PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

May 23, 2025

Abigail Slater
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington DC 20530

Re: Anticompetitive Regulations Task Force – Public Inquiry

Dear Assistant Attorney General Slater,

Thank you for the opportunity to provide input into the Justice Department's Anticompetitive Regulations Task Force. We appreciate your efforts to identify laws and regulations that create unnecessary barriers to competition, and support state and federal agencies in revising or eliminating such laws or rules.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care among independent physicians and practices to reduce costs, improve quality, empower patients and physicians, and increase access to care. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association (CMA), 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.

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. However, consolidation in the health care sector has put the future of independent practice at risk and in turn jeopardizes access to affordable care in patients' own communities. In 2022, fewer than 47 percent of physicians worked in private practice, a decrease from over 60 percent in 2012. This consolidation has led to higher costs, diminished access and stagnated quality. Making matters worse, at a time of widespread burnout, employed physicians report reduced satisfaction, autonomy and patient relationships.

In our vision of the future, this important piece of the health care system not only survives, but thrives, as a result of policies that place independent physicians on a level playing field with other providers and create opportunities to test new models of care that reflect their unique circumstances.

Below, we highlight considerations for the Task Force as it considers opportunities to reduce burden and make it easier for physicians to provide higher-quality, lower-cost health care.

Physician Payment Policies

Robust and predictable fee-for-service (FFS) reimbursement is essential to maintain a competitive health care market with a thriving independent physician landscape, as the most common reason physicians opt to sell their practice to a hospital or health system is to receive higher payment rates. 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 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. We urge the Administration and Congress to work together to ensure a long-term solution to Medicare Part B

reimbursement, including an inflation-based update to the conversion factor, to ensure physicians are adequately compensated for their services.

We also recommend that CMS revisit and remove unnecessary services from the Medicare Inpatient Only (IPO) list and expand upon existing site neutral payment policies, both of which will create a more level playing field across practice settings. A significant driver of provider consolidation is payment disparities across sites of services, which unfairly penalize 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. The Congressional Budget Office (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. The savings associated with this policy *must* be put back into the fee schedule, as current Part B reimbursement is inadequate.

Medicare Shared Savings Program

Quality Reporting

A key motivation for moving away from FFS and adopting accountable care models is streamlined reporting requirements and reduced burden. Recent CMS changes have taken the opposite approach – increasingly intertwining advanced alternative payment model (APM) requirements with burdensome Medicare Merit-based Incentive Payment System (MIPS) reporting requirements. The Administration should work to disentangle advanced APMs from complex MIPS requirements to the greatest degree possible. As a first step, CMS should remove the requirement that all Qualified Participants (QPs) must report the MIPS Promoting Interoperability (PI) performance category. This is particularly important for small and independent practices who lack the resources of hospitals and systems and face the greatest challenges in complying with costly reporting requirements.

Prepaid Shared Savings Option

PEPC supports the prepaid shared savings option in the Medicare Shared Savings Program (MSSP). Upfront cashflow is essential to support the transition to accountable care delivery, particularly for small and independent practices. However, restrictions and burden associated with this option has limited the impact. CMS should remove restrictions regarding how shared savings are spent and requiring ACOs to submit a spend plan. This creates significant and unnecessary burden, as ACOs are inherently incentivized to invest in services that will improve beneficiary health. Each provider's needs are unique and ACO's should be given the autonomy to use earned shared savings dollars as they see fit – whether it be on health care infrastructure, staffing, or reinvesting their savings into provider reimbursement.

Information Blocking

The Administration should rescind provisions of the final rule, *21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking*, which bans a provider who has committed information blocking from the MSSP for one year. As noted in our comments on the proposed rule, we remain concerned that the rule disproportionately penalizes MSSP physicians for information blocking, creating a disincentive for physicians to join accountable care organizations (ACOs) and unnecessarily deny Medicare beneficiaries access to the additional services that come from being part of an MSSP ACO. CMS should also consider providing technical assistance to small and independent practices, and engaging in more education and physician communication to ensure that providers understand what is permitted for other providers, IT vendors and other stakeholders.

Anti-Competitive Contracting Behaviors

The Administration should work to end anti-competitive anti-tiering, anti-steering, and gag clauses, which prevent insurers from providing information to enrollees. Patient steering and tiered or narrowed network programs should adhere to the following principles:

1. Networks or health systems should not be exclusively based on the cost-of-care delivered or by utilization measures attributed to the physician.
2. Programs should provide full, adequate access to necessary physicians and non-physician providers.
3. Insurers that do not have a sufficient number of skilled and proficient physicians in their network should provide coverage for the out-of-network services without additional cost to the patient.
4. Quality-of-care assessments should be a prominent feature of steering programs and based on accepted national standards using evidence-based medicine clinical guidelines whenever possible.
5. Programs should provide educational and reference materials to assist patients in making informed health care decisions.
6. Programs should fully disclose to a patient or employer the participation and availability of primary care physicians, sub-specialty physicians, and health care facilities prior to making decisions regarding a payer's steering program.
7. Quality and cost data used in steering programs must be accurate and specific to the identified physician.
8. All patient data used to evaluate a physician should be age, gender, and severity adjusted, including adjustments for socioeconomic factors.
9. If a physician is removed from a network, they should have sufficient opportunity to challenge the decision of the network.
10. Health plans should notify physicians when new plans are created so physicians have the opportunity to participate in those plans without recredentialing.

Noncompete Clauses

As noted in our comments on the Federal Trade Commission's (FTC) rule on noncompete clauses, PEPC supports a ban the use of non-compete clauses in most instances. Noncompete agreements can be particularly restricting and harmful in health care given the rapid consolidation in the market, negatively impacting patients by impeding access to care, disrupting care continuity, and deterring advocacy for patient safety. However, there may be some circumstances where the anti-competitive risk is lower than in other circumstances, or where the benefit of a reasonable non-compete clause outweighs any risks or harm. In some instances, reasonable noncompete clauses may serve as a retention tool for small and independent practices competing against hospitals and health systems, particularly in rural areas that already face physician shortages.

We believe that the Commission should robustly engage with independent practices, particularly in these rural and underserved areas, to develop a framework for evaluating these cases and implement a policy that reflects this nuanced landscape. These practices, who suffer the most from health care consolidation, should be at the forefront of policy decision-making.

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Thank you in advance for your consideration of these comments. Please do not hesitate to reach out to me if you have questions or the Partnership to Empower Physician-Led Care (PEPC) can be a resource to you. I can be reached at kristen@physiciansforvalue.org or 202-640-5942.

Sincerely,

Kristen McGovern
Executive Director