October 13, 2023

The Honorable Michael Burgess
Chair, Health Care Task Force
House Budget Committee
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

RE: Request for Information (RFI) on Solutions to Improve Patient Outcomes and Reduce Health Spending

Dear Chair Burgess:

Thank you for your leadership of the House Budget Committee Health Care Task Force. We appreciate the Task Force's efforts to modernize and personalize the health care system; support innovation; increase patient access to quality and affordable care; and ensure policymakers are equipped with the best available data when evaluating potential impacts of health policies.

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 believe that physicians – especially independent physician practices – are essential to a competitive health care marketplace that put patients at the center. However, consolidation in the health care sector has put the future of independent practice at risk and in turn jeopardizes equitable access to care in patients' own communities.

In 2022, the American Medical Association found that fewer than 47 percent of physicians worked in private practice, a decrease from over 60 percent in 2012. This has led to higher costs without measurable improvements in quality. Recent studies highlighted in a March 2020 Medicare Payment Advisory Commission (MedPAC) report found that provider consolidation with hospital/health systems led to an increase in commercial prices from three percent to 14 percent, without corresponding increases in efficiencies or quality. The report found that physicians whose practices were acquired by hospitals were more likely to bill for more services in the hospital setting and fewer in the office setting; and hospital acquisitions of a physician practice had little effect on improved outcomes on a range of issues, such as mortality, acute circulatory conditions, and diabetes complications.

Earlier this month, new research added to this evidence base, finding that vertical integrations between primary care physicians and large health systems led to steering of patients into health systems and increased spending on patient care, with no measurable impacts on quality

With this framework in mind, we provide feedback on specific policy solutions raised in the RFI below, in addition to other steps the Task Force can consider to improve outcomes while lowering health care

spending, through promoting competition, value-based care, and supporting the independent physician workforce.

RFI Solutions

Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending

As highlighted in our response to the Congressional RFI on the Medicare Access and CHIP Reauthorization Act (MACRA), we believe that implementation of the MACRA framework has fallen short of congressional intent and could be improved to achieve its original objective of changing the way that Medicare rewards clinicians to drive them to value over volume; a goal which we applaud and share.

Under MACRA, physicians and practices have three options: 1) remain in fee-for-service (FFS) and receive a nominal and/or no annual payment adjustment; or participate in the Quality Payment Program (QPP) through 2) Merit-Based Incentive Payment System (MIPS) and receive a greater payment adjustment based on performance on indicators related to cost, quality, clinical practice improvement, and promoting interoperability; or 3) an advanced alternative payment model (A-APM) and receive a bonus for participating (currently 3.5 percent), which requires taking "more than nominal risk" for the patient panel.

However, there is broad consensus across the health care industry that the QPP increased administrative burden and complexity without providing physicians the opportunity to take on meaningful risk. This burden is felt most acutely by small and independent practices, who struggle to come up with the resources to meet QPP requirements, which continue to change year after year. Since there is a dearth of APMs and the MIPS requirements do not closely align with any existing APM, MIPS is primarily a reporting program with arbitrary requirements that do not meaningfully contribute to improved patient outcomes. The significant burden associated with these programs forces practices to direct their time and resources on complying with reporting requirements rather than building the skills and infrastructure that would allow them to succeed in value-based payment.

We encourage Congress to continue its efforts to improve the MACRA framework, including addressing these issues and encouraging providers to both adopt and deepen their value-based care arrangements across payers. This could include establishing a middle track for providers who are doing more than is required under MIPs and who have adopted value-based care, but who are not yet derive the majority of their revenue from these models. The incentive offered to these providers should be more than what is available under MIPs, and should reflect the accountability and reporting requirements already present through those models.

Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes

Our country has been testing various innovative payment and delivery system reform models for decades and independent physicians have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. For example, through the Comprehensive Primary Care Plus (CPC+) Model, 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 performance year (PY) 2017 and 18 percent in PY 2019, even though both practice types improved their performance on overall utilization. Further, during the COVID-19 pandemic, independent practices

participating in the CPC+ model were better able to respond to rapidly changing conditions and were less likely to report that the pandemic had a strong adverse impact on their finances.

Additionally, CMS data shows 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 have consistently shown that, across the health care system, ACOs led by physicians (referred to as "low revenue"), typically create more savings than hospital-led ACOs (known as "high revenue"). According to CMS data, in 2022, physician-led ACOs achieved far greater net savings ($228 per capita) than hospital-led ACOs ($140 per capita).

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 a 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 FFS chassis. **We encourage Congress to work with CMS to ensure that their work is designed with physicians in mind, including prioritizing physician-led APMs and providing physicians a glide-path to make the transition to value-based care more attainable.**

A key component of supporting independent physicians in value-based care is the APM incentive payment, which is set to expire at the end of this year. The incentive payments not only encourage physicians and other health care providers to enter models, but also provide additional resources that can be used to expand services beyond traditional FFS – which is especially important for independent physicians and practices who lack the resources of larger groups or health systems. **We urge Congress to extend the APM bonus payment beyond 2023.**

Other Steps Congress Can Take to Improve Outcomes and Lower Costs in Health Care

Physician Payment Reform

The services of doctors, nurses and other skilled clinicians have been systematically undervalued by the Medicare program, with the gap between actual costs and reimbursed costs widening over time as costs increase. Failure to update these pricing inputs over time has contributed to the increasingly difficult climate for independent practices to survive. It has led to an imbalance across practice settings with hospitals, skilled nursing facilities and other facilities receiving annual Medicare payment updates to account for increasing costs while physicians and other clinicians are forced to figure out how to do more with less. This imbalance is fueling rapid consolidation in health care, which contributes to rising health care costs and stagnant, or sometimes worse, quality.

Over the long run, fair and robust Medicare payment rates will preserve patient choice and competition, resulting in improved outcomes and lower costs. **We urge Congress to increase provider reimbursement to ensure patients continue to have access to the services and care they need. This includes investing in the Medicare Physician Fee Schedule to ensure adequate reimbursement for Part B Medicare services.**

Promoting Competition in Health Care

Increasing consolidation in the provider market creates greater urgency to ensure that value-based care is a path to sustainability for practices and physicians who are independent and wish to remain so. A significant driver of provider consolidation is payment disparities across sites of services, which stack the deck against independent physicians and practices who receive lower reimbursement than a hospital outpatient department (HOPD) for the provision of an identical service. Patients are also harmed by this through increased cost sharing and reduced choice. We believe that beneficiaries and the physicians treating them should have their choice of lower-cost sites of service and not be encouraged to receive or provide care in higher paid settings solely for financial reasons.

To this end, we urge Congress to build upon the Trump Administration's site-neutrality rules and create more fairness in the payment system by passing legislation that creates parity across practice settings. CBO has estimated that implementing site neutral payments for all off-campus HOPDs and for certain services at on-campus HOPDs would reduce deficits by about $140 billion over 10 years.

Additional steps to improve competition in health care include prohibiting anti-competitive behavior, such as information blocking, and conducting oversight of the Federal Trade Commission to ensure it has adequate resources and is correctly utilizing its statutory authority to investigate harmful consolidation and promote competition.

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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

cc: The Honorable Drew Ferguson, D.M.D.
The Honorable Lloyd Smucker
The Honorable Earl "Buddy" Carter
The Honorable Blake Moore
The Honorable Rudy Yakym
The Honorable Jodey Arrington