September 8, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Comments on the CY 2024 Medicare Physician Fee Schedule Proposed Rule [File code CMS-1784-P]

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) "Calendar Year 2024 Physician Fee Schedule Proposed Rule" that was published in the Federal Register on August 7, 2023.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work on provider payment reform aims to re-orient the health care system toward delivering higher quality, less costly care that improves health outcomes. A primary focus is accelerating the adoption of accountable care organizations (ACOs), which give providers greater flexibility to deliver the care their patients need while holding them accountable for quality and total cost of care. ACOs are a promising alternative to fee-for-service payment, which often results in inefficient and inequitable care.

We want to thank the agency for its important work to improve the Medicare Shared Savings Program (MSSP) and the Medicare Physician Fee Schedule (MPFS), given your many competing priorities, and for the opportunity to provide input. Our comments focus on proposed changes to the MSSP and MPFS including:

- Revisions to the MSSP benchmarking methodology, including removing the negative regional adjustment;
- Changes to beneficiary assignment under the MSSP to increase program participation;
- The request for comments on the future development of the MSSP, including incorporating a hybrid capitated payment for primary care; and
- Implementation of the evaluation and management (E/M) visit complexity add-on and request for comment on evaluating E/M services more accurately and comprehensively.

Proposed Changes to the Medicare Shared Savings Program (MSSP)

The MSSP has demonstrated the ability to generate modest net savings while maintaining or improving quality. CMS has a key opportunity to build on the successes of the MSSP, including by increasing participation and strengthening incentives for ACOs to reduce Medicare spending.

Arnold Ventures is supportive of the MSSP changes in the proposed rule, including improvements to the benchmarks to strengthen incentives for providers to join or remain in the program, particularly for high-cost providers, and changes to increase the number of Medicare beneficiaries attributed to ACOs. While we support the proposed benchmarking changes, we view them as short-term solutions. To that end, we encourage the Administration to set a long-term vision that moves the MSSP towards administrative benchmarks and to contemplate additional strategies to increase participation among high-cost providers, who have a greater opportunity to reduce spending. Arnold Ventures supports the changes to beneficiary assignment, which will increase the assignable population and better reflect ACOs' team-based care model and use of non-physician providers. **Lastly, we appreciate the opportunity to provide feedback on the future of the MSSP and urge CMS to implement a hybrid capitated payment model for primary care providers in the MSSP.**

Proposal to Mitigate the Impact of the Negative Regional Adjustment on the Benchmark

The methodology for setting benchmarks is fundamental to the success of the MSSP. Benchmarks should be designed to encourage and sustain participation while also creating strong savings incentives, a challenging balance given the voluntary nature of the program. Encouraging providers with higher spending to join and remain in the MSSP is particularly important because high-cost ACOs (ACOs with spending above regional averages) represent the greatest potential for Medicare savings. The evidence suggests that high-cost ACOs have generated significantly more savings for Medicare than low-cost ACOs (ACOs with spending below regional averages).[1,2]

However, MSSP participation has increasingly shifted to low-cost ACOs. After the introduction of regional adjustments to the benchmarks, which subject high-cost ACOs to negative adjustments and enable low-cost ACOs to receive an upward benchmark adjustment, a large share of high-

[1] J. Michael McWilliams and Alice J. Chen. Understanding The Latest ACO "Savings": Curb Your Enthusiasm and Sharpen Your Pencils—Part 1. Health Affairs Forefront. November 12, 2020.
[2] J. Michael McWilliams, Laura A. Hatfield, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. Early Performance of Accountable Care Organizations in Medicare. New England Journal of Medicine, 374(24). June 2016.

cost ACOs exited the program.[3,4] This evidence of selective participation in the program raises two concerns. First, it generates costs to the Medicare program because low-cost ACOs can achieve shared savings without reducing spending. Second, it reduces the likelihood that high-cost ACOs participate in the MSSP even though these ACOs have the greatest potential to reduce spending and generate savings to Medicare.

In the CY 2023 MPFS Rule, CMS finalized a proposal to reduce the negative regional adjustment to improve incentives for high-cost ACOs to enter and remain in the program. In this rule, CMS proposes to fully eliminate the negative regional adjustment. **Arnold Ventures supports the removal of the negative regional adjustment as a near-term solution for addressing selective participation in the MSSP.** This change will incrementally increase benchmarks for high-cost ACOs, which will encourage their participation and enable larger aggregate savings to Medicare. If finalized, CMS estimates that removing the negative regional adjustment will increase participation by ten percent and generate nearly $500 million in net savings over ten years.[5]

While Arnold Ventures supports this proposed change, it represents a short-term solution and does not address the remaining issues caused by the positive regional adjustment, which will continue to favor low-cost ACOs.[6] Additionally, to increase the long-term effectiveness of the MSSP, CMS will need to address structural issues with the benchmarks, such as the reliance on an ACO's historical spending which becomes increasingly stale over time and the ratchet effects created when ACOs successfully reduce spending.

