PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

August 10, 2018

The Honorable Mike Kelly
U.S. Representative
1707 Longworth House Office Building
Washington, DC 20515

The Honorable Ron Kind
U.S. Representative
1502 Longworth House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
U.S. Representative
1113 Longworth House Office Building
Washington, DC 20515

The Honorable Ami Bera
U.S. Representative
1431 Longworth House Office Building
Washington, DC 20515

Dear Representatives Kelly, Mullin, Kind and Bera:

Thank you for the opportunity to provide input into the Health Care Innovation Caucus's activities. We applaud your interest in exploring and advancing successful, innovative payment models. Given that the evidence shows that the most successful payment models have been led by physicians, we expect that policies and models that put independent physicians and practices in the "quarterback" role will be a natural area of focus for the Caucus.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association (CMA), Florida Medical Association, Medical Group Management Association (MGMA), and Texas Medical Association.

We believe that physicians – especially independent physician practices – are the lynch pin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. In our vision of the future, independent practice not only survives, but thrives as a result of policies that place them on a level playing field with other providers and opportunities to test new models with components that reflect their unique circumstances.

However, too often the significant role independent physicians play in leading the movement to value-based care is overlooked. Many stakeholders don't realize that independent physicians and practices are able to take risk for their patients, or that independent practices can lead alternative payment models like accountable care organizations (ACOs), often providing higher quality care and generating more savings than other types of models.

For example, a report on the Medicare Shared Savings Program from the HHS Office of Inspector General found that nearly half (45 percent) of physician only ACOs earned savings, and that they were significantly

more likely to do so than other types of ACOs.[1] Other data clearly shows that physician-owned groups achieve better quality at a lower cost than other groups. For example, a 2014 study found that physician-owned practices had 33% fewer preventable readmissions than hospital-owned groups;[2] and a 2013 study found that hospital-based groups have higher rates of hospitalizations and hospital outpatient department visits than smaller groups.[3]

As we strive to transform our health care system, it is critically important for policymakers and stakeholders to hear the voices of independent practices on the front lines of care and to ensure that a range of practice arrangements – including independent practice – are allowed to flourish.

There are a number of opportunities for CMS and Congress to take action to make that a reality. We have three specific recommendations below:

1. **Prioritize physician-led advanced alternative payment models, including physician-led accountable care organizations (ACOs) and other approaches to achieve improved outcomes for patients, greater value, and the preservation of independent clinical practice.**

Models should be accessible to a wide range of physicians, including physicians choosing to remain independent. As you know, physicians practice in large and small offices, in rural and urban settings, and in a variety of different employment arrangements. CMS should consider the unique circumstances of physicians in independent practice when developing models, ensuring that there are options available for this cohort of the workforce and recognizing that certain models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all.

New models should also allow physician practices to assume appropriate financial risk for reducing costs proportional to their finances while offering greater reward over time for practices agreeing to take on more risk. To attract independent practices, risk must be proportional to their finances and not so large as to favor consolidation of practices. An example of a recent model that is calibrated to reflect the financial realities faced by small physician practices is Track 1+, which incorporates risk that is meaningful but not so large as to be an existential threat to a physician's business. CMMI should also provide more predictable and accurate risk adjustment and benchmarks that work for a range of physician practices.

Finally, models should test a range of innovations aimed at encouraging consumers to engage in their care while not imposing substantial new administrative burdens or paperwork requirements on physician practices.

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[1] U.S. Department of Health and Human Services, Office of the Inspector General, "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality," August 28, 2017. Available at: https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp

[2] Casalino et al, "Small Primary Care Physician Practices Have Low Rates of Hospital Admissions," Health Affairs (2014).

[3] McWilliams et al, "Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries," JAMA Intern Med (2013)

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2. **Take action to reduce regulatory incentives that undermine physician independence, create excessive consolidation, and thus drive up costs.**

The primary care physician-patient relationship is most transformative when there is patient choice and provider competition within local markets. We thus support the following to encourage competition in the provider market and ensure patients have adequate provider options:

- Level the playing field for physician practices through policies that create payment parity across practice settings (e.g., facility fees creating higher payment for the same services); and
- Prohibit anti-competitive abuses of market power (e.g., data blocking, anti-tiering provisions, physician non-compete requirements).

3. **Harmonize quality measures across new and existing models to the extent possible.**

CMS should use a parsimonious list of meaningful measures that reduce the burden of reporting. Quality measurement and improvement is of the utmost importance for value-based care, and should be incorporated into all alternative payment models, including physician-led models. We urge CMS to harmonize measures across new and existing models, focusing on those measures that have the greatest impact on patient care.

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Thank you again for the opportunity to provide feedback. We look forward to working with the Health Care Innovation Caucus to advance innovative policy ideas that improve the quality of care and lower costs for consumers. Please do not hesitate to reach out if we can be a resource. I can be reached at kristen@physiciansforvalue.org or 202-640-5942.

Best,

Kristen McGovern
Executive Director