**California Public Employees' Retirement System**
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The Honorable Ron Wyden
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

July 3, 2024

**Subject: Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B**

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the California Public Employees' Retirement System (CalPERS), I am writing in response to your request for information (RFI) in the white paper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." We appreciate the Senate Finance Committee's bipartisan efforts to address challenges in Medicare Part B physician payments and improve care for Medicare beneficiaries, particularly individuals with chronic diseases.

CalPERS is the largest commercial health benefits purchaser in California and the second largest commercial purchaser in the nation. We secure health benefits for approximately 1.5 million active and retired state, local government and school employees, and their family members. In 2022, CalPERS enrolled 150,427 members in Medicare Supplement plans and 166,429 in Medicare Advantage (MA) plans.[1] We contract with numerous large health insurance companies to provide our members with a variety of health plan offerings, including health maintenance, preferred provider, and exclusive provider organization (HMO, PPO, and EPO) plans.

We are responding to the RFI's questions on addressing payment update adequacy and sustainability, incentivizing participation in alternative payment models, supporting chronic care in the primary care setting, and ensuring continued access to telehealth.

[1] *See* CalPERS 2022 Health Benefits Program Annual Report, *available at* https://www.calpers.ca.gov/docs/forms-publications/health-benefits-program-annual-report-2023.pdf

Addressing Payment Update Adequacy and Sustainability

1. As an alternative to the current-law updates, how should the conversion factor (CF) be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?

CalPERS mitigates medical trend increases through cost and quality conscious actions such as promoting narrow hospital networks, adding narrow health plan networks, utilizing value-based purchasing including total cost of care guarantees, integrated health models, and increasing competition within the CalPERS insurance marketplace. However, moderating premium trend increases has become more challenging with medical costs rising sharply. For 2024, CalPERS Medicare plan premiums increased by 9.55 percent overall.[2]

CalPERS is pleased that the Committee is exploring policy options that would update the CF in a more predictable manner and by an amount that better accounts for shifts in input costs and other relevant economic dynamics. Greater certainty in future health care costs would help strengthen the ability of our actuarial models to minimize year-over-year fluctuations in rates and premiums.

Incentivizing Participation in Alternative Payment Models

1. Are there other A-APM programmatic designs that would make participation more attractive for providers?

CalPERS is committed to growing participation in alternative payment models (APMs), with a focus on advanced primary care (APC). CalPERS' Chief Health Director serves as a non-voting member of the Health Care Affordability Board in the Office of Health Care Affordability (OHCA) that sets statewide targets for cost growth, adoption of APMs, and primary care spending. We also actively participate in statewide workgroups with our purchaser partners in California to achieve alignment in purchaser and regulator goals around the adoption of APMs and primary care spending targets.

CalPERS has made significant changes to our health plan contracts to promote APC and APM adoption. We require our HMO and PPO health plans to expand the adoption of primary care payment models in order to increase the percent of primary care providers paid through an APM and to align with OCHA's targets. The contract language also includes APM-related reporting requirements using the *Health Care Payment Learning and Action Network Alternative Payment Model*[3] (HCP LAN APM) categories and sub-categories for "service with no link to quality and value," "fee for service with a link to quality and value," and "alternative payment models built on a fee for service structure such as shared savings and population management." The plans must also report on behavioral health care spending and total health care spending.

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[2] *See* CalPERS Announces Health Plan Premiums for 2024 Along With Expanded Cost-Saving Options for Members, *available at* https://www.calpers.ca.gov/page/newsroom/calpers-news/2023/calpers-announces-2024-health-plan-premiums-expanded-cost-saving-options-for-members

[3] *See* APM FRAMEWORK, *available at* https://hcp-lan.org/apm-framework/

As the Committee considers how to support A-APM adoption through intentional programmatic design, understanding the status of APM adoption, both within Medicare and other plans, will be important. The Committee should consider incorporating the HPC LAN APM categories and the other metrics discussed above into Medicare reporting. The HCP LAN categories and subcategories can also be used to create a glidepath for moving from fee-for-service payment to value-based care. The Committee could also consider requiring MA plans to report on the HCP LAN APM categories to better monitor APM activity in Medicare Advantage (the most recent HCP LAN survey only represented 69% of the MA market).

2. How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage Accountable Care Organizations led by independent physician groups and/or with a larger proportion of primary care providers?

Through our coalition relationships and contract requirements, we are working to promote APC adoption. CalPERS urges the Committee to consider emerging evidence on the relationship between primary care spending, especially through APC, and overall quality and cost of care. Based on this evidence, we recommend that the Committee empower Medicare payment models, MA, and other payers to set evidence-based minimum primary care spend requirements that encourage APC adoption.

<u>Supporting Chronic Care in the Primary Care Setting</u>

Access to high-quality primary care is critical for improving population health outcomes, reducing disparities, and slowing health care cost growth. CalPERS believes that payment for primary care should be sufficient to support the adoption and maintenance of APC attributes, including the ability to assess and address patients' behavioral health and social needs. Payment for primary care should also shift away from volume [fee-for-service (FFS)] and toward value (prospective, outcome-based, population-based) and multi-payer alignment on primary care investment, measurement, and value-based payment are essential to strengthening primary care.

