AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

September 30, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Becerra:

America's Physician Groups (APG) would like to congratulate you on your first eight months in Washington, D.C. working to best serve the nation and its healthcare system. As an association that represents hundreds of healthcare organizations that are engaged in serving patients through the Medicare program and the various advanced payment models currently ongoing within CMS and CMMI, we recognize the important work that you do in supporting these models and the providers who work within them.

Ours is an association of physician-focused healthcare organizations focused on the good of patients who have successfully utilized Medicare Advantage (MA) to better care for patients and the healthcare system. It is in this spirit that we write this letter to address recent complaints and recommendations made by Drs. Don Berwick and Rick Gilfillan regarding MA and CMMI's Global and Professional Direct Contracting (GPDC) pilot programs.

Drs. Berwick and Gilfillan have presented you and other healthcare policy professionals in Washington with a 66-page PowerPoint presentation outlining some of their concerns with MA's cost and payment issues among participating physicians, organizations, and health plans and GPDC's potential to do the same.

APG has tremendous respect for Drs. Berwick and Gilfillan, their decades of experience, and what they have achieved and contributed on behalf of the movement toward value-based care. However, we would like the opportunity to address some of what we believe to be inaccuracies in what they have presented to you in their arguments against the MA and GPDC programs.

About America's Physician Groups

APG is a national professional association representing over 340 physician groups that employ or contract with approximately 195,000 physicians providing care for nearly 45 million patients as well as over 25% of the Nation's Medicare Advantage beneficiaries. Just as you do, we have deep Californian roots, starting as the California Association of Physician Organizations (CAPO) in 2002, transitioning to the California Association of Physician Groups (CAPG), then expanding to become APG in 2018. No matter our name, APG has always been the leading association representing accountable, coordinated physician groups. Our tagline, "Taking Responsibility for America's Health," represents our members' vision to move away from the antiquated fee-for-service (FFS) reimbursement system where clinicians are paid "per click" for each service rendered rather than on the outcomes of the care provided. Our preferred model of

accountable, risk based, and coordinated care avoids incentives for the high utilization associated with FFS reimbursement. APG is strongly committed to Medicare Advantage and comprehensive, affordable, and efficient care it provides for seniors.

Comments

In their materials, Drs. Berwick and Gilfillan suggest that CMS replace the HCC RAF scoring process in two years and begin a process to develop an approach that does not rely on provider reporting. They claim this is necessary because of significant MA "overpayment" they attribute to risk score inflation through risk adjusted coding.

Risk adjustment was designed to estimate a beneficiary's future health care costs and align compensation with acuity and severity of disease and the related costs of care as complex patients require the use of more resources. Risk adjustment encourages the enrollment of the sickest patients, and those in a lower socioeconomic status and is widely used in MA and the Medicare Shared Savings Program (MSSP) to appropriately risk adjust quality, expenditure benchmarks, and cost metrics, allowing for a more precise measurement of performance. Alignment of payment and performance goals rewards coordinated care and enhances the achievement of improved health and care among all individuals.

Accurate, complete coding data is analyzed to identify sickness, predict outcomes, stratify patient populations, create disease registries, conduct outreach, and a host of other invaluable opportunities to strengthen physicians' ability to care for their most sick patients, a stark contrast to Drs. Berwick and Gilfillan's claims that coding is replacing care management under MA as the focus of investment.

Risk adjustment promotes quality care be offered for beneficiaries who experience high rates of comorbidities. The adjusted compensation for high-risk patients provides physicians, healthcare organizations, and health plans resources to create additional programs and services to support and manage patients with important and impactful diseases and conditions. Risk adjustment plays a pivotal role in MA and thus, expanding access to high quality care nationwide.

In recent years, there has been concern that risk adjusted coding has incented Medicare Advantage Organizations (MAOs) to increase premium revenue by coding more diagnoses through home visits and health risk assessment (HRA) tools. APG believes comprehensive diagnosis coding should be performed by the treating physician (or affiliated provider) as close to the point of care delivery as possible, and each coded diagnosis should be accompanied by supporting documentation, including the status and management plan for the condition, as applicable.

APG stands in support of any investigative efforts of potentially fraudulent coding in MA and subsequent "prosecution," just as we support investigation and prosecution of those submitting fraudulent claims for traditional Medicare beneficiaries.

