AMERICA'S PHYSICIAN GROUPS

November 4, 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: https://cmsgov.secure.force.com/forms/request_info_make_your_voice_heard

Re: Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs RFI

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 accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE). We welcome the agency's openness to stakeholder input and ongoing commitment to improving the Medicare program.

As CMS considers ideas for addressing key issues facing healthcare and Medicare in particular that will shape the program's future, 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-VII) more extensive versions of our recommendations. Together they reflect our commitment to working with CMS to build on Medicare's potential to provide all beneficiaries with consistently accessible, high-quality, person-centered healthcare.

I. About America's Physician Groups

APG is a national association representing 360 physician groups committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). 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. APG members 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 90 million patients.

II. Summary of APG's Comments and Recommendations

Topic 1: Accessing Healthcare and Related Challenges

Comments	Recommendations
APG members regularly take time to help patients choose between health plans and other options.	CMS should reward plans and providers for doing more to engage patients in careful decision-making around plan and program selection — for example, by reflecting tailored patient engagement measures of this type in the Star ratings. In the context of MA plans, CMS should provide incentives for provider groups to help beneficiaries choose the plan best suited to their needs.
APG members want beneficiaries to have longer-term and more accountable relationships with their plans and providers.	CMS should do more to encourage longer-term, more accountable relationships among enrollees, providers, and plans and other program once enrollees have selected plans and programs most appropriate to their needs.
APG members also want the accountable relationships with their patients to serve as a foundation for encouraging them to be more engaged in their care.	Rules that restrict marketing should be relaxed, especially for ACOs and any models like primary care first that are designed to manage and coordinate care for beneficiaries. CMS could also support these efforts in the agency's communications with beneficiaries.
Mental and behavioral health is in crisis nationwide amid a lack of capacity among providers.	Given the urgency of the crisis, CMS should deploy its regulatory authority to fullest extent possible with respect to the provision of mental and behavioral health, including ensuring that MA plans have adequate provider networks, driving more integration of behavioral and primary health care, adding waivers to Innovation Center models that would allow groups that take full responsibility for the quality and cost of care to employ care teams composed of both licensed clinicians and community health workers, and including similar options in the Medicare Shared Saving Program through rulemaking.
Telehealth and other flexibilities implemented during the COVID-19 public health emergency support patients' access to care.	CMS should use its regulatory authority to continue as many telehealth and other flexibilities as possible and encourage specialists and underserved patients to use them.
Ensuring that patients have adequate access to healthcare begins with ensuring there is a sufficient healthcare workforce.	See additional comments and recommendations regarding provider workforce under Topic 2.

Topic 2: Understanding Provider Experiences

Comments	Recommendations
Administrative burden and workforce shortages go hand in hand. Providers have identified these issues as top concern and asked CMS to address them for years.	CMS should act to address administrative burden and workforce shortages rather than continuing to ask for input on these issues. If needed, CMS should consider creating a task force comprised of clinicians to develop a plan for addressing these issues.
As policymakers have adopted new ideas to improve healthcare, the resulting policies place additional burdens on providers.	CMS should carefully consider if each new policy will place additional burdens on providers (Topic #2), impact patients' access to care (Topic #1), and is equitable to all (Topic #3).
Clinicians are burdened not just by variations on policies implemented by mulitple payers and programs. Wasteful administrative costs account for up to 15 percent of the nation's total healthcare spending, translating to anywhere from $285 billion to $570 billion a year, new research finds.	All-payer synchronization should be the goal wherever possible, for example using the same quality measures, designing a single website that could populate every application and form that providers must complete, and implementing an all-payer claims clearinghouse.
APG members believe that the best option for patients and providers are delegated full-risk arrangements where groups take full accountability for the quality and total cost of care.	CMS should explore options to allow and encourage more opportunities for providers to participate in delegated risk arrangements.
Amid the ongoing provision of low-value care, Medicare Advantage's various utilization management (UM) strategies, including prior authorization, direct expenditures to high-value providers practicing evidence-based care, and away from procedures, drugs, and other interventions that do not improve patient outcomes. However, prior authorization too often proves to be a burden on front-line providers.	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.

