-risk optional track in MSSP that includes prospective population-based payments (capitation), and is designed with small and independent physicians in mind. Prospective population-based payments should have the following characteristics:

1. The ACO should have a choice of whether CMS pays the prospective payments to the ACO or directly to the practices. ACOs composed of independent practices who have joined together to participate in the MSSP typically need to share services through the ACO. In these cases, paying the prospective payment directly to the ACO makes the most sense.
2. For ACOs in the ENHANCED track (or a new full-risk track), the ACO should be able to receive prospective primary care payments in an amount greater than Medicare's historical payments to its providers to provide funds for innovative care delivery strategies. This has been tested now in Next Gen ACO and in ACO REACH and should be made available to MSSP ACOs.

3. The prospective primary care payments should be treated like any other Medicare part B expense for purposes of benchmarks and shared savings calculations.
4. The new primary care payments should be available as of January 1, 2025, so that primary care practices do not feel compelled to leave ACOs for the sole purpose of accessing prospective primary care payments in the Making Care Primary model. A second application cycle should be available for ACO REACH participants to begin the model January 1, 2027.

We believe that the experiences and successes of prior CMS Innovation Center models, including ACO REACH, provide the experience to address CMS' concerns regarding increasing program expenditures and/or avoiding high-risk beneficiaries. For example, the ACO REACH model included risk corridors, benchmarking, and risk adjustment provisions to adequately account for the cost of treating complex, higher-cost patients. ACO REACH also included an early termination policy to prevent ACOs from leaving the program if experiencing significant losses, which will provide fiscal protection to CMS. With thoughtful and intentional design, as was done in ACO REACH and other models, we believe these concerns can be mitigated.

Expanding the ACPT Over Time and Addressing Overall Market-wide Ratchet Effects
CMS seeks comment on the following: (1) replacing the national component of the two-way blend with the ACPT; and (2) scaling the weight given to the ACPT in a two-way blend for each ACO based on the collective market share of multiple ACOs within the ACO's regional service area.

PEPC supports policies that reduce the "ratchet effect," which serves to penalize high performing ACOs. To support the transition away from FFS to value-based care, it is essential for CMS to create incentives for providers remain in the MSSP long-term. We encourage CMS to work with stakeholders to assess benchmarking changes that will achieve CMS' goals and may be more equitably applied.

PEPC also strongly encourages CMS to take action to address the MSSP "rural glitch." 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.

Quality Payment Program

Increasing Alignment Across Value-Based Care Programs
CMS proposes to consolidate the previously finalized Promoting Wellness and Optimizing Chronic Disease Management MIPS Value Pathways (MVPs) into a single consolidated primary care MVP that aligns with the adult Universal Core set of quality measures.

We applaud CMS' commitment to alignment across programs and urge CMS to do so wherever possible. 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, including increased reporting requirements. We urge CMS to keep this in mind and consolidating quality reporting requirements across value-based care programs wherever possible.

Aligning CEHRT Requirements for Shared Savings Program ACOs with MIPS
CMS proposes to remove the MSSP Program certified electronic health record technology (CEHRT) threshold requirements beginning PY 2024, and add a new requirement, for PYs beginning on or after January 1, 2024, that all MIPS eligible clinicians, QPs, and Partial QPs participating in the ACO, regardless of track, are to report the MIPS Promoting Interoperability (PI) performance category measures and requirements to MIPS.

While we appreciate CMS' intention of reducing burden for ACOs, we have serious concerns that this policy will do the opposite. This proposal would result in subjecting QPs to MIPS, given that PI is the only reporting requirement for ACOs. Reduced reporting burden is an important non-financial incentive for a provider to join an Advanced APM, especially for small and independent practices who lack the resources and support to comply with reporting requirements. We fear that this proposal would be a step in the wrong direction.

QP Determinations
CMS proposes to end the use of APM Entity-level Qualifying Participant (QP) determinations and instead make all QP determinations at the individual eligible clinician level.

We urge CMS to reconsider this policy, which, if finalized, we believe would make it nearly impossible for independent physicians to qualify as a QP. We believe this will also disincentivize specialists from participating in ACO-related activities, which runs counter to CMS' commitment to bring more specialists in accountable care relationships.

MIPS Performance Threshold
CMS proposes to increase the performance threshold to avoid a penalty in the MIPS from 75 points to 82 points. CMS estimates this would result in approximately 54% of MIPS eligible clinicians receiving a penalty of up to -9%.

We encourage CMS to consider the potential negative impact an increased MIPS performance threshold would have on providers with low performance. In the context of other major proposed changes to MIPS and the elimination of the Advanced APM bonus, we believe this would be a step too far and urge CMS to not finalize this proposal.

Transforming the Quality Payment Program – Request for Information
CMS seeks comment on how it can modify the Quality Payment Program to foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries.

PEPC believes traditional MIPS should remain available to reflect the diverse needs of different physician groups, while streamlining requirements for providers participating in both MSSP and MIPS whenever possible. MVPs should serve 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 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.

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.

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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. I can be reached at kristen@physiciansforvalue.org.

Best,

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