PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

July 30, 2021

The Honorable Patty Murray
Chair, Senate HELP Committee
U.S. Senate
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Frank Pallone, Jr.
Chairman, House Energy & Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Re: Request for Information (RFI) on a Public Health Insurance Option

Dear Chair Murray and Chairman Pallone:

Thank you for the opportunity to respond to the RFI on a Public Health Insurance Option ("Public Option").

Developing a robust, competitive public option is an incredibly complex undertaking with many considerations for the entire health care industry, including independent physicians and practices. Without opining on the broader need or structure of a public option, we offer our thoughts on two such considerations: 1) the role of payment and delivery reform in a public option; and 2) site neutral payment policies that lower costs and facilitate a competitive provider marketplace.

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, Florida Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

In recent years, there has been a historic pendulum swing between employed physicians and private practice. At the time the survey was fielded in September-October 2020, the American Medical Association's (AMA's) 2020 Physician Practice Benchmark Survey found that 49.1 percent of physicians worked in physician-owned practices, 38 percent were practice owners, 8.2 percent were employed by physician-owned practices, and 2.5 percent were independent contractors working for physician-owned practices.

An analysis commissioned by the Physicians Advocacy Institute showed an even steeper move to hospital employment when it looked at data from the two-year period of January 1, 2019 to January 1, 2021. As of January 2021, approximately 70 percent of physicians were employed by hospitals or corporations. Over the previous two years, 48,400 physicians left independent practice and became employees. Nearly half that movement occurred after the onset of COVID-19, suggesting that the pandemic had a significant impact on employment decisions for many of our nation's physicians.

While physicians may select an employment arrangement or choose to sell their practice to a larger provider like a hospital for a range of factors, it is clear that increasing rates of provider consolidation

negatively impacts the cost and quality of health care in this county. The March 2020 report by the Medicare Payment Advisory Commission (MedPAC) noted that: 1) patients are more likely to choose a high-cost, low quality hospital when their provider is employed by a hospital; 2) physicians whose practices are acquired by hospitals are more likely to bill for more services in the hospital setting and fewer in the office setting, driving up costs; 3) hospital acquisitions of a physician practice have little effect on improved outcomes on a range of issues, such as mortality, acute circulatory conditions, and diabetes complications; and that 4) vertical integration between hospitals-physicians has a limited effect on quality metrics.

To combat the negative effects of provider consolidation, PEPC's members believe that value-based care must be designed as a path to sustainability for independent practice for those who want it. The COVID experience highlighted the flaws of the FFS system, as practices heavily reliant on utilization-based payment methods were hit hard when practice visits dropped at the height of the pandemic. In contrast, practices who relied on value-based payments for at least a portion of their income were somewhat insulated or at least had resources that could be repurposed to help generate income from virtual visits.

This is good not only for physicians, but also for patients. The data shows that physician-led value-based care models have generated superior results compared to other models. Comprehensive Primary Care+ is an example of a model where physicians and physician practices demonstrated their ability to reduce emergency room and acute care visits through advanced primary care medical homes. Independent practices outperformed system-owned practices by 15 percent in PY2017 and 18 percent in PY2019, even though both practice types saw improvements in overall utilization.

Physician-led accountable care organizations (ACOs) are also creating a better experience for patients while lowering costs across the entire system. Medicare Shared Savings Program (MSSP) results from 2019 show that, across the health care system, ACOs led by physicians, often called "low revenue," typically create more than twice the Medicare savings per beneficiary than hospital-led ACOs, often known as "high revenue." According to CMS data, in 2019, physician-led MSSP ACOs had gross per-beneficiary savings of $458 compared to $169 per beneficiary for hospital-led MSSP ACOs. In the new Pathways to Success program, physician-led ACOs had per-beneficiary savings of $429 while hospital-led ACOs had per-beneficiary savings of $258.

With this background in mind, we offer thoughts in response to Questions 2, 3, 7 and 8 in the RFI below.

Question 2: How should Congress ensure adequate access to providers for enrollees in a public option?