Topic 3: Advancing Health Equity

Comments	Recommendations
APG members, particularly those in delegated arrangements, are highly incentivized to address care disparities and already undertake a variety of strategies to address the needs of marginalized populations.	CMS should allow providers at risk for quality and for the total costs of care more leeway to tailor benefits to meet the needs of marginalized patients.
APG recognizes that expanded data collection and reporting that encompasses greater detail on beneficiary characteristics is integral to CMS's efforts to address health inequities. However, increasing data collection expectations places additional burden on front-line clinicians while they are already facing burn-out and workforce shortages.	As CMS begins the process of measuring organizations' performance on health disparities by collecting data, the agency should ensure that any new demands on front-line clinicians' time are levied as judiciously as possible, that all collected data are actionable, and that collection instruments are standardized. Providers that accept responsibility for the quality and total cost of care should be credited and rewarded for the adoption of internal race,

	ethnicity, and gender recognition tracking systems, similar to past projects that provided incentives for the adoption of EMR technology, population health systems, and meaningful use. Rapid and broad-based adoption of this type of tracking will aid health plans and CMS in improved measurement of disparities reduction.
Disparities impact all healthcare programs, providers, and patients.	CMS should create consistency in the health equity measures that are applied across the Medicare program. CMS should also work to standardize requirements, measures, and other features across programs and payers.
Existing quality measures may reinforce some inequities.	CMS should review existing and proposed quality measures for potential bias.
Use of the Area Deprivation Index (ADI) in the Medicare Shared Savings Program (MSSP) to determine which beneficiaries live in areas with high levels of socioeconomic deprivation, as proposed in the 2023 Medicare Physician Fee Schedule and MSSP proposed rule, raises concerns for APG and its members.	CMS should continue to refine and test use of the ADI, including comparing alternatives and potentially designing a blend of the ADI with other indices, in this context before settling on one definitive process for determining advance-investment payments (AIPs).
Comments on Second Section	
Current reimbursement rates in traditional Medicare and Medicare Advantage in certain geographic areas are insufficient to attract and retain physicians and other clinicians. When physicians and other clinicians move to areas where pay is better matched to the local cost of living, it is the beneficiaries in the abandoned areas, especially disadvantaged beneficiaries who already lack adequate access to care, who suffer.	When considering physician pay rates, which are currently at risk of significant cuts, policymakers must consider not just the extent to which pay rates are adequate on average but also the impact of geographic differences. We recognize that this will require a change in legislation, but we are flagging this to CMS because it is a real problem affecting beneficiaries.

Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

Comments on First Section	Recommendations
Many of the flexibilities implemented in response to the COVID-19 PHE have proven to be instrumental in maintaining beneficiaries' access to and quality of care. As we look ahead to the eventual end of the PHE, it is important to remember that public health emergencies have long been and will continue to be a way of life for many Medicare beneficiaries and providers.	APG supports CMS' codification of the 151-day extension on telehealth flexibilities, as proposed in the 2023 Medicare Physician Fee Schedule and MSSP proposed rule, and encourages the agency to continue to work with Congress on finding permanent solutions, particularly for audio-only telehealth and regardless of the beneficiary's location. While Congress continues to weigh the future of other flexibilities implemented during the PHE, we recommend that CMS use its regulatory authority to extend as many flexibilities as possible.

