PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

Independent Practice Success in CMS Innovation Center Models

White Paper

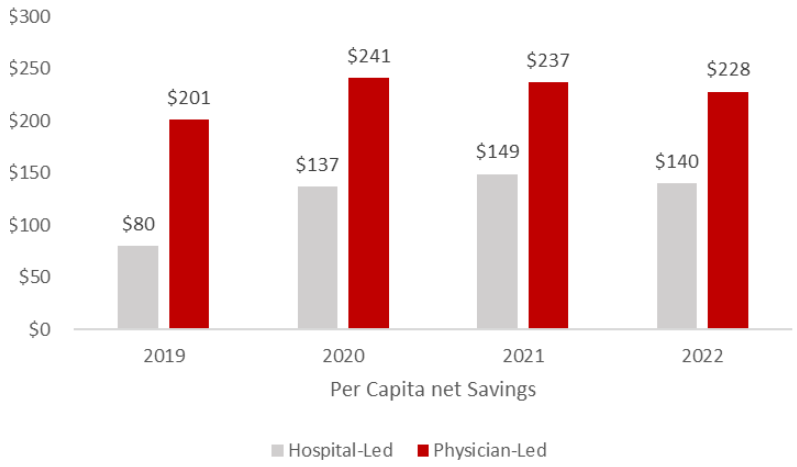
Introduction

Bipartisan, conventional wisdom is that health care payment must move away from a utilization-based fee-for-service (FFS) system to realize the significant quality improvements and cost reductions reflective of a best-in-class health care system.

Over the past decade, there have been significant public and private sector investments in value-based care. During this time, the Centers for Medicare and Medicaid Services (CMS) has made significant progress in expanding the reach of accountable care delivery; in 2022, nearly one-third of traditional Medicare beneficiaries were in two-sided risk alternative payment models (APMs), and less than 16 percent remained in FFS without links to quality and value. This progress is largely due to growth in the Medicare Shared Savings Program (MSSP) and the Center for Medicare and Medicaid Innovation (CMS Innovation Center) payment and delivery system models.

MSSP, Medicare's flagship accountable care organization (ACO) program, now encompasses more than 10 million Medicare beneficiaries. Small and independent physician practices consistently succeed in the program, outperforming hospital-led ACOs year over year (Figure 1).

Figure 1. Physician-Led MSSP ACOs vs. Hospital-Led ACOs in the MSSP



Additionally, the CMS Innovation Center has tested over 50 payment and service delivery models intended to improve patient care, lower costs, and align payment systems to promote patient-centered practices. Less is known, however, about the experience and success of small and independent practices that have participated In Innovation Center Models.

To better understand the independent physician practice experience in CMS Innovation Center models, the Partnership to Empower Physician-Led Care (PEPC) reviewed evaluation reports from several CMS Innovation Center models: the ACO Investment (AIM) Model, Next Generation ACO (NGACO) Model, Comprehensive Primary Care (CPC) Initiative and CPC Plus (CPC+).

Key Findings

Through this review, PEPC found:

- Independent practices are more agile, flexible, and timely in their implementation of care interventions.
- Independent practices deliver benefits of value-based care directly to patients, with higher enrollment in care management and disease management programs and directly providing acute care to attributed patients.
- Once a model test ends, independent practices generally sustain participation in value-based care by moving into the MSSP or other Innovation Center models.
- Independent practices are uniquely positioned to adapt and provide flexible care delivery in changing circumstances, such as during the COVID-19 pandemic.
- Independent practices are more resourced constrained than other practices in some circumstances, often starting from a point of fewer resources when entering a new model, and particularly benefit from models that provide upfront resources to invest in accountable care delivery.
- Competitive dynamics can serve as both a deterrent and accelerator for independent practices participating in value-based care efforts.

Evaluation Analysis

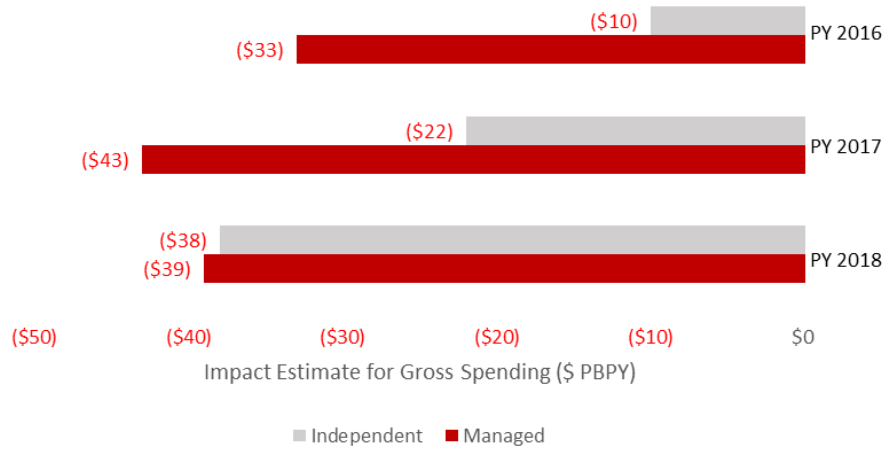
ACO Investment Model

The ACO Investment Model (AIM) was an initiative that tested the use of pre-paid shared savings for ACOs in MSSP. The goal of the model was to encourage new ACOs to form in rural and underserved areas and to encourage current MSSP ACOs to transition to arrangements with greater financial risk. AIM consisted of 45 participating ACOs, that served beneficiaries across 38 states.

