AMERICA'S PHYSICIAN GROUPS

August 31, 2022

Chiquita Brooks LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201
Submitted via http://www.regulations.gov

Re: Medicare Advantage Program: Request for Information [CMS-4203-NC]

Dear Administrator Brooks LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) request for information on the Medicare Advantage program. We applaud the agency's commitment to ensuring that Medicare Advantage evolves in ways that reflect its rapid growth, changing demographics, unique payment structure, and the ongoing need to improve the quality of care and outcomes for Medicare beneficiaries, while also being accountable to the nation's taxpayers for reasonable costs.

At its best, Medicare Advantage (MA) is a major force in the transition from volume to value, with some evidence suggesting that MA performance exceeds even that of alternative payment models in traditional Medicare that are transitioning away from fee-for-service payment.[1] APG salutes, endorses, and fully supports the Biden Administration's stated objective of ensuring that all enrollees in traditional Medicare be in accountable relationships with their care providers by 2030. It is essential that CMS apply a similar goal to the MA program.

Although the MA program must meet extensive federal requirements, there is still great heterogeneity among plans, including in the contractual and financial relationships between plans and providers. Even if the plans themselves are accountable for meeting a variety of quality and other standards, it is not always the case that MA enrollees are in truly accountable relationships with their providers, nor that their relationships with providers will be maintained over time to help produce long-lasting improvements in enrollees' health.

As CMS considers Medicare Advantage policies that reflect the maturation of the program and that will shape its further evolution, APG is grateful that the agency seeks input from provider groups such as APG. Below, (I) we first provide a brief description of APG, followed by (II) a summary of our comments and then (III-XII) more extensive versions of our recommendations. Together they reflect our commitment to working with CMS, our partner health plans, and others, to create and enhance our accountable relationships with Medicare beneficiaries and capture the full potential of MA to improve their health, health care, and well-being.

I. About America's Physician Groups

APG is a national professional association representing more than 300 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage. Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

Our APG member groups collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians). These professionals in turn provide care for nearly 45 million patients, of whom an estimated 8 million are Medicare Advantage enrollees. In total, roughly 28 million Medicare beneficiaries, or 49 percent of all eligible beneficiaries, are now covered by Medicare Advantage plans. [2.] APG groups thus care for about 29 percent of all MA enrollees. The projection that more than half of all Medicare-eligible seniors may be enrolled in MA by 2026 suggests that APG members' footprint in the program is only likely to grow.

II. Summary of APG's Comments

- The laudable goal of having all Medicare beneficiaries in accountable care relationships by 2030 should apply across the entire program, including Medicare Advantage (MA). "Accountability" should be defined as being responsible for the quality -- and fully at risk for the costs -- of care.
- Despite the many federal requirements that apply across MA, there is heterogeneity across plans, including in the financial and contractual relationships between plans and providers.
- The best of these relationships from APG members' standpoint are those in which risk is fully delegated to providers. These providers then have the greatest incentives and available revenues to design and fund systems to improve patient care and pay attention to costs. They also tend to have more sustained, long-term relationships with their patients and patients' families than do providers in other MA arrangements.
- CMS should adopt policies that reward plans for shifting more risk to providers so that enrollees are in truly accountable relationships with them. These policies could include amending Star ratings to encourage and reward more accountable partnerships among payers and providers, and in turn, between providers and beneficiaries.
- With respect to advancing health equity, providers at risk for the costs of care are highly incentivized to address care disparities, factors related to the social determinants of health, and other sources of inequity. Therefore, CMS should allow them more leeway to tailor benefits to meet the needs of marginalized patients. CMS should also create consistency in the health equity measures that are applied across the Medicare program.
- CMS should reward providers and plans for engaging beneficiaries in careful decision-making in plan selection – for example, through the Star ratings. The agency should crack down on deceptive practices that spark churn in MA enrollment.
- The agency should allow the use of telehealth in appropriate circumstances for the purposes of fulfilling network adequacy requirements.