We note that many of the concerns raised by critics of the flexibilities are addressed in situations where ACOs and other organized care providers that accept risk for total cost of care and the quality of patients' outcomes. When providers are reimbursed through capitation rather than fee-for-service, there is no incentive to provide unneeded telehealth visits.	For flexibilities that are not extended broadly within the Medicare program, we recommend that CMS and CMMI use their authority to extend them for organizations that are fully accountable for the quality and total cost of care.
Flexibilities related to scope of practice, hospital at home, and others are as important as telehealth.	CMS should review and include all types of flexibilities in their extension efforts. We recommend that CMS extend the Hospital at Home program while developing a more extensive and defined permanent program, which should build on the success of current efforts and refine various characteristics, for example by not requiring patients to first go to the Emergency Department to be eligible for the program.
Flexibilities that have allowed audio-only telehealth services and the relaxation of HIPAA rules have been tremendously beneficial in maintaining access to and continuity of care, especially for mental health services.	CMS should extend audio-only and HIPAA flexibilities. As we requested in our response to the 2023 Medicare Physician Fee Schedule and MSSP proposed rule, APG asks that CMS reconsider the implementation of its in-person visit requirement for telehealth mental services.
While not yet permitted, allowing MA plans to collect diagnoses during audio-only telehealth visits would prevent any disincentive for providing audio-only services when patients prefer this choice or do not have the means to access audio-video telehealth.	CMS should allow the collection of diagnoses for risk adjustment via audio-only telehealth.
Potentially denying Medicare beneficiaries services that are of benefit to them and that they have had access to for going on three years because policymakers fear that the government will not be able to protect against fraud and abuse for these services as they do for others is unprecedented and perverse.	CMS should address any risk of fraud and abuse associated with extending beneficial flexibilities beyond the PHE through expansions to existing CMS programs and allow leeway for providers at risk quality and for the total costs of care.

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

In its comprehensive Request for Information (RFI), CMS seeks public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE). The agency indicates that it plans to use the comments received in response to this RFI to identify potential opportunities for improvement and increased efficiencies across CMS policies, programs, and practices. In addition, CMS hopes to learn how specific policies have benefited providers, practices, and the people served by the agency as it works to continually improve its programs.

IV. Topic 1: Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. The RFI requests personal perspectives and experiences, including narrative

anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across all CMS programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Marketplace, and the CMS Innovation Center models. CMS also requests recommendations for how the agency can address these challenges through its policies and programs.

APG response:

Patients often struggle to understand the myriad of choices they face in terms of signing up for health plans, programs, and models. Information about these choices is often so complex that healthcare professionals report challenges in assisting family members with these decisions. APG members regularly take time to help patients choose between health plans and other options. "There is nothing worse than a poorly informed patient making a poor choice" among available options, as one of our members put it.

APG members believe that CMS should do more to encourage longer-term, more accountable relationships among enrollees, providers, and plans and other programs once enrollees have selected plans and programs 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 (MA) enrollment.[1] 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."

APG members also want the accountable relationships with their patients to serve as a foundation for encouraging them to be more engaged in their care. However, plans and provider organizations are constrained by CMS rules about marketing to beneficiaries. Members would like to do more to reach out to patients who need to come in for an annual wellness visit, get caught up with vaccinations, and schedule other needed care, but are concerned about running afoul of CMS' marketing proscriptions. Even when permission is granted, it takes time to have materials reviewed and approved. These rules should be relaxed, especially for ACOs and any models like Primary Care First that are designed to manage and coordinate care for beneficiaries. CMS could do more to support these efforts in the agency's communications with beneficiaries. For example, Medicare sends emails to beneficiaries encouraging them to get vaccines. It would be more helpful for beneficiaries if those emails suggest calling your doctor if you have questions and include the individual's doctor's name and phone number. Tailored communications like this could help to avoid situations where patients delay coming in for routine care and develop worse symptoms and poorer outcomes, as has unfortunately occurred during the ongoing COVID-19 public health emergency (PHE).

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.

On the role of telehealth, APG members believe that the expanded telehealth and scope of practice capabilities during the PHE have been essential in meeting care needs, particularly of populations in underserved areas. Continuing these flexibilities after the PHE ends could greatly contribute to helping to maintain patients'

[1] Coleman K, CMS memo, Oct. 8, 2021, accessed at https://medicareadvocacy.org/wp-content/uploads/2021/11/Third-Party-Marketing-Memo-10-8-2021.pdf

access to and continuity of care. (See additional comments and recommendations regarding PHE flexibilities under Topic 4.) CMS should allow the use of telehealth to fulfill network adequacy requirements for MA plans. Together these changes 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.

Ensuring that patients have adequate access to healthcare begins with ensuring there is a sufficient healthcare workforce. As an APG member observed, providers realize that patients lack access to the care they need, "but what are you going to do when you can only see so many patients in a day?" (See additional comments and recommendations regarding provider workforce under Topic 2.)