Congress should ensure adequate access to providers for enrollees through policies that support robust provider competition and compensation sufficient to attract a broad network of interested providers. Public option policies should promote parity across practice settings, and align incentives to enable a range of providers to move toward value-based care.

One way to promote parity across practice settings is to implement site neutral payments. The concept behind site neutral payments is that providers who practice in different settings (e.g., independent clinics, hospital outpatient departments, etc.) should get paid the same amount for the same service or procedure. Unfortunately, today that is not the way that Medicare works. Hospital outpatient departments performing ultrasounds, for example, charge a facility fee in addition to the fee for the

procedure itself while independent clinics simply charge for the procedure. This payment differential — which is solely based on the location where the service is delivered — creates a strong financial incentive for hospitals to acquire physicians' practices so that they can take advantage of the higher payment rates available to HOPDs.

Under its current policy, the Centers for Medicare and Medicaid Services (CMS) has implemented site neutral payments for clinic visits performed for Medicare patients. We continue to encourage CMS to expand its site neutral payment policy, and recommend that Congress build site neutral payment into its payment structure for any public option from the outset.

We also recommend that a public option align incentives to enable a range of providers to move to value-based care. For example, models should be accessible to a wide range of physicians, including physicians choosing to remain independent. The physician workforce is not homogenous. Instead, there are physicians in large practices and small practices, in rural and urban settings, 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 models that are appropriate for large hospital-led groups and/or large physician practices may not be appropriate for all.

There is also a need for a clear glide path towards taking on more risk, and for a clear "off ramp" when models begin to sunset. Taking on full risk at the start can be difficult for independent practices, and full downside risk is not always needed to get results. Having an entry into shared savings and gradually moving into more aggressive risk profiles has been helpful for physicians, as has starting in models that enable care transformation but do not require shared risk. At the end of a model, there should be a cliff for providers participating in sunsetting models. It is important for there to be a glide path to support those practices so that they do not fall back into fee-for-service after the model sunsets.

Question 3: How should prices for health care items be determined? What criteria should be considered in determining prices?

As discussed above, site neutral payments are critical to creating a dynamic, competitive provider marketplace. **We recommend that there is parity in Medicare payments for physician services across practice settings.** Congress should ensure that policies that have proven to drive up costs without measurable quality improvements in other programs like Medicare are not carried over to a public option.

Question 7: How should the public option interact with public programs including Medicaid and Medicare?

We strongly believe that the public option should build on the important payment and delivery system reform work of CMS. **We recommend that CMS, including but not limited to the CMS Innovation Center, have the authority to test alternative payment models (APMs) covering the public option population. We also recommend that the public option payment models should provide incentives consistent with those of the Innovation Center models to encourage participation in both.**

For an integrated approach to payment and delivery system reform to be successful, we recommend the following:

1. CMS should prioritize physician-led APMs for the public option population, while building on models that have demonstrated proven results.
2. Public option models should be accessible to a wide range of physicians, including physicians choosing to remain independent.
3. There should be a range of models available under the public option with varying levels of financial risk.
4. Quality measures should be harmonized across new and existing models to the extent possible and CMS should use a parsimonious list of meaningful measures that reduce the burden of reporting. This includes harmonizing quality measurement across Medicare, Medicaid, the public option and commercial payers to the extent possible.
5. Public option 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.
6. Participation in the public option APM should count towards the "Other Payer APM" threshold for qualifying for Quality Payment Program incentive payment.

Question 8: What role can the public option play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities?

If Congress adopts the above recommendations, we believe that a public option could deepen and exponentially expand cost savings and quality improvements for the broader health care system. **We believe that adopting a more holistic view of the metrics of model success – particularly metrics related to quality, access, and equity – would be beneficial in aligning metrics/incentives in multi-payer models tailored to underserved or vulnerable communities.** Similar to our recommendation on quality measures, measures of health equity or health care disparities should be aligned across programs to ensure solutions aimed at addressing disparities scale across markets.

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Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org.

Sincerely,

Kristen McGovern
Executive Director