PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

STATEMENT FOR THE RECORD

"Building on the ACA: Legislation to Expand Health Coverage and Lower Costs"
U.S. House Committee on Energy and Commerce, Subcommittee on Health
March 23, 2021

Dear Chair Eshoo, Ranking Member Guthrie, and Members of the Subcommittee on Health:

The Partnership to Empower Physician-Led Care (PEPC) welcomes the opportunity to provide input to the Committee on the *"Building on the ACA: Legislation to Expand Health Coverage and Lower Costs"* hearing. We applaud your continued leadership and critical role in strengthening the Affordable Care Act (ACA) to expand access to quality, affordable health care.

PEPC is dedicated to supporting independent physicians and practices in adopting value-based care models to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans. 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.

One of the key ways that the Committee can build on the ACA over the coming months and years is by re-affirming the ACA's commitment to value-based payment and delivery system models. While there is much attention rightfully paid to ACA's coverage provisions, the health care system writ large has also significantly benefited from testing and implementing new models of payment and care such as the Medicare Shared Savings Program and the range of models tested by the Centers for Medicare and Medicaid Services' (CMS's) Innovation Center. These models seek to make our health care system more sustainable by moving payment and delivery off the fee-for-service chassis, and more closely linking cost savings and quality improvement to payment. While difficult, the transition to value-based care through alternative payment models (APMs) is a crucial component of the effort to expand access to care – by allowing us to stretch federal dollars and deliver better, more efficient care to Americans.

Bipartisan Commitment to Value-Based Care

Since the passage of the ACA, bipartisan leaders across Congress and the Department of Health and Human Services (HHS) have re-affirmed their continued commitment to value-based care models. In 2015, then-HHS Secretary Sylvia Mathews Burwell announced ambitious value-based care goals – 85% of all Medicare fee-for-service payments tied to quality or value by 2016 and 90% by 2018, with 30% and 50% of Medicare payments tied to APMs by the end of 2016 and 2018, respectively.[1] Building on these goals, former CMS Administrator Seema Verma announced an overhaul of the Medicare Shared Savings Program ("Pathways to Success") in 2018, an aggressive move designed to push more providers to move more quickly along the value-based care continuum toward greater risk.[2]

Bipartisan members of Congress have demonstrated their commitment to value-based care as well. A major bipartisan legislative accomplishment was the passage of the Medicare Access and CHIP

[1] https://www.nejm.org/doi/full/10.1056/nejmp1500445
[2] https://www.cms.gov/newsroom/press-releases/cms-finalizes-pathways-success-overhaul-medicares-national-aco-program

Reauthorization Act (MACRA) of 2015 (Pub. L. 114-10). This legislation fundamentally changed the way that Medicare pays clinicians, allowing additional flexibilities and incentives for those who take the important step of moving away from fee-for-service and toward adoption of alternative payment models. A key component of the legislation was the creation of the Advanced Alternative Payment Model (AAPM) track, which rewards providers who participate in models requiring "more than nominal risk." This 5% annual bonus has been effective in creating a stretch goal for providers to work toward even if they start their value-based care journey in models that do not meet the requirements of an APM. In 2018, almost 200,000 clinicians participated in AAPMs, compared to less than 100,000 the previous year.

Congress has also taken other steps to build on models that have demonstrated success, making improvements where necessary. For example, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 was enacted by Congress as part of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) and included statutory changes to make it easier for accountable care organizations (ACOs) to identify and offer services to chronically ill patients. More recently, Congress took action to bolster value-based care during the pandemic, freezing the risk thresholds for clinicians seeking to qualify for the AAPM bonus established by MACRA.

Physicians as Leaders of the Value-Based Care Movement

We believe that physicians – especially independent physician practices– are the lynchpin of our nation's health care system. As evidenced by the specific examples below, physician-led groups have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. 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 and practices on a level playing field with other providers and opportunities to test new models with components that reflect their unique circumstances.

Physician-led groups have demonstrated their ability to generate positive results for the health care system through multiple payment and delivery system reform models. For example, the evidence generated by participants in the Medicare Shared Savings Program (MSSP), shows that physician-led ACOs participating in MSSP achieve superior results compared to ACOs led by other providers. According to CMS data, in 2019, physician-led MSSP ACOs had gross per-beneficiary savings of $458 per beneficiary 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.

Under the Comprehensive Primary Care Plus (CPC+) model, physicians and physician practices demonstrated their ability to improve quality and reduce emergency and acute care through advanced primary care medical homes. During the first three years, practices increased the percentage of beneficiaries receiving recommended diabetes services, breast cancer screenings and hospice services. Both entry-level and more advanced practices demonstrated significant decreases in emergency department visits, and advanced practices reduced the rate of hospitalizations by almost 2%. Independent practices outperformed system-owned practices by 15% in PY 2017 and 18% in PY 2019, even though both practice types improved their performance on utilization overall.

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Principles for Supporting Physician-Led Models

As Congress considers how best to support HHS as it continues the important work of advancing the value-based care movement pursuant to the ACA, we believe the following principles should serve as a guide for shaping future value-based care priorities for HHS and CMS:

- ***Prioritize physician-led APMs, while building on models that have demonstrated proven results.*** Physician-led accountable care organizations (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.

- ***Ensure models are appropriate for and 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.

- ***Harmonize quality measures across new and existing models to the extent possible, using a parsimonious list of meaningful measures that reduce the burden of reporting.*** Quality measurement and improvement is of the utmost importance for value-based care, and should be incorporated into all alternative payment models, including physician-led models. We urge CMS to harmonize measures across new and existing models, focusing on those measures that have the greatest impact on patient care.

- ***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, CMS 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 CMS 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 CMS 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 CMS to consider how attribution policies that include telehealth services are impacting alignment across different provider types.

- ***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. CMMI 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.

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Thank you for reviewing our statement on the importance of value-based care models to the future of health care access. To continue to build on the progress of the ACA, we encourage the Committee to consider the important role independent physicians and practices play in transforming health care delivery though these models. We hope that you will continue to prioritize value-based care in your health care discussions during the 117th Congress.

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