APG recommendations:

- CMS should reward plans and providers for doing more to engage patients in careful decision-making around plan and program selection — for example, by reflecting tailored patient engagement measures of this type in the Star ratings. In the context of MA plans, CMS should provide incentives for provider groups to help beneficiaries choose the plan best suited to their needs.
- CMS should do more to encourage longer-term, more accountable relationships among enrollees, providers, and plans and other programs once enrollees have selected plans and programs most appropriate to their needs.
- Rules that restrict marketing should be relaxed, especially for ACOs and any models like Primary Care First that are designed to manage and coordinate care for beneficiaries. CMS could also support these efforts in the agency's communications with beneficiaries. For example, Medicare sends emails to beneficiaries encouraging them to get vaccines. It would be more helpful for beneficiaries if those emails suggest calling your doctor if you have questions and include the individual's doctor's name and phone number.
- Given the urgency of the crisis, CMS should deploy its regulatory authority to fullest extent possible with respect to the provision of mental and behavioral health, including ensuring that MA plans have adequate provider networks, driving more integration of behavioral and primary health care, adding waivers to Innovation Center models that would allow groups that take full responsibility for the quality and cost of care to employ care teams composed of both licensed clinicians and community health workers, and including similar options in the Medicare Shared Saving Program through rulemaking.
- CMS should use its regulatory authority to continue as many telehealth and other flexibilities as possible and encourage specialists and underserved patients to use them.
- See additional comments and recommendations regarding provider workforce under Topic 2.

V. Topic 2: Understanding Provider Experiences

CMS seeks a better understanding of the factors impacting provider well-being and the supply and distribution of the healthcare workforce. In particular, the RFI requests comments on the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, and communications on provider experiences. CMS also requests recommendations for policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.

APG response:

Administrative burden and workforce shortages go hand in hand. Providers have identified these issues as top concerns and asked CMS to address them for years. The burnout resulting from leaving these problems to worsen has left many providers to question why CMS continues to ask for input on these issues, rather than taking action to address them. As APG member, Dr. Colleen Inouye of the Hawaii Independent Physicians

Association observed "physicians want to take care of their patients, and they would like to enjoy it and some of that joy has been taken away."

As policymakers have adopted new ideas to improve healthcare, such as adopting quality measures, testing various ideas through Innovation Center models, and addressing disparities, the resulting policies place additional burdens on providers. Often providers must hire outside consultants or expand their administrative team to handle the additional work. As CMS develops the rules for each new policy, the agency should consider the impact on providers for each of the topics included in this RFI, especially for smaller practices and those that serve marginalized communities. CMS should carefully consider if each new policy will place additional burdens on providers (Topic #2), impact patients' access to care (Topic #1), and is equitable to all (Topic #3).

Clinicians are burdened not just by policies implemented by CMS, but by variations on policies implemented by other payers and programs as well. Wasteful administrative costs account for up to 15 percent of the nation's total healthcare spending, translating to anywhere from $285 billion to $570 billion a year, new research finds.[2] All-payer synchronization should be the goal wherever possible, for example using the same quality measures, designing a single website that could populate every application and form that providers must complete, and implementing an all-payer claims clearinghouse.

APG members believe that the best option for both patients and providers are delegated full-risk arrangements where groups take full accountability for the quality and total cost of care. Arrangements such as these allow for revenue streams to providers that support a holistic care spectrum that is integral to delivering high-quality, patient-centered care that lowers total costs while improving health outcomes and advancing equity. Providers who opt for delegated full-risk arrangements observe a powerful effect of swapping the frustrations and perverse incentives of fee-for-service healthcare for an approach designed to both incentivize physician groups to improve care and provide 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.

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.[3] Because of various utilization management (UM) strategies, Medicare Advantage 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. Prior authorization requirements are an important element of this broad UM toolbox. However, prior authorization too often proves to be a burden on front-line providers. Even when providers are forced to hire administration staff to manage prior authorizations, they still must devote time themselves to these activities, taking time away from direct patient care. Thus, 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.

