acofp | AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS

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August 1, 2022

VIA ELECTRONIC SUBMISSION

Ms. Judith Steinberg
Senior Advisor
Office of the Assistant Secretary for Health
Department of Health and Human Services
200 Independence Avenue, SW
Room 716G
Washington, DC 20201

Dear Ms. Steinberg:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment in response to the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health request for information regarding actions the federal government can take to strengthen primary care in the United States.

ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents and students throughout the United States who are deeply committed to advancing our nation's healthcare system by improving healthcare delivery and outcomes and ensuring that patients have access to high-quality care.

ACOFP is committed to taking steps to strengthen primary health care in our healthcare system, including through preserving the family medicine model of care. However, there are barriers facing primary health care including workforce shortages, Medicare reimbursement policies, unnecessary paperwork requirements, and underutilization of osteopathic manipulative treatment, and federal action is needed to address these barriers.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

Bruce R. Williams, DO, FACOFP
ACOFP President

Below, we address three of the four topics HHS requests information on, including: (1) successful models or innovations that improve primary health care and help achieve the HHS goal state for primary health care; (2) barriers to implementing successful models or innovation; and (3) proposed HHS actions.

Successful Models or Innovations That Improve Primary Health Care and Help Achieve the HHS Goal State for Primary Health Care

Preserving the Family Medicine Model of Care

The goal of any healthcare system is to improve the overall health of the patients it serves, and to achieve this goal, primary care must play a more prominent role. Many studies show dramatic benefits in geographic areas that have higher primary care provider (PCP) use and PCPs per capita.[1] A retrospective literature review by Dr. Barbara Starfield found that overall health is better in areas in the United States with more PCPs. Areas with higher ratios of PCPs per capita had better health outcomes, including lower rates of all-cause mortality, mortality from heart disease, cancer and stroke, as well as infant mortality. In addition, areas with higher ratios of PCPs per capita had lower healthcare costs than other areas, possibly due to better preventative care and lower hospitalization rates. This contrasts with areas where there are higher numbers of specialists—characterized by more spending, but worse health outcomes.[2]

ACOFP believes strongly in strengthening the role of primary health care, including through the preservation of the family medicine model of care. Family medicine plays a critical role in the provision of primary care, which ensures improved patient outcomes and reduced healthcare costs. The Family Medicine Model of Care is a successful and innovative model that focuses on delivering high-quality patient-centered care through physician-led teams. The model emphasizes the importance of the patient-provider relationship to ensure patients receive individualized care and increase patient and provider satisfaction. As well as providing high-quality care, family physicians follow evidence-based guidelines and provide access to community resources to ensure patients have the necessary resources to improve their overall health.

Also, physician-led care teams are the gold standard for care delivery; non-physician-led care teams are not equivalent because they do not have the same training or education. A family physician will spend an additional 18,900 hours on education and training than mid-level practitioners.[3] Decades of evidence have shown that physicians are better positioned to deliver high-quality care because of their demanding education and professional training requirements, and, as a result, beneficiaries experience better health outcomes and Medicare realizes overall savings from healthier seniors.[4] While the use of non-physician practitioners may be appropriate under certain circumstances and with adequate physician supervision, such a model is not an equivalent substitute to the use of family physicians.

Barriers to Implementing Successful Models or Innovations & Recommended HHS Actions

Primary Healthcare Workforce Shortage

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[1] Shi L. The impact of primary care: A focused review. *Scientifica (Cairo)*. 2012. doi:10.6064/2012/432892

[2] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457–502. doi:10.1111/j.1468-0009.2005.00409.x.

[3] Compare the education gaps between primary care physicians and nurse practitioners. Texas Academy of Family Physicians website. Published November 1, 2010.

[4] Lohr RH, West CP, Beliveau M, et al. Comparison of the quality of patient referrals from physicians, physician assistants and nurse practitioners. Mayo Clin Proc. 2013;88(11):1266–1271. doi: 10.1016/j.mayocp.2013.08.013; Hughes DR, Jiang M, Duszak R. A comparison of diagnostic imaging ordering patterns between advanced practice clinicians and primary care physicians following office-based evaluation and management visits. *JAMA Intern Med*. 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349; Muench U, Perloff J, Thomas CP, Buerhaus PI. Prescribing practices by nurse practitioners and primary care physicians: A descriptive analysis of Medicare beneficiaries. *Journal of Nursing Regulation*. 2017;8(1):21–30. doi:10.1016/S2155-8256(17)30071-6.

Primary health care is currently struggling with workforce shortages. As more family physicians reach retirement age, the United States is facing shortages of 18,000–48,000 primary care physicians by 2034.[5] ACOFP recommends that HHS take steps to address this shortage and increase the number of residents choosing primary care.