CalPERS supports the Committee's efforts to explore establishing a hybrid per beneficiary, per month (PBPM) payment model in FFS Medicare to promote access to primary care. Moving away from FFS payment and toward capitation better aligns payment incentives and supports investments, such as in care management, with the potential to improve clinical quality, patient experience, and health outcomes. We suggest providing transparency regarding primary care payment structure and methods for attributing services to providers so that incentives are clear and there is adequate oversight of that care.

1. Should a hybrid model design include a hybrid-specific risk adjustor for primary care?

CalPERS encourages the Committee to explore a hybrid-specific risk adjustor for primary care. A risk adjustment model that accurately reflects what it costs to care for beneficiaries could help ensure adequate provider payments. We recognize that a concurrent risk adjustment model – that uses conditions diagnosed in the prediction year to predict costs in the same year – may be

appealing for a hybrid model, there are concerns that such a model may incentivize upcoding.[4] The Committee should strive to accurately adjust for health risks and social complexity of patients while limiting gaming.

2. How can such a policy account for quality?

The hybrid model should require participating providers to report a set of primary care-specific quality measures. Using the same quality measures would allow for comparison across providers, reduce the administrative burden associated with reporting, and align with existing measure sets, such as those utilized by the Purchaser Business Group on Health's Advanced Primary Care initiative, or the California Department of Managed Health Care's Quality and Equity measure set. Both of these measure sets utilize National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures in wide use across regulators, purchasers and health plans. These measure sets also focus on measures with high impact on primary care and population health.

CalPERS, in alignment with our purchaser partners in California, adopted a subset of measures on both of these lists and tied significant financial accountability to performance on these measures for our health plans because of their impact on population health outcomes. These measures, known as the Quality Alignment Measure Set (QAMS) and related financial incentives focus on improving care for clinically important conditions for which there are major opportunities for improvement and evidence-based HMOs in 2024.

The QAMS consists of five measures, all of which are nationally endorsed, evidence-based NCQA HEDIS measures:

- Childhood Immunizations
- Controlling High Blood Pressure
- Comprehensive Diabetes Care – Poor Control (HgbA1c >9 percent)
- Colorectal Cancer Screening
- Maternity Care – reflecting a combined score for:
    - Timeliness of Prenatal Care
    - Postpartum Care

In addition to the QAMS, all of CalPERS HMOs and its PPO plans are required to report on the following NCQA HEDIS measures for each of its products:

- Depression Screening and Follow-Up for Adolescents and Adults, and
- Pharmacotherapy for Opioid Use Disorder

CalPERS is utilizing the same measures and the same benchmark – the NCQA-derived national 66th percentile – for both its HMO and its PPO plans, with similar incentive structures. Specifically, for each measure with a result below the benchmark (66th percentile), the PPO

[4] *See* Berenson RA, Shartzer A, Pham HH. Beyond demonstrations: implementing a primary care hybrid payment model in Medicare, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10986246/

plans, administered by both the third-party administrator and the population health management vendor, must each make a payment as outlined below:

- Below 25th percentile: full payment for each measure result
- At or above the 25th to the 65th percentile: payment per measure is assessed proportional to position in that range (sliding scale – meaning, the amount increases the closer it is to the 25th percentile)
- At or above 66th percentile: no measure payment

CalPERS recommends the Committee consider incorporating these quality measures, as appropriate, into the hybrid PBPM payment model.

Ensuring Beneficiaries' Continued Access to Telehealth

CalPERS strongly supports telehealth and other virtual services to expand access and we encourage the Committee to support continued access to telehealth, especially for beneficiaries in rural areas. The telehealth services that were expanded during the COVID-19 pandemic continue to be an important way to supplement members' access to care.[5] Our health plans have demonstrated how useful telehealth can be for both providers and patients, particularly for behavioral health services where there is such a well-documented workforce shortage.

The Committee should ensure that beneficiaries and providers can continue to use telehealth or virtual services where appropriate. While CalPERS and other purchasers can continue to work with our plans to provide telehealth coverage, Medicare is an important driver of payment policies and technology adoption. If Medicare telehealth flexibilities are allowed to lapse, we are concerned that providers may no longer choose to offer telehealth, which could negatively impact access and quality of care across the health care ecosystem.

We thank you for your consideration and we welcome the opportunity to work with you on our shared goal to improve health care affordability. Please do not hesitate to contact Donald Moulds, Chief Health Director, at (916) 795-0404, or Danny Brown, Chief of our Legislative Affairs Division, at (916) 795-2565, if we can be of any assistance.

Sincerely,

Marcie Frost
Chief Executive Officer

[5] *See* CalPERS 2022 Health Benefits Program Annual Report, *available at* https://www.calpers.ca.gov/docs/forms-publications/health-benefits-program-annual-report-2023.pdf