[2] "Research Brief: Administrative Waste's Role In Excess US Health Spending", Health Affairs Forefront, October 6, 2022. DOI: 10.1377/forefront.20221005.831062

[3] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA.* 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

APG recommendations:

- CMS should act to address administrative burden and workforce shortages rather than continuing to ask for input on these issues. If needed, CMS should consider creating a task force comprised of clinicians to develop a plan for addressing these issues.
- CMS should carefully consider if each new policy will place additional burdens on providers (Topic #2), impact patients' access to care (Topic #1), and is equitable to all (Topic #3).
- All-payer synchronization should be the goal wherever possible, for example using the same quality measures, designing a single website that could populate every application and form that providers must complete, and implementing an all-payer claims clearinghouse.
- CMS should explore options to allow and encourage more opportunities for providers to participate in delegated risk arrangements.
- 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.

VI. Topic 3: Advancing Health Equity

CMS wants to further advance health equity across programs by identifying and implementing policies that may help eliminate health disparities. The agency wants to better understand individual and community-level burdens, health-related social needs, and strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

CMS also wants to understand the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs.

CMS requests recommendations for how the agency can promote efficiency and advance health equity through policies and programs.

APG response on first section:

APG members, particularly those in delegated arrangements, already undertake a variety of strategies to address the needs of marginalized populations. 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."

Effectively reducing health disparities and reaching out to underserved communities requires providers to be able to bring services to people in their homes, such as providing internet services or electronic tablet, which requires supplemental benefits, flexibilities, or waivers. Some of these are in place for ACO REACH, MSSP, and MA, but many are set to expire with the end of the PHE, and in other scenarios Medicare regulations prevent these services.

APG members believe that CMS can do even more to encourage approaches that will advance health equity. Specifically, CMS should allow ACOs and other organizations that take full risk for total cost or care and the quality of patients' outcomes, as well as providers in delegated arrangements with MA 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 MA 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 or according to rules designed for fee-for-

service Medicare since patients' physicians have a window into individuals' medical and social needs that health plans and CMS cannot capture from coding and claims.

APG recognizes that expanded data collection and reporting that encompasses greater detail on beneficiary characteristics is integral to CMS's efforts to address health inequities. Medicare Advantage, states, and other payers are also building out their data collection and reporting efforts in pursuit of improving health equity. All of these new and expanded data collection efforts rely on front-line physicians and other clinicians taking time to ask questions of patients and to enter this information into tracking systems. Our members are eager to address health inequities, but given the multiple demands on front-line staff, want to ensure that any new demands on their time are levied as judiciously as possible. Active participation will be enhanced if front-line clinicians have confidence that payers will use collected information to change the communities they serve through an increase in resources and flexibilities where needed, resulting in better outcomes for marginalized patients. In addition, 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.[4] CMS should mandate that all states have fully functional health information exchanges (HIEs) in place by January 2024.

Disparities impact all aspects of healthcare, and no payer, plan, or program is insulated from these effects. As noted above, APG members already focus on addressing inequities and welcome CMS's goal of embedding health equity in every aspect of CMS Innovation Center models. But just as increased data collection efforts put additional burdens on clinicians' extremely limited time, learning and complying with multiple health equity efforts, introduces burdensome inefficiencies.

Existing quality measure can reinforce disparities by driving attention and services to conditions that are more prevalent among majority populations and diverting efforts from conditions that have a greater impact on minority groups. For example, gastrointestinal cancers are more prevalent among Asian populations, but are largely ignored by cancer-related quality measures that focus on breast and prostate screenings.

Although many researchers in the field of the social determinants of health believe that the Area Deprivation Index (ADI) is the best tool currently available to account for levels of neighborhood socioeconomic disadvantage, use of the ADI in the context adopted by CMS has not been appropriately evaluated and validated. Providers in both California and New York note that the ADI does not accurately depict levels of deprivation in areas within their states and regions. As an example, the Tenderloin district of San Francisco has a high overall ADI, despite the growing presence of luxury housing in the area, so that use of the ADI to "label" the neighborhood as socioeconomically disadvantaged will paradoxically capture high-income populations in the calculation.