We urge the Administration to develop a long-term vision for benchmarks that relies on an administrative benchmarking approach. While not without their own set of challenges, administrative benchmarks have the potential to increase participation in the MSSP and strengthen incentives to save over the long term. Administrative benchmarks allow for the creation of a payment differential or "wedge" between observed fee-for-service spending and ACO spending.[7] Unlike benchmarks that rely on historical spending, this approach can create

[3] Michael McWilliams, Bruce E. Landon, Vinay K. Rathi, and Michael E. Chernew. Getting More Savings from ACOs: Can the Pace be Pushed? New England Journal of Medicine, 380(23). June 2019.
[4] Peter Lyu, Michael E. Chernew, and J. Michael McWilliams. Benchmarking Changes And Selective Participation In The Medicare Shared Savings Program. Health Affairs. May 1, 2023.
[5] Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS). CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1784-P). August 7, 2023.
[6] Medicare Payment Advisory Commission. MedPAC Comment on CMS's Proposed Rule on CY 2023 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. September 2, 2022.
[7] J. Michael McWilliams, Alice Chen, and Michael E. Chernew. From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-based Payments. USC-Brookings Schaeffer Initiative for Health Policy. October 13, 2021.

better incentives for long-term participation by allowing ACOs to share in the savings and continually benefit from their greater efficiency while ensuring long-term savings potential for the government. We also encourage CMS to contemplate additional policies they could implement administratively to increase the negative financial consequences of opting out of the MSSP, which would incentivize greater participation beyond benchmarking changes.

Determining Beneficiary Assignment Under the MSSP

Accurate patient attribution is important for the success of MSSP participants and for increasing the share of traditional Medicare beneficiaries in ACOs. Under current policy, CMS assigns beneficiaries to ACOs based on their use of certain primary care services delivered by an ACO physician in the past 12 months. In this rule, CMS proposes expanding the assignment window, attributable providers, and definition of primary care services to capture additional beneficiaries. Under the proposal, beneficiaries may be assigned to an ACO if they received at least one primary care service with a *non-physician* ACO provider, such as a nurse practitioner or physician assistant, in the past 12 months *and* they received at least one primary care service from an ACO physician in the past 24 months. The proposed rule would also expand the services that are considered primary care for the purpose of assigning beneficiaries to an ACO.

Arnold Ventures supports improvements to the assignment methodology which will enhance program participation and increase the size of the assignable population. CMS estimates that the proposed changes could grow the assignable population by almost 3 percent and enable more ACOs to meet minimum size requirements to participate in the MSSP.[8] In addition, the changes will better reflect ACOs' team-based care approaches that leverage non-physician providers to manage population health and costs.[9]

Comments on Potential Future Developments to MSSP Policies

In this rule, CMS discusses the option of strengthening primary care within the MSSP by "providing prospective payments to primary care providers that would reduce reliance on fee-for-service payments."[10] **Arnold Ventures strongly urges CMS to use its authority to implement a hybrid capitated payment model that incorporates a prospective monthly per-beneficiary payment for primary care providers in the MSSP.** A diverse group of stakeholders including

[8] Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS). CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1784-P). August 7, 2023.
[9] Shana F. Sandberg and Clese Erikson. Evolving Health Workforce Roles in Accountable Care Organizations. The American Journal of Accountable Care. June 12, 2017.
[10] Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS). CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1784-P). Page 672. August 7, 2023.

health policy experts, primary care providers, and ACOs have called for CMS to use its existing authority to implement capitated primary care payments as an option within the MSSP.[11,12,13]

A key challenge with fee-for-service is that it fails to give primary care providers flexibility to deliver high-quality, patient-centered care. Even within ACOs, primary care providers receive fee-for-service payments, which incentivize them to focus on reimbursable services and visit volume and run contrary to the value-based incentives of the ACO to manage costs and improve population health. Implementing an optional track with hybrid capitated payments for providers within the MSSP would better position primary care providers to deliver more comprehensive, personalized, and equitable care.[14] In a landmark 2021 report on implementing high-quality primary care, the National Academy for Science Engineering and Medicine recommended that hybrid capitated payment become the default payment model for primary care and called on CMS to lead the way in transitioning to this model.[15]

The MSSP is the ideal platform for implementing primary care capitation given primary care's central role in supporting population health. Relative to fee-for-service, hybrid capitated payments enable greater flexibility for primary care providers to enact care delivery changes that facilitate successful collaboration between them and ACOs to effectively manage population health and costs. ACOs with advanced primary care models tend to perform better on quality and population health outcomes compared to those without such models, and MSSP ACOs that have more primary care providers and deliver more primary care services have been shown to generate greater savings compared to MSSP ACOs with fewer primary care providers.[16,17,18] Arnold Ventures does not view incorporating a higher-risk track in the MSSP as a substitute for creating a MSSP track with primary care capitation.