HCC Coding is not the only coding system that could be used to assess disease burden in a population. If better ways exist to determine the acuity and social determinants of health of a population, we support your agency's exploration of such possibilities and would be very interested in helping to develop them. In the meantime, for all the reasons stated above, we believe that appropriate risk adjustment is needed as an integral part of MA and the Medicare Shared Savings Program (MSSP).

Drs. Berwick and Gilfillan have also criticized the percent of premium contract used by some MA plans and some physician groups. Percent of premium contracts create ownership and accountability for all parties to create better programs for beneficiaries. While topline revenue may increase in percent of premium agreements, the true goal in MA is to lower total cost of care while achieving quality goals and putting the patient at the forefront of programs and activities designed to keep them healthy and at home. The additional premium received for sicker patients allows the creation of these programs and activities.

Primary care is vulnerable in this country, and MA percent-of-premium contracts with appropriate risk adjustment provides resources to achieve the larger goal of ensuring primary care remains strengthened and accessible for all. Primary care thrives in prospectively paid value-based models and is integral to address our nation's increasing burden of chronic disease.

While we acknowledge that MA is not perfect and work must be done to ensure the program is working as fairly and efficiently as possible, we also caution HHS not to do more harm than good in making the necessary corrections and reforms, such as the use of state benchmarks for end stage renal disease, county benchmark caps, and removing future data from 2020 cost rebasing, all of which APG recommended in our November 2020 comment letter on the MA program advance notice. A strong MA program allows physicians to directly build strong relationships with patient populations, the majority of which express satisfaction with their experiences in the MA program.

Recent polling conducted by *Morning Consult* found that of the 1,200 MA beneficiaries polled, 98% were satisfied with the MA coverage, 97% expressed satisfaction with their provider networks, and 98% were pleased with the program's response to the COVID-19 pandemic. MA provides an opportunity for participating providers to focus on and find opportunities to reduce waste across care continuum. The growth of the program also belies this patient satisfaction as the annual rate of growth of MA enrollment reached nine percent between 2019 and 2020 with the Congressional Budget Office (CBO) projecting that MA enrollees will comprise as much as 51% of all Medicare beneficiaries by 2030.

A robust MA program is beneficial not just for physicians and health plans, but for patients and the future of America's healthcare system. Through their participation in MA that begins with total population risk-based MA contracts, physicians are then able to develop key core competencies that allow them to address total cost of care along the continuum.

Finally, Drs. Berwick and Gilfillan argue that the GPDC model will bring these same costly MA dynamics to the Medicare fee-for-service spend which will subsequently impair accountable care organization (ACO) program and is forcing primary care providers to choose between continuing in their ACOs or joining a direct contracting entity (DCE). In their presentation, they ask that both CMS and Congress redefine the GPDC model through various methods such as requiring DCEs to follow the same ACO requirement for 75% provider governance, limiting the size of the model, and creating guardrails for investor DCEs.

Contrary to these claims, the direct contracting model has been viewed as the next iteration of the ACO framework, **empowering** PCPs' transition to performance-based risk contracting while delivering better value to patients through the coordination of care across multiple settings and the improved care management of patients suffering from significant chronic diseases.

Whereas earlier ACO models did not sufficiently drive providers toward the acceptance of risk and delivering value-based care to Medicare beneficiaries and the Medicare Trust Fund, DCEs build upon the framework that those earlier ACO models, from 2012 Pioneer ACOs to 2016 Next Generation ACOs, set and represent the gradual, evolutionary path toward educating providers on how best to manage a population and accept risk that is tied to quality outcomes.

GPDC presents an invaluable opportunity to study the effects that a capitated payment system could have on primary care in real-time and opens the door for expansion of primary care into distressed communities and proactively **empowers** PCPs to serve underserved communities and minority populations that are harmed by the consequences of health inequities and disparities. As reform efforts in the healthcare space seek the best way to lower costs without negatively affecting patient care, the opportunity represented by direct contracting must be supported and allowed to grow.

Thank you for your attention to the above comments. We look forward to meeting with you soon and continuing to work with you during your time at HHS. Please feel free to contact Valinda Rutledge, Executive Vice President, Federal Affairs, (vrutledge@apg.org) with the best available times to connect, if you have any questions, or if America's Physician Groups can provide any assistance as you consider these issues.

Sincerely,

Donald H. Crane
President and CEO

America's Physician Groups

cc: Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services
Elizabeth Fowler, Deputy Administrator & Director, Center for Medicare and Medicaid Innovation