APG response on effect of provider departure and removal:

Current reimbursement rates in traditional Medicare and Medicare Advantage in certain geographic areas (e.g., Hawaii and Puerto Rico) are insufficient to attract and retain physicians and other clinicians. When physicians and other clinicians move to areas where pay is better matched to the local cost of living, it is the beneficiaries in the abandoned areas, especially disadvantaged beneficiaries who already lack adequate access to care, who suffer. When considering physician pay rates, which are currently at risk of significant cuts,

[4] Common Agreement for Nationwide Health Information Interoperability, Version 1. The Office of the National Coordinator for Health Information Technology, January 2022. Accessed at https://www.healthit.gov/sites/default/files/page/2022/01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf

policymakers must consider not just the extent to which pay rates are adequate on average but also the impact of geographic differences.

APG recommendations

- As we recommended in our response to the MA RFI, CMS should allow providers at risk for quality and for the total cost of care more leeway to tailor benefits to meet the needs of marginalized patients.
- As CMS begins the process of measuring organizations' performance on health disparities by collecting data, the agency should ensure that any new demands on front-line clinicians' time are levied as judiciously as possible, that all collected data are actionable, and that collection instruments are standardized.
- Providers that accept responsibility for the quality and total cost of care should be credited and rewarded for the adoption of internal race, ethnicity, and gender recognition tracking systems, similar to past projects that provided incentives for the adoption of EMR technology, population health systems, and meaningful use. Rapid and broad-based adoption of this type of tracking will aid health plans and CMS in improved measurement of disparities reduction.
- CMS should create consistency in the health equity measures that are applied across the Medicare program. CMS should also work to standardize requirements, measures, and other features across programs and payers.
- CMS should review existing and proposed quality measures for potential bias.
- As we recommended in our response to the 2023 Medicare Physician Fee Schedule and MSSP proposed rule, CMS should continue to refine and test use of the ADI, including comparing alternatives and potentially designing a blend of the ADI with other indices, in this context before settling on one definitive process for determining advance-investment payments (AIPs). APG is disappointed in CMS' recent decision to finalize the ADI and urges the agency to continue evaluate the ADI and explore alternatives.
- When considering physician pay rates, which are currently at risk of significant cuts, policymakers must consider not just the extent to which pay rates are adequate on average but also the impact of geographic differences. We recognize that this will require a change in legislation, but we are flagging this to CMS because it is a real problem affecting beneficiaries.

VII. Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

The RFI asks about the impact of waivers and flexibilities issued during the COVID-19 PHE to identify areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

CMS requests recommendations for policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

APG response:

Many of the flexibilities implemented in response to the COVID-19 PHE have proven to be instrumental in maintaining beneficiaries' access to and quality of care. As we look ahead to the eventual end of the PHE, it is important to remember that public health emergencies have long been a way of life for many Medicare beneficiaries and providers, from hurricanes and floods on the coasts, to hurricanes in the heartland, to wildfires in the West, and snow and ice storms in cities and rural areas throughout the country. HHS has and will continue to declare PHEs that allow the resumption of flexibilities that have been relied on during the COVID pandemic. However, just as the pandemic has highlighted existing disparities in our healthcare system, it has also brought attention to the reality that beneficiaries face community, family, and personal emergencies that do not rise to the level of official PHEs. Local hospitals, emergency rooms, and other essential providers close down. People

lose their homes or means of transportation. Even fairly common inconveniences, like stormy weather or a bout of influenza can present outsized challenges to accessing healthcare in person for beneficiaries managing chronic conditions.

APG members and the beneficiaries that they serve have found the array of flexibilities to be of tremendous benefit in maintaining continuity of care. The uncertainty of their future presents significant questions about ongoing investment in and development of programs that rely on these flexibilities. We note that many of the concerns raised by critics of the flexibilities are addressed in situations where ACOs and other organized care providers that accept risk for total cost of care and the quality of patients' outcomes. When providers are reimbursed through capitation rather than fee-for-service, there is no incentive to provide unneeded telehealth visits. And when providers are held accountable for the quality of care that their beneficiaries receive, there is a strong incentive to opt for the best mode of access, care team members, and mix of services for each patient. In fact, delegated risk models offer the ideal environment for equipping providers with continued PHE flexibilities so that they can draw on these tools as needed to tailor care to the unique needs of each of their patients.