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[11] Ann Greiner, Hoangmai H. Pham, and Clif Gaus. An Option for Medicare ACOs to Further Transform Care. Health Affairs Forefront. July 15, 2022.
[12] Ann Greiner et al. A New Approach to Paying for Primary Care in the Medicare Shared Savings Program. NAACOS Blog. April 13, 2023.
[13] Primary Care Collaborative. 27 Organizations, Led by PCC and NAACOS, Urge CMS to Create Primary Care Hybrid Payment Option in MSSP. March 23, 2023.
[14] Mark Del Monte et al; The Commonwealth Fund. Paying Differently for Primary Care for Better Health and Greater Equity. September 12, 2022.
[15] The National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
[16] Center for Medicare & Medicaid Services (CMS). Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 and Continues to Deliver High-Quality Care. CMS.gov. August 30, 2022.
[17] Kelsey Stevens, Dani Cronick, and Hunter Schouweiler. Wakely, an HMA Company. Wakely Risk Insight For the Medicare Shared Savings Program: Performance Year 2021 Results. October 2022.
[18] Patient-Centered Primary Care Collaborative. Advanced Primary Care: A Key Contributor to Successful ACOs. August 2018.

Proposed Changes to the Medicare Physician Fee Schedule (MPFS)

Beyond the MSSP, we appreciate CMS's interest in improving the MPFS. The MPFS has substantial influence on our nation's health care system, determining not just Medicare payments but also influencing other payors' payment determinations. Furthermore, most alternative payment models, the MSSP included, are built on a fee-for-service chassis, so improving the MPFS is critical for increasing value in our health care system.

Arnold Ventures is supportive of the Administration's efforts to more accurately value evaluation and management (E/M) services. We support implementation of the complexity add-on payment and recognize that this change, along with previous adjustments to the relative value unit (RVU) for E/M visits, aim to address the undervaluing of primary care. To further ensure services are accurately valued, we encourage CMS to shift the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) to more of an advisory role and to expand CMS' own data collection efforts to lead the determination of RVUs.

Implementation of the Office/Outpatient (O/O) E/M Visit Complexity Add-on

Under fee-for-service, payment is not always well aligned with the value of services. The fee schedule overvalues certain services while undervaluing others. Historically, the Medicare fee schedule has not accurately valued primary care services and is not structured to support an evolving, comprehensive primary care system. Recognizing these challenges, CMS finalized a separate E/M add-on payment (HCPCS code G2211) to help cover the costs for more complex, longitudinal care in the CY 2021 final rule, and significantly increased the RVU for E/M visits. However, to prevent a conversion factor decrease amidst the pandemic, Congress suspended the add-on code until January 1, 2024, and there is currently no add-on payment available. In this rule, CMS proposes to implement the separate add-on payment for HCPCS G2211 to better recognize the resource costs associated with E/M visits. HCPCS G2211 would be billed alongside codes for office/outpatient E/M visits to account for the unique and inherent complexity of services provided through longitudinal patient care.

Arnold Ventures strongly supports CMS' effort to compensate primary care providers more accurately for the time and intensity associated with longitudinal care relationships and consistently treating complex needs over time. Strengthening primary care has important impacts for population health and health care costs. Studies find that that better continuity in

primary care reduces mortality, health care expenditures, and hospitalizations.[19,20] Evidence suggests that the average length of primary care visits has remained short, yet the complexity of care has increased. Technological advances and the need to screen for and manage behavioral and social needs has increased the workload for primary care providers.[21] Implementing the G2211 add-on code continues CMS' efforts to realign the fee schedule to accurately value primary care and reflect the current costs incurred by primary care providers.

We are also supportive of the guardrails included in the proposed rule to ensure the new add-on code is applied for the most appropriate visits. Under the proposal, code G2211 will not be payable when an E/M visit occurs on the same day as another minor procedure or service. CMS also emphasized that many E/M visits will not require the add-on code because no long-term, complex care needs will be addressed. Additionally, certain types of providers unlikely to have a longitudinal care relationship should not be using the add-on code. CMS previously assumed code G2211 would be reported with 90% of all office/outpatient E/M services. Under the current proposed rule, CMS assumes the add-on code will only be reported with 38% of all visits initially and 54% of visits when fully adopted.[22] These guardrails ensure appropriate, accurate payment of providers and reflect primary care providers' longitudinal care relationships with patients.