As access to capital can be a barrier in taking on financial risk and participating in value-based models for many independent providers and practices, upfront investments provided through models like AIM are particularly important. Independent practices participating in AIM reported that the model provided an opportunity to gain experience with value-based care and for physicians to remain independent, with the funding helping practices from being acquired by large hospital systems in their markets. By the end of 2020, the majority (nearly 60 percent) of the providers in the three independent ACOs that exited the model transitioned into another MSSP ACO.

While independent practices often start from a point of fewer resources when entering a new model and require time to make the investments and transitions needed for system transformation, within three years, independent ACOs reduced per beneficiary per month (PMPM) Medicare spending by the same amount as larger, managed ACOs in AIM (Figure 2).

Figure 2. Gross Medicare Reductions by Independent vs. Managed ACO, PY 3



Savings accrued by the AIM Model were generated by smarter spending and the use of preventative services, improving patient experience and outcomes through less intensive utilization. Compared to other ACOs, physician-only AIM ACOs invested nearly twice as much on "care coordination and disease management" activities per-patient.

Next Generation ACO Model

The Next Generation ACO (NGACO) Model was an initiative that enabled ACOs to assume higher levels of financial risk and reward than were available under MSSP. The goal of NGACO was to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, could improve health outcomes and lower expenditures for Medicare FFS beneficiaries. The model consisted of three initial performance years (PYs) and two optional one-year extensions.

As NGACO was a more advanced model, many ACO leaders indicated that they recruited independent practitioners with value-based experience, such as MSSP or commercial ACOs, which they believed indicated practitioners' readiness to participate and to assume risk. Nearly two-thirds of participating independent practitioners across all NGACOs had experience in another ACO model prior to participating in NGACO.

Over the model's six PYs, physician practice-affiliated NGACOs had the largest average reductions in gross Medicare spending among the three organization types (Figure 3). This trend increased over time; by the final two years of the model, physician practice-affiliated NGACOs reduced Medicare expenditures by more than double other ACO types (Figure 4).

Figure 3. Gross Medicare Reductions by Physician-Practice vs. Hospital-Affiliated ACOs, PY 1-6

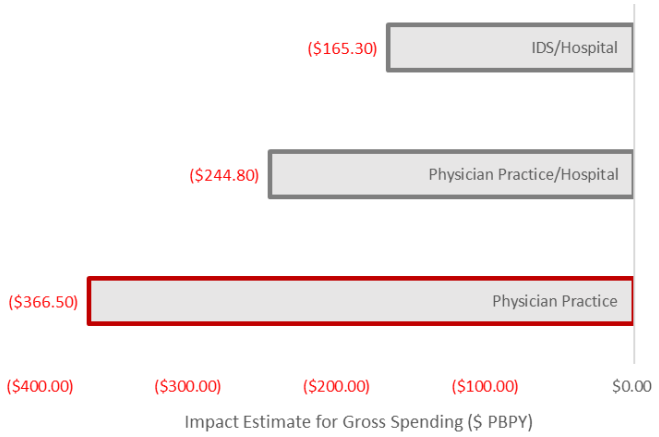
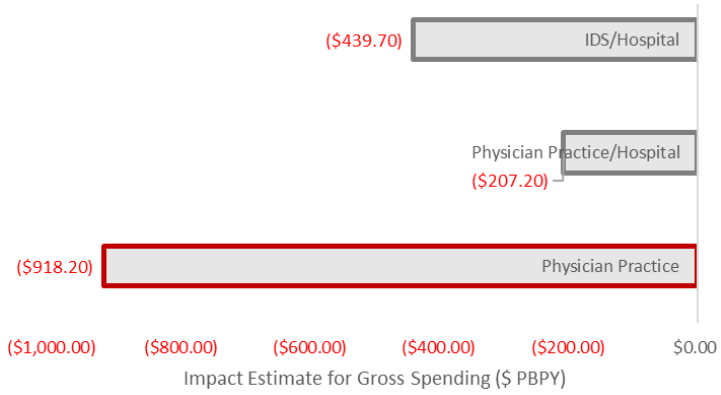


Figure 4. Gross Medicare Reductions by Physician-Practice vs. Hospital-Affiliated ACOs, PY 5-6



Reductions in spending were driven by a reduction in hospitalizations: physician-practice affiliated ACOs reduced ambulatory care-sensitive conditions (ACSC) hospitalizations by nearly five percent, compared to a slight increase in hospitalizations among hospital affiliated-ACOs.