- CMS should step up its activity with respect to the provision of mental and behavioral health, which is in crisis nationwide amid a lack of capacity among providers. Necessary steps include ensuring that MA plans have adequate provider networks and driving more integration of behavioral and primary health care.
- Amid the ongoing provision of low-value care, utilization management techniques such as prior authorization are necessary. APG supports efforts to move toward "smart" electronic prior authorization and other means to lessen the burden on physicians who routinely provide high-value care.
- On data exchange, CMS should require plans to be more transparent about their attribution methodology and require all states to have functional health information exchange networks in place by January 2023.
- More improvements are needed in HEDIS measures and Star ratings to emphasize outcomes as opposed to processes, in part because plans have already achieved many gains in existing process measures.
- It is essential that physicians conduct Health Risk Assessments and Hierarchical Condition coding to understand the spectrum of enrollees' conditions and develop effective care plans. The risk adjusted payments that flow from this process are also essential in providing a revenue stream that enables care strategies and innovations tailored to patients' needs.
- CMS and other government agencies have tools to pursue instances of fraud and abuse in risk adjustment in should use these even more aggressively if they suspect these issues are widespread.
- A vibrant market of MA plans is essential, but there are risks to competition such as a "race to the bottom" among plans. Lack of competition in markets where there are dominant MA plans also poses challenges. CMS should collect more granular information about conditions across MA markets, including on total costs of care in markets where plans or providers have high degrees of market power.

III. APG's Fuller Responses: Driving Innovation to Promote Person-Centered Care

In its comprehensive Requests for Information (RFI), CMS asks how MA plans work with providers to engage in value-based care, and what steps CMS could take to support value-based contracting in the MA market. It also asks important questions about the alignment of features of other value-based arrangements with MA.

MA has been at the vanguard of the transformation to value-based and is now the largest risk-based insurance model in the United States. MA enrollment exceeds the number of patients attributed to risk-based models in traditional Medicare, Medicaid, or commercial health plans. Even so, the dynamics behind Medicare Advantage plans differ within and across markets.

APG members believe—and data support—that the best MA plans are those that delegate full risk, and thus full accountability for patient care, to physicians and their care teams. MA arrangements such as these allow for revenue streams to providers that support a holistic care spectrum that simply does not exist in fee-for-service care, let alone in Accountable Care Organizations (ACOs) and other alternative payment models.

The delegated model, in which the risk for the cost of health care service is transferred from insurers to health care providers, is integral to delivering high quality, patient-centered care that lowers total costs while improving health outcomes and advancing equity. Research shows that, in California, providers at full risk in 2017 had total costs of care that were 8.5 percent lower and achieved quality scores that were higher (66.2 percent on a composite score of quality versus 57.6 percent), than when providers were paid on a fee-for-service basis.[3]

Research submitted for publication shows similar results for delivery organizations carrying full risk in the care of MA beneficiaries in six states (Arizona, California, Florida, Nevada, Texas, and Utah). Compared to a matched sample of beneficiaries in the traditional, fee-for-service Medicare program, these MA enrollees had 18 percent lower odds of inpatient admission; 42 percent lower odds of hospitalization for chronic obstructive

pulmonary disorder or asthma exacerbation; 11 percent lower odds of emergency department utilization; and 9 percent lower odds of 30-day readmission.

Results such as these underscore the powerful effect of taking on full risk in both incentivizing physician groups to improve care and providing them with the resources to do so. By receiving prospective funding, provider organizations can implement targeted programs that improve the quality of care provided to beneficiaries. In effect, instead of receiving dollars to provide acute, "sick" care to patients, that same funding can be preemptively directed at programs designed to maintain and improve health.

APG members describe a variety of approaches that they have undertaken in this vein. A case in point is APG member Central Ohio Primary Care (COPC), which cares for equal numbers of Medicare Advantage and traditional Medicare patients, the former through global full-risk arrangements. As a result, it has been able to employ care teams and strategies for all its Medicare patients that would not have been possible through fee-for-service Medicare payment alone. For example, nurses and nurse practitioners employed by COPC are stationed in Columbus-area hospitals to respond quickly when COPC primary care patients arrive unexpectedly. The COPC nurses quickly assess the patients; if they don't need to be hospitalized, they connect them back to primary care providers or other appropriate level of service, averting many hospitalizations. If patients are hospitalized, COPC nurse practitioners assist the institution's hospitalists to ensure that the COPC patients get all appropriate care and timely discharge.

As noted above, although the MA program must meet extensive federal requirements, there is still great heterogeneity across plans, including in the contractual and financial relationships between plans and providers. Not all APG members operate in markets where health plans are amenable to transferring full risk to them or even sharing substantially in both upside and downside risk. As a result, even if the plans themselves are accountable for meeting a variety of quality and other standards, it is not always the case that MA enrollees are in truly accountable relationships with their providers, nor that their relationships with providers will be maintained over time to help produce long-lasting improvements in enrollees' health.

