PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

August 1, 2022

Submitted electronically to OASHPrimaryHealthCare@hhs.gov

The Honorable Admiral Rachel L. Levine, MD
Assistant Secretary for Health
Office of the Assistant Secretary for Health
Department of Health and Human Services
Hubert H. Humphrey Building, Room 716-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Request for Information: HHS Initiative To Strengthen Primary Health Care

Dear Assistant Secretary Levine,

Thank you for the opportunity to provide input into the HHS Initiative to Strengthen Primary Health Care, and for your leadership on this initiative to improve primary health care and address health equity.

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, 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.

We support the many efforts of the Biden-Harris Administration to prioritize equity for all, including through initiatives to support value-based care. Robust access to primary care is a central component of health equity, and is key to the success of new payment and delivery models.

Below are comments in response to the specific questions posed in the Request for Information (RFI) as it pertains to the intersection of primary health care and value-based care in improving overall health and wellbeing, and the role of independent physicians and practices in providing these critical services to communities across the country.

Successful Models or Innovations that Help Achieve the Goal State for Primary Health Care

Our members believe that independent physicians and practices are well-positioned to continue to lead the value-based care movement, achieving superior results in value-based care models through their commitment to improving outcomes and reducing costs. For many practices and physicians, a key part of value-based care is primary health care. Independent practices and physicians are often integral parts of their communities. Identifying and addressing unmet needs is part of the longitudinal patient-physician relationship and is made possible through non-utilization-based reimbursement models that allow providers to spend time with their patients, assessing their needs and connecting them to services.

The evidence is strong that more physician participation in models is as important a factor in generating savings as increasing risk. For example, through Comprehensive Primary Care+ 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% in PY2017 and 18% in PY2019, even though both practice types improved their performance on overall utilization.

Additionally, CMS recently released data showing that physician-led accountable care organizations (ACOs) are creating a better experience for patients while lowering costs across the entire system. Medicare Shared Savings Program (MSSP) results from 2020 show that, across the health care system, ACOs led by physicians, often called "low revenue," typically create more savings than hospital-led ACOs, often known as "high revenue." According to CMS data, in 2020, 90 percent of low revenue ACOs generated savings against the benchmark, compared to only 75 percent of high revenue ACOs.[1] Additionally, low revenue ACOs saved more than 5.3 percent, twice as much as high revenue ACOs, who only saved 2.5 percent. In 2020, low revenue ACOs also generated more than an additional $100 in per beneficiary savings ($241) compared to high revenue ACOs ($137).[2]

Barriers to Implementing Successful Models or Innovations

Fee-for-service (FFS), the dominant model of physician payment, is consistently underinvested, administratively burdensome, and encourages siloed care and carve-outs of other services, such as behavioral health, that when integrated with primary care improve care management and increase accessibility.[3] These problems are exacerbated by the fact that FFS payment models, including the Medicare physician payment system, fail to keep up with the pace of inflation, leading to low payment rates that contribute to workforce shortages and reduce beneficiaries' access to care.[4] As such, the National Academies of Science, Engineering, and Medicine (NASEM) consensus report confirmed that FFS does not adequately support or value longitudinal, person-centered care.

While there has been great momentum in supporting value-based care at the federal level, many barriers still exist, particularly for independent physicians and practices. Access to capital continues to be significant barrier to independent physicians and practices entering value-based care models. Unlike physicians employed by large hospitals or health systems or physicians working in medical groups with access to investment dollars, many small, rural and independent practices and physicians are resource-constrained in their ability to make the investments needed to transition off the fee-for-service chassis. Given the time lag between when practices begin making investments and when they can realistically expect to receive sufficient savings to recoup their investments, organizations with less access to capital may be less likely to enter or sustain participation in shared savings initiatives.

Additionally, the lack of a clear and predictable glidepath has also been a challenge. When models or model tracks are ended with little explanation, it makes it difficult to encourage physicians to participate in future value-based care models. Adopting, implementing, and scaling value-based care models requires

[1] https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results
[2] https://www.advancinghealthvalue.org/?r
[3] Balasubramanian BA, Cohen DJ, Jetelina KK, et al.; Outcomes of integrated behavioral health with primary care. J Am Board Fam Med. 2017;30(2):130-139.
[4] Medicare Payment Advisory Commission. Physician and other health professional services. March 2022 Report to Congress. Available at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch4_SEC.pdf

a significant investment from any provider, but the lift is particularly heavy for independent practices and physicians operating with limited time and resources while focusing first and foremost on patient care. Physician owners and leaders making the choice to move away from fee-for-service must understand the consequences and benefits of doing so, and be able to business plan over the short, medium, and long-term for the future of their practices (i.e., small businesses).

Physicians, like other model participants, need a clear understanding of how their model investments can continue to be leveraged to achieve key health care goals even if the model they were participating in is not expanded. To that end, we must design models with an "off ramp" in mind at the outset, particularly if the "off ramp" is unlikely to be actuarial certification for program-wide expansion. Failing to create and consistently communicate regarding the "off ramp" may discourage physicians and practices from seeking the value of participating in payment and delivery system models over time.