Comments about Evaluating Services More Accurately and Comprehensively:

In this proposed rule, CMS seeks additional input on different approaches to improve the accuracy of valuing services, particularly E/M services. Determining accurate, appropriate payments for providers requires robust data collection and increased information gathering by CMS. Under current policy, CMS determines values of services based on recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), an expert panel with substantial influence on relative values and, subsequently, physician payment. Unfortunately, there are structural flaws with the RUC that undermine the accuracy of its recommendations, including inherent conflicts of interest among RUC members and a reliance on surveys from medical societies that lead to overvaluation of certain specialty services.[23]

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[19] Richard Baker et al. Primary Medical Care Continuity and Patient Mortality: A Systematic Review. British Journal of General Practice. September 2020.
[20] Andrew Bazemore et al. Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations. Annals of Family Medicine. November 2018.
[21] Mark Linzer et al. The End of the 15-20 Minute Primary Care Visit. Journal of General Internal Medicine. November 2015.
[22] Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS). CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1784-P). August 7, 2023.
[23] GAO. Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy. GAO-15-434. May 21, 2015.

Furthermore, current CMS processes for valuing services lack external validation and do not leverage a diverse, evolving data set which would be more accurate and comprehensive.

Arnold Ventures urges CMS to shift to a more comprehensive, data-based system for determining code valuations and to initiate new, independent data collection to validate RVUs. We recognize that CMS cannot change the RUC's structure, but CMS should supplement the RUC's recommendations with additional research and external data. This would position CMS to more actively lead the determination of relative values, with consultation from the RUC, consistent with expert recommendations.[24, 25] To achieve this goal, Arnold Ventures recommends the following:

- **Implement accurate and ongoing data collection to independently validate RVUs and establish an empirical source of information on time and costs associated with services.**[26, 27, 28] While this will take time to fully implement, CMS should start putting in place the building blocks for a robust data collection infrastructure to shift away from less accurate survey data that is currently gathered by specialty groups and used by CMS. CMS could implement a rotating panel of practices that provide real-time data from a variety of providers. Data provided by the rotating panel could improve the calculation of relative resources to reflect notable differences in cost structures in various practice settings. Code-specific time data from practices would help identify work values that are likely too high.[29]
- **Establish an expert advisory panel within CMS to provide crucial advice on improving valuation processes and ensure independence and transparency**.[30] Even with access to robust empirical data, CMS would still need qualitative assessments from independent experts to inform whether to further modify payment in particular situations. An expert advisory panel, staffed by experts with no financial interests, could supplement the RUC's work by advising CMS on a variety of issues such as data collection priorities, new and

[24] Robert A. Berenson; the Urban Institute. RE: Comment on NPRM Calendar Year 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Requirements, etc. September 2, 2022.
[25] The National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
[26] Maura Calsyn and Madeline Twomey; Center for American Progress. Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services. July 2018.
[27] Stephen Zuckerman et al; The Urban Institute. Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units. December 14, 2016.
[28] Thomas Waldrop, Marquisha Johns, and Sarah Millender; Center for American Progress. How to Improve Value in Medicare. October 26, 2022.
[29] Robert A. Berenson; the Urban Institute. RE: Comment on NPRM Calendar Year 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Requirements, etc. September 2, 2022.
[30] Ibid.

alternative approaches to determining relative values, and opportunities for bundling services. To ensure transparency, advisory panel proceedings should be public.

Conclusion

We appreciate the Administration's commitment to building on the successes of the MSSP. The overall direction of the proposed changes to the MSSP strengthen the program in the short-term and leave opportunities for continued reforms to incentivize greater participation and aggregate program savings in the long-term. We also support proposed changes to increase the size of the assignable population, which will increase the number of beneficiaries attributed to ACOs.

We encourage CMS to continue exploring ways to value primary care services more accurately and support a comprehensive primary care system. We strongly urge CMS to implement a hybrid capitated payment model for primary care within the MSSP, which would better position primary care providers to deliver comprehensive and personalized care. We support implementation of the complexity add-on code to accurately cover the costs of longitudinal primary care relationships. Finally, we recommend CMS begin shifting away from subjective, survey-based recommendations towards independent, empirical data collection to determine code valuations and to ensure more accurate valuing of services, particularly primary care.

Thank you for the opportunity to comment on the proposed rule. Please contact Erica Socker at esocker@arnoldventures.org or Mark Miller, Ph.D., Arnold Ventures' Executive Vice President of Health Care, at mmiller@arnoldventures.org with any questions.

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