For example, APG member Vancouver Clinic, a 450-clinician group in Washington state, has a goal of negotiating full risk and full delegation arrangements with all the MA payers with which the clinic currently contracts. However, results have been mixed, with success in both contract negotiations and data exchange with payers proving to be difficult.

Along with the goal of having all traditional Medicare enrollees benefiting from accountable relationships with their providers by 2030, CMS should do what it has not yet done: use all the tools at its disposal to create these fully accountable and responsible patient-and-provider relationships in MA. To rectify this deficit, CMS should collect data on the contractual relationships between MA plans and providers to determine which plans are delegating risk, and how. It should devise a rating system for plans that captures the degree of risk delegation, using this system as a proxy for determining the degree to which beneficiaries are in accountable relationships with providers.

CMS should also fully incentivize Medicare Advantage plans to delegate more risk to providers, and for the same reason, penalize MA plans that do not. An example would be a change in Star ratings that would reflect the degree to which MA plans had in fact delegated risk to provider groups.

IV. Advancing Health Equity

The RFI asks what steps CMS should undertake to "ensure that all MA enrollees receive the care they need," and identifies a range of marginalized groups of greatest concern. MA plans overall are already primed to address the needs of many racial and ethnic groups, given that more than half of Latinx Medicare beneficiaries (roughly 54 percent) and nearly half of Black American Medicare beneficiaries (about 49 percent) are enrolled in MA rather than in traditional Medicare.[4] Many APG members care for MA patients who have, on average, five chronic conditions. Often these are low-income seniors who are struggling to manage their multiple conditions in the face of corresponding, complicating adverse social determinants of health.

APG members, particularly those in delegated arrangements, already undertake a variety of strategies to address the needs of marginalized populations in the MA program. APG member WellMed, for example, serves more than 550,000 older adult patients in Texas and Florida through physician-led teams of case managers, social workers, pharmacists, transportation providers, and telemedicine specialists, "all in an effort to ensure that our patients are guided through every aspect of their health care journey," as WellMed's president, Dr. Carlos Hernandez, describes it. "All of this is possible," he adds, "through the funding provided by Medicare Advantage."

APG members believe that CMS can do even more to encourage approaches that will advance health equity. Specifically, CMS should allow providers in delegated arrangements with plans more leeway to provide expanded benefits (including additional supplemental ones) expressly tailored to the needs of individual marginalized patients. The chief medical officer of one APG member cites one example of the need: a poor Black patient with cancer who, under the current supplemental benefit structure, may be allowed only ten rides per year, but who may require far more. CMS could allow greater flexibility so that decisions to expand or change some benefits could be made at the provider rather than plan level since patients' physicians have a window into individuals' medical and social needs that health plans cannot capture from coding and claims.

APG applauds the fact that CMS has announced several proposed changes to the Star rating program focused on health equity, including the creation of a health equity index. As discussed further below, we encourage CMS to create consistency in how equity is measured, incentivized, and rewarded across MA and all Medicare alternative payment model programs. This perspective is consistent with APG's longstanding advocacy on behalf of standardized measures across Medicare Advantage, the Medicare Shared Savings Program, the dual-eligible population, and other types of alternative payment models.

V. Expanding Access: Coverage and Care

The RFI asked several questions pertaining to how beneficiaries choose MA plans; the role of telehealth in MA; and access to behavioral health services, among others. APG members have three crucial points that are responsive to these questions.

On the topic of how beneficiaries choose plans, APG members report varying approaches that reflect the heterogeneity in the MA program. In California, for example, our members actively guide patients through the benefit packages of various plans and help them understand what they are buying. "There is nothing worse than a poorly informed patient making a poor choice" of MA plan, as one of our members put it. CMS should reward plans and providers for doing more to engage patients in careful decision-making around plan selection -- for example, by reflecting tailored patient engagement measures of this type in the Star ratings.

APG members also believe that CMS should do more to encourage longer-term, more accountable relationships among enrollees, providers, and plans once enrollees have selected plans most appropriate to their needs. For example, CMS should examine policies that crack down on misleading information and deceptive practices from health plan brokers that result in "churn" in Medicare Advantage enrollment.[5] CMS has noted its

concern about potentially deceptive marketing practices, citing in particular "words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government."