Successful Strategies to Engage Communities

Value-based care is essential to improve quality, empower patients and physicians, and increase access to primary health care services. Value-based care models also provide additional flexibility and financial stability, which primary care providers can leverage to hire additional staff and provide advanced primary care services not reimbursed under fee-for-service. These models are successful in achieving these goals largely because they move away from utilization-based payment approaches, and instead incentivize health care stakeholders to ensure that patients get the right care in the right setting. This often means using primary care services for prevention, care coordination, and treatment of routine health conditions.

The primary care physician-patient relationship is most powerful when there is patient choice and provider competition within local markets. Having trust between physician and patient is critical for addressing disparities. To build on this trust, we encourage federal policymakers to more intentionally design models from the beginning for underserved communities. Traditional alternative payment models (APMs) have been focused on Medicare, and changing some aspects to fit the needs of Medicaid and safety-net providers can make the difference between someone accessing the care they need and delaying it indefinitely. Furthermore, models should be tested all across the country and in different communities to make sure they meet the needs of all Americans.

Policies that "level the playing field" are also important to create consistency across practice sites, to encourage different types of providers to participate in models, and to ensure beneficiaries have similar model experiences regardless of the provider from whom they receive care. Examples of two policies supported by PEPC to level the playing field include implementation of site neutral payments for clinic visits (and also other services in the future) and information blocking regulations that discourage larger providers from using critical clinical information as a strategic asset to retain and/or recruit patients.

Proposed HHS Actions

We encourage HHS to consider the following as part of the Initiative to Strengthen Primary Health Care:

- *HHS should expand its site neutral payment policy*. In 2019, HHS implemented site neutral payments for clinic visits. We strongly encourage HHS to over time implement site-neutral policies and remove payment disparities for additional services. Following the same approach taken in the current proposed rule with respect to clinic visits, HHS should prioritize other services, such as procedures, radiology, etc., for site neutral payment if there is a demonstrated and unnecessary

shift and/or spike in volume from physician office to the hospital outpatient department. In addition to the negative impact on beneficiaries, we note that payment disparities between sites of services makes it difficult for independent practices to recruit and retain new physicians. It also negatively impacts the ability of independent practices to negotiate with payers, as physician practices purchased by hospitals can get higher payment rates from payers, both from facility fees and from the greater leverage that hospitals have with private payers in negotiating payment rates for their employed physicians.

- *HHS should prioritize physician-led APMs, while building on models that have demonstrated proven results.* Physician-led ACOs have consistently generated more savings than hospital-led ACOs based on MSSP results, largely because financial incentives in physician-led ACOs are fully aligned with key components of value-based care. Implementing more physician-led models can encourage participation and achieve quality outcomes and savings.

- *Models should be accessible to a wide range of physicians, including physicians choosing to remain independent.* Despite deepening provider consolidation, the physician workforce is not homogenous. There continue to be physicians caring for patients in large practices and small practices, in rural and urban settings, in a variety of different employment arrangements. HHS 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.

- *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.* In implementing new models, HHS could consider a range of beneficiary-focused design elements including allowing Medicare beneficiaries to voluntarily enroll in the model(s) with the primary care physician of their choice; or rewarding beneficiaries for decision-making that results in cost reductions by, for example, sharing in any savings obtained by the practice if the practice is participating in a shared savings model, receiving added benefits from their physicians and/or having their cost-sharing reduced or eliminated. As HHS considers requiring practices to voluntarily enroll and/or recruit patients to participate in care models, we caution that this would be a significant barrier to participation for many independent practices. We urge HHS to consider maintaining and improving processes for attributing patients based on historical claims for practices and clinicians that do not have the resources or desire to implement robust patient outreach and enrollment strategies. We also urge HHS to consider how attribution policies that include telehealth services are impacting alignment across different provider types.

- *New models should continue to 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 or deter program participation. HHS should also provide more predictable and accurate risk adjustment and benchmarks that work for a range of physician practices, including excluding an entity's own beneficiaries from benchmark calculations as appropriate and risk adjusting for social factors.

- *HHS should improve health data sharing with primary care and reduce administrative burden:* HHS must work to improve information sharing from hospitals, specialists, and other care team members to equip primary care physicians with the data they need to provide comprehensive, whole-person care. Larger providers should not be permitted to use information as a strategic asset to retain patients also being cared for by other community-based providers. Smaller providers, including independent physicians and practices, should have access to technical assistance resources to ensure that they are able to utilize data available to them under 21st Century Cures, and to ensure that they are appropriately sharing information where required.

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Thank you in advance for your consideration of these comments. Please do not hesitate to reach out to me at kristen@physiciansforvalue.org or 202-640-5942 if you have questions.

Sincerely,

Kristen McGovern
Executive Director