Throughout the model, physician practice NGACOs were associated with significantly larger spending declines in markets with lower hospital concentration (1.4 percent reduction) than those with higher hospital concentration (0.01 percent reduction), highlighting the importance of a competitive market to drive efficiency and reduce spending. The report identified that NGACOs that did not reduce spending were commonly operating in more concentrated hospital markets, where there may be less incentive to decrease hospital spending. The evaluation concluded that "*physician practice NGACOs may be less likely to form in markets with higher hospital concentration, and hospitals and delivery systems focused on increasing market share may be less willing to engage with physician practice ACOs comprised of independent practices.*"

Comprehensive Primary Care (CPC) & CPC Plus

The Comprehensive Primary Care (CPC) initiative was a four-year multi-payer initiative designed to strengthen primary care by integrating a defined payment model with a specific practice redesign model. The initiative supported practices with multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology (HIT). CPC serves as the foundation for Comprehensive Primary Care Plus (CPC+), a five-year advanced primary care medical home model launched in 14 regions.

Evaluations of the CPC model found that system-affiliated and independent practices tended to have different implementation approaches, which enabled independent practices to make more rapid changes:

> *"In independent practices, local champions (typically a clinician) or formal practice leaders (for example, a solo practitioner owner) made key decisions about CPC implementation either alone or in consultation with other physician-owners. In many cases, these local leaders played a critical role in championing the implementation process and making sure that practice processes were changed to meet the demands of the CPC model, either through their participation in quality improvement teams or through informal processes."*

Independent practices had greater autonomy to make changes tailored to their local environment and were able to quickly make improvements based on patient feedback, positioning them to adapt and provide flexible care delivery in changing circumstances, such as during the COVID-19 pandemic. For example, some small, independent practices reported pivoting quickly to alternative platforms such as FaceTime, Zoom, and telephone calls as soon as payers began covering services provided through those platforms, while some system-based practices were slower to respond. Physicians in independent practices were also more likely to receive utilization and cost feedback and have more autonomy in carrying out CPC+ requirements than other practices, offering the agility and flexibility to support tailored, person-centered care delivery.

However, independent practices often struggled with more complex and technical requirements, while system-owned or -affiliated practices tended to have greater access to management resources and HIT expertise to support CPC implementation. Most small independent practices reported that CPC did not provide enough funds to hire a full-time care manager. For those that did higher management, many expressed concerns about their ability to maintain newly hired care managers after CPC funding ended, highlighting the importance of resources and supports for independent practices to sustain implemented change.

Despite these limitations, independent practices in CPC+ had greater reductions in acute medical hospitalizations and expenditures compared to system-owned practices. A large utilization gap persisted throughout the PYs, with independent practices outperforming system-owned practices by 17 percentage points in PY1 and by 20 percentage points in PY 5 (Figure 4). In particular, Track 2 independent practices reduced acute hospitalizations seven times that of hospital-or system-owned practices.

Figure 5. CPC+ Impact on Acute Hospitalizations and Medicare Expenditures Across PYs

	Hospital- or System-Owned	Independent
Hospitalizations		
Track 1 Overall	-0.5%	-1.5%
Track 2 Overall	0.0%	-2.7%

Track 1 SSP	-1.6%	-1.7%
Track 2 SSP	0.1%	-1.8%
Track 1 non-SSP	0.6%	-1.3%
Track 2 non-SSP	0.1%	-3.2%
Expenditures		
Track 1 Overall	0.5%	-0.3%
Track 2 Overall	0.6%	-0.7%
Track 1 SSP	-0.7%	-0.9%
Track 2 SSP	-0.8%	-0.8%
Track 1 non-SSP	1.7%	0.2%
Track 2 non-SSP	2.0%	-0.4%

Conclusion

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. These results were evident through the evaluation reports of several CMS Innovation Center Models, including the ACO Investment (AIM) Model, Next Generation ACO (NGACO) Model, Comprehensive Primary Care (CPC) Initiative and CPC Plus (CPC+).

Independent physicians are uniquely positioned to drive the transition to value-based care, due to their agility and flexibility in responding to changing circumstances and implementing care interventions; delivery of value-based care benefits directly to patients, providing higher rates of care and disease management; and aligned incentives, which supports sustained participation in value-based care delivery once a model ends.

Unlike physicians employed by large hospitals or health systems or physicians working in medical groups with access to investment dollars, many independent practices and physicians are resource-constrained in their ability to make the investments needed to transition off the FFS chassis. A competitive marketplace is also essential for independent physicians and practices to thrive, and models have generated superior results in markets with lower concentration. To these ends, CMS should continue to focus on models that include upfront resources and supports for independent practices to implement care transformations, and work across the federal government to promote a competitive health care market.

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