On the role of telehealth, APG members believe that the expanded telehealth capabilities during the Public Health Emergency have been essential in meeting care needs, particularly of populations in underserved areas. With respect to MA, CMS should allow the use of telehealth to fulfill network adequacy requirements for health plans. Such a change would especially benefit rural and underserved communities that struggle to recruit both primary care providers and specialists, and patients who would otherwise have to travel to receive needed care.

With respect to mental and behavioral health, APG members report that access is in a state of crisis almost nationwide. Amid a pronounced lack of psychiatrists and psychologists willing to contract with plans or medical groups to provide care, some APG members are primarily engaging licensed clinical social workers to provide services. Other APG members report that local MA plans may meet network adequacy requirements on paper, but that these APG members themselves know that the mental and behavioral providers in the area have no capacity to take on new patients. The collective sense is that this is an area in which CMS must step up its activity, particularly in ensuring that plans have functional behavioral health networks as opposed to "ghost" networks. CMS should also look for ways to drive more integration of behavioral health with primary care across the board, and especially in MA.

V. Utilization Management

Research suggests that as much as one-third of the health care provided in the United States does not improve health outcomes or quality of life, and much of it may be harmful. Because of various utilization management (UM) strategies, MA is better positioned to direct expenditures to high-value providers practicing evidence-based care, and away from procedures, drugs, and other interventions that do not improve patient outcomes.

APG providers and health plans participating in MA also have evolved their utilization management strategies, in positive ways. For example, many patient referrals to specialists are now automatically approved – and in instances where they are not, what follows is often worthwhile discussion among peers to consider what would be the appropriate evaluations and interventions that would be in a patient's best interest according to evidence-based guidelines.

Prior authorization requirements are an important element of this broad UM toolbox. Prior authorization can also be combined with other strategies that clearly benefit patients – for example, when decisions to authorize use of specific high-cost medications can be combined with steps to lower patients' out-of-pocket costs by passing along negotiated discounts on these drugs.

However, depending on how they are structured and implemented, APG supports efforts to move toward electronic prior authorization enabled by natural language processing and other advanced artificial intelligence techniques. Again, depending on the details of implementation, our members also support other means of lessening the burden of prior authorization on physicians who have a demonstrable record of accomplishment in providing high-value care.

VI. Data Exchange

The RFI asks how CMS could "better support efforts of MA plans and providers to appropriately and effectively collect, transmit, and use appropriate data." Here again, APG members point to the virtues of the delegated model. Since provider participants in delegated arrangements are actively managing care and paying claims, they have holistic, real-time information on patients' care needs, which providers who are paid on a fee-

for-service basis by plans frequently lack. APG members view this reality as another argument for CMS to incentivize more delegated risk arrangements.

An additional void of information that occurs in non-delegated arrangements regards patient attribution. Providers often do not know in a timely way which patients are being attributed to them, describing many plans' attribution methodology as a "black box" that is often not shared with providers. Provider groups report that it is often the case that patients with excessive claims are assigned to them for no apparent reason. CMS should require plans to be more transparent about their attribution methodology.

APG members also believe that CMS (in tandem with the Office of the National Coordinator of Health Information Technology) must expand its focus on interoperability of information exchange beyond electronic health records to accelerate state implementation of health information exchange networks under the Common Agreement for Nationwide Health Information Interoperability[6]. CMS should mandate that all states have fully functional health information exchanges (HIEs) in place by January 2024.

VII. Quality Measures

The RFI asks whether the MA Star Ratings accurately reflect the quality of care that enrollees receive. APG members believe that the HEDIS measures and Star ratings must continue to shift in direction away from process to outcomes measures – for example, by increasing prescription drug adherence measures, as well as disease and other outcomes measures. Medicare Advantage health plans have effectively topped-out on the current slate of process measures, meaning that most incremental improvements in such measures do little to improve patient care. Focusing quality measures that reflect how patient outcomes is a much more effective way to gauge quality.

VIII. Program Integrity and Risk Adjustment

The RFI asks about methodologies that CMS should consider to "ensure risk adjustment is accurate and sustainable." In response, APG reiterates its prior contention that having physicians conduct Health Risk Assessments and Hierarchical Condition Category (HCC) coding is essential. These activities are key to understanding the spectrum of an enrollee's health conditions, as well as to devising both individual care plans and effective population health strategies to close care gaps and improve quality. Importantly, these activities also translate into an effective risk adjustment process that matches per capita payments to patient needs and provides the necessary resources to deliver and transform care accordingly.