Flexibilities that have allowed audio-only telehealth services and the relaxation of HIPAA rules have been tremendously beneficial in maintaining access to and continuity of care, especially for mental health services. Given the ongoing nationwide mental health crisis, we cannot afford to abandon any strategies that have proven effective at matching patients in need with available providers. These flexibilities actually help to address health disparities by allowing people who do not have a smart phone, computer, or tablet with video capabilities or who have poor connectivity to participate in telehealth. Most people have at least a basic cell phone or land line that allows them to access their providers by audio-only telehealth.

While not yet permitted, allowing MA plans to collect diagnoses during audio-only telehealth visits would prevent any disincentive for providing audio-only services when patients prefer this choice or do not have the means to access audio-video telehealth. APG is disappointed in CMS' recent decision to not extend this option beyond the PHE and urge the agency to reconsider.

Telehealth flexibilities receive the most attention, but many other flexibilities have been important and interact with telehealth. Numerous flexibilities have broadened the scope of practice for non-physician practitioners and relaxed physician supervision of training physicians and other members of the medical team. The Hospital at Home waiver has allowed health systems to invest in programs that allow eligible beneficiaries to receive the same level of acute inpatient and post-acute care that they would typically have to be admitted to a facility to receive in their homes.

Policymakers have already made some of the flexibilities permanent features of the Medicare program and have extended some others beyond the end of the official PHE. Yet many flexibilities remain in limbo, with beneficiaries and providers who have come to rely on them uncertain of their future. Critics have raised concerns about the risk of overuse and fraud and abuse. However, these risks are not unique to the flexibilities extended during the PHE. In fact, CMS has established process for maintaining beneficiaries' access to goods and services that have been deemed to be high-risk while policing bad actors. Potentially denying Medicare beneficiaries services that are of benefit to them and that they have had access to for going on three years because policymakers fear that the government will not be able to protect against overuse and fraud and abuse for these services as they do for others is unprecedented and perverse.

APG recommendations:

- APG supports CMS' codification of the 151-day extension on telehealth flexibilities included in the 2023 Medicare Physician Fee Schedule and MSSP final rule. However, APG is disappointed in CMS' recent decision to not extend an audio-only telehealth option beyond the PHE and urges the agency to reconsider and to

continue to work with Congress on finding permanent solutions, particularly for telehealth provided via audio-only technology and regardless of the beneficiary's location.

- While Congress continues to weigh the future of other flexibilities implemented during the PHE, we recommend that CMS use its regulatory authority to extend as many flexibilities as possible.
- We recommend that CMS extend the Hospital at Home program while developing a more extensive and defined permanent program, which should build on the success of current efforts and refine various characteristics, for example by not requiring patients to first go to the Emergency Department to be eligible for the program.
- For flexibilities that are not extended broadly within the Medicare program, we recommend that CMS and CMMI use their authority to extend them for organizations that are fully accountable for the quality and total cost of care.
- CMS should review and include all types of flexibilities in their extension efforts.
- CMS should extend HIPAA flexibilities.
- As we requested in our response to the 2023 Medicare Physician Fee Schedule and MSSP proposed rule, APG asks that CMS reconsider the implementation of its in-person visit requirement for telehealth mental services.
- CMS should allow the collection of diagnoses for risk adjustment via audio-only telehealth.
- CMS should address any risk of overuse and fraud and abuse associated with extending beneficial flexibilities beyond the PHE through expansions to existing CMS programs and allow leeway for providers at risk quality and for the total cost of care.

VIII. Conclusion

The Medicare program is significantly shaped by the four topics that CMS seeks stakeholder input on: beneficiaries' access to healthcare, provider experiences, health equity, and the waivers and flexibilities provided in response to the COVID-19 PHE. Value-based care arrangements where providers take responsibility for quality and total cost of care offer a far more promising path for addressing these issues than traditional fee-for-service Medicare. Given that CMS has a goal of having all Medicare beneficiaries in accountable relationships by 2030, we encourage the agency to harness the power of these accountable entities by granting them additional flexibilities.

Sincerely,

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