PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

Submitted to Rural_Urban@mail.house.gov

November 29, 2019

The Honorable Richard E. Neal
Chairman
House Ways & Means Committee
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
House Ways & Means Committee
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

Thank you for the opportunity to provide a response to the Request for Information (RFI) from the House Ways & Means Committee's Rural and Underserved Communities Health Task Force. We appreciate your leadership and the leadership of the Task Force's co-chairs on this important issue.

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, Florida Medical Association, Medical Group Management Association (MGMA), and Texas Medical Association's Practice Edge. 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.

Below are our responses to specific questions included in the RFI.

What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional systems or factors outside of the health care industry that influence health outcomes within these communities?

One of the main factors influencing patient outcomes in rural and underserved areas is the amount of provider competition in a given geography.

The evidence shows that the primary care physician-patient relationship is most powerful when there is patient choice and provider competition within local markets. Studies cited by in recent testimony before the House Judiciary Committee Subcommittee on Antitrust, Commercial Law and Administration Law catalogue the overwhelming evidence shows the negative impact that lack of provider competition has on cost and quality. For example, for cost, Capps et al. (2016) find that hospital acquisitions of physician practices led to prices increasing by an average of 14 percent and patient spending increasing by 4.9 percent. For quality, McWilliams et al. (2013) find that larger hospital owned physician practices have higher readmission rates and perform no better than smaller practices on process-based measures of quality.

We support policies that facilitate greater provider competition, as well as action to address provider shortages given that competition only works if there is an adequate volume of providers to compete. This includes legislative and regulatory action that creates parity across practice settings; aligns incentives to enable a range of providers to move toward value-based care; prohibits anti-competitive behavior such as information blocking; facilitates recruitment and retainment of physicians and other health care

providers in rural and underserved areas. We also encourage Congress to consider how technology can be leveraged to increase access to vital services.

What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities?

Physicians have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. They are the most powerful tool we have to foster an affordable, accessible system that puts patients first.

This is evident in the results generated through accountable care organizations (ACOs). CMS Administrator Verma announced that in 2018 low-revenue ACOs (which tend to be physician-led) showed an average reduction in spending relative to targets of $180/beneficiary, compared to $27 for high-revenue ACOs. A September 2018 study published in the New England Journal of Medicine found that physician-led ACOs' spending "reductions grew with longer participation in the program and were significantly greater than the reductions in hospital-integrated ACOs."

To realize the promise of physician-led models, we encourage Congress to advance legislation that would result in more predictable and accurate risk adjustment and benchmarks for ACOs, including physician-led ACOs rural areas. H.R. 51212, the Accountable Care in Rural America Act, would improve the accuracy of payment models in rural areas by eliminating the "headwind" that results from an ACO's own beneficiaries being included in the regional benchmark and trend. This would make these models more attractive to providers in rural areas.

We also urge Congress to consider avenues for supporting additional testing of physician-led models through the Innovation Center, including by directing the agency to use a significant portion of the next $10 billion in funding to test physician-led models.

Are there two or three institutional, policy or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

A range of provider stakeholders must collaborate to strengthen safety and quality in rural/underserved populations, including both health systems and independent practices. We recommend the following:

<u>Quality Measures</u>

Quality measures should be harmonized across new and existing models to the extent possible. We urge Congress to work with CMS, national specialty societies, and the physician community to incorporate a harmonized measure set, focusing on measures that have the greatest impact on safety and quality.

<u>Payment Parity</u>

We strongly supported recent proposals to establish a single reimbursement rate for clinic visits. Our experience across the country validates the concern that the growth rate in some hospital-based E&M visits can be attributed to payment incentives, rather than patient acuity or medical necessity. Patients and their physicians should have their choice of lower-cost sites of service.

Information Blocking

We strongly support efforts to discourage anti-competitive information blocking. We do not believe that patient information should ever be used for the purpose of gaining or maintaining "control" over patients. Also, while interoperability is improving, it is far from being an integrative part of the physician workflow. Physicians should have access to patient information from disparate systems with minimal cost and effort.

Guidance and Support

It is imperative for Congress to provide funding for no-cost education, resources, clinical tools, and technical assistance to independent physicians serving rural and underserved populations. This will increase engagement, reduce burden, and empower independent physicians with the requisite knowledge to be successful in any new program or physician-led care model.

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Please do not hesitate to reach out if you have any questions.

Sincerely,

Kristen McGovern