As an example, APG members use HCC coding to stratify their patient populations and focus their efforts on individuals most in need of care – for example, in building disease registries and using them to better plan and coordinate care for beneficiaries. As physicians undertake HCC coding, their awareness of disease and treatment interactions in each patient is heightened, and they are better able to tailor effective and personalized care plans.

This careful and detailed coding practice enabled one APG member organization to identify MA beneficiaries early in the COVID-19 pandemic. The organization then contacted these beneficiaries to determine whether they needed assistance with obtaining medication or food and connected them with community resources. It also educated these beneficiaries about how to access care virtually. Another APG member organization initiated a program after a series of natural disasters, in which patients who had been identified through HCC coding were also contacted to determine their health, medication, and food needs. The organization's team members then delivered medications directly to the patients and worked with local pharmacies and community-based services organizations to address the other needs.

The growing use of ICD-10-CM "Z codes," which provide descriptions for symptoms that do not point to a specific disorder but still warrant treatment, also allows for social determinant and other information to be recorded that can be used to provide holistic patient care. In fact, some APG members believe that CMS should create HCC values for Z codes as a potentially preferable means of addressing social determinants, rather than using the Area Deprivation Index rankings of neighborhoods by socioeconomic disadvantage. Another approach could be adding specific risk adjustment factor (RAF) codes related to the social determinants of health.

We reiterate our previously voiced perspective that physicians or affiliated providers should make the final decisions to assign diagnosis codes to patients, and that the medical record should reflect the assessment and clearly record plans for dealing with patients' conditions. Physician education and internal audits by physician groups should prevent coding errors that are not supported with documentation.

Finally, government-backed programs that have reached the size and scope of Medicare Advantage should not escape federal oversight. APG members believe that CMS and other government agencies have the appropriate tools to pursue any instances of fraud and abuse in risk adjustment and can use them more aggressively if needed.

IX. **Barriers to Entry and Other Obstacles to Competition**

The RFI asks a series of questions about competition, plan consolidation, and other features in the MA marketplace. APG members' views on these questions are nuanced. In principle, APG supports the notion of a vibrant and competitive MA market. In practice, there are both upsides and downsides to competition.

Some APG members note that many new plans are entering the MA market and attempting to buy market share by emphasizing very low premiums, as well as zero co-pays and premium rebates to enrollees. In APG members' views, many of these new entrant plans lack the infrastructure to be effective partners in managing the care of beneficiaries, particularly as far as their ability to share meaningful claims, utilization, quality, or network data. There is concern that hyper-competition in some markets is leading to a "race to the bottom" among MA The market churning that can result also works against stability of both plan-to-provider and provider-to-patient relationships. APG members say that the optimal relationships with MA plans result in 3–5-year contracts; which in turn create the conditions for longer-term relationships between physicians and patients, and the greater likelihood of influencing patients' care and outcomes over time.

At the other extreme, market consolidation and lack of competition also poses risks. APG members find that, when a given MA plan has close to 30-40 percent or more market share in each market, plans have what APG members deem excessive leverage over them. MA plans may in effect have to pay out 85 percent of premiums under Medical Loss Ratio rules, but in practice, APG members report that plans may further restrict payment to providers by another 13 to 15 percent by claiming that they are providing patient services that APG members are already providing. Often, the physician group is better equipped to provide these services, and patients may prefer to receive them from their providers rather than from their health plan.

APG members believe that federal policymakers need more granular information about the competitive dynamics within individual MA markets. Important aggregate data is gathered by MedPAC (Medicare Payment Advisory Commission), but there is insufficient information below the national level to understand fully the situation across markets.

An example of the type of information that would be useful is understanding of total costs of care when providers in any care delivery organization or MA plan are employed by hospitals, especially by hospitals in a

consolidating market. Such analysis could extend to the formation of MA plans by large hospitals and health systems as well. A similar issue calling out for study is a "good news, bad news" situation in which regions that are high-cost in terms of fee-for-service Medicare receive better county benchmarks in MA, thus providing greater incentives for MA plans to grow in these markets.

X. Conclusion

In 2021, CMS's Innovation Center outlined five "Strategic Pillars" intended to present a framework for ensuring that Americans have access to the highest quality health care.[7] The pillars include driving accountable care, advancing health equity, supporting innovation, expanding access, addressing affordability, and partnering to achieve system transformation. APG members fully support this framework and are eager to work with CMS to ensure that Medicare Advantage is central to achieving it. We look forward to ongoing engagement with the agency as it considers further changes and improvements in this vitally important program.

Sincerely,

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