Significantly higher reimbursement for specialists relative to primary care physicians contributes to the current imbalance between primary and specialty care. Medical students are financially incentivized to choose specialty training (e.g., cardiology or pulmonary medicine) over primary care because of higher reimbursement for certain specialty medicine services.[6] Primary care physicians are poorly compensated relative to their peers in specialty services. From 2003 to 2004, the ratio of average annual income for a specialty physician compared to a primary care physician in the United States was 1.6:1. In 2017, the median compensation in radiology, procedural and surgical specialties had an almost twofold difference compared to primary care physicians. Data from the Medical Group Management Association indicate that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent, while that for specialists increased by 37.5 percent. The median compensation for nonsurgical procedural specialties, surgical specialties and primary care in 2017 was $426,000, $420,000 and $242,000, respectively. This compensation gap is associated with the reduction in medical students choosing primary care careers and the shift of teaching hospital graduate medical education (GME) priorities away from primary care.[7]

Recent efforts to increase Medicare reimbursement, including through the calendar year (CY) 2020 Medicare Physician Fee Schedule Final Rule, have been positive steps toward payment equalization. However, a significant reimbursement differential still exists between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients and to the Medicare program overall.

We recommend that HHS support incentives for medical students to choose family medicine, including equalizing federal health program reimbursement between various settings of care (e.g., office, outpatient clinic, emergency department) and between family medicine and specialty medical services; enhancing reimbursement by rewarding care that is proven to ensure high-quality patient outcomes and patient satisfaction; and providing financial support in the form of loans, loan forgiveness and loan deferment. More training opportunities are also needed for medical students choosing family medicine, and medical education funding and programs must be preserved and expanded, including Medicare GME, Teaching Health Center GME (THCGME) and Title VII.

Reimbursement Policies

A significant reimbursement differential still exists between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients. To help address such concerns, we recommend that HHS support reimbursement policies that reward care provided by family physicians who are proven to ensure high-quality care and improved patient outcomes at lower cost. HHS can also recognize the clinical value and cost-savings from physician-led care coordination and establish appropriate reimbursement policies for such activities. Equalizing reimbursement across settings of care and between primary care and specialty care will help ensure primary care providers have the resources to improve quality and reduce costs.

While primary care physicians are demonstrated to be a critical asset for high-quality healthcare delivery, more needs to be done to support family physicians who have upgraded their electronic health record (EHR) systems in compliance with federal programs, including the Medicare Quality Payment Program (QPP), at great expense. A 2011 study

[5] The complexities of physician supply and demand: Projections from 2019 to 2034. Association of American Medical Colleges website. Published June 2021. https://www.aamc.org/media/54681/download.

[6] Shi L. The impact of primary care: A focused review. *Scientifica (Cairo)*. 2012. doi:10.6064/2012/432892.

[7] National Academies of Sciences, Engineering, and Medicine. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. 2021. doi.org/10.17226/25983.

estimated that EHR implementation in a five-physician practice would require an average cost of $46,659 per physician.[8] Many small, rural and solo practices—especially in underserved areas—are unable to change their EHR system as rules shift annually. ACOFP recommends that HHS commit to avoid implementing policies that require physicians to invest additional funds in EHR updates, management and repairs without adequate federal support. We also recommend HHS take into consideration the need for primary care physicians to make IT systems investments and associated costs for any new EHR requirements that are considered.

Unnecessary Paperwork Requirements

Unnecessary paperwork requirements are barriers to implementing successful models or innovations. Specifically, cumbersome EHR systems, utilization management policies (e.g., prior authorization) and continuously changing regulatory rules are forcing physicians to spend more time on administrative tasks rather than patients. According to recent studies, physicians spend approximately half their time on EHRs and desk work, in addition to completing paperwork after hours. For every hour a physician spends on clinical time, nearly two hours are spent on EHR and administrative tasks every day.[9] Burdensome paperwork requirements are also contributing to the physician shortage and are inhibiting appropriate patient care.[10] Many physicians, burned out by paperwork requirements, decide to retire early or leave medical practice for another profession—especially those in small, rural and solo practices where they do not have the resources to manage all the paperwork requirements.[11] As more of these practices are forced to close or relocate, healthcare shortage areas widen, and more communities lose access to care.

We recommend that HHS take steps to reduce burdensome paperwork requirements across federal programs to allow physicians more time treating patients; promote EHR interoperability and standardize reporting requirements to reduce time spent on EHRs; allow physicians to be reimbursed for time spent preparing for patient visits and logging medical information into the electronic medical record beyond the day of the patient visit; and streamline utilization management policies across payers in a way that all stakeholders can quickly and efficiently address patient needs.

Osteopathic Manipulative Treatment (OMT)

It is well-established that OMT, a clinically appropriate pain management treatment that can help reduce the need for addictive medications, is a valuable tool that can be used to provide holistic care and treatment to all patients. OMT is an underutilized service that improves health outcomes and should be protected and more available to patients. ACOFP proposes HHS support efforts to increase access to and knowledge of OMT as a pain management treatment option. We also propose HHS improve reimbursement policies for OMT to ensure doctors of osteopathy (DOs) continue to train in and certify as OMT providers. The clinical benefits OMT provides should also be considered when determining OMT reimbursement.

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[8] Fleming NS, Culler SD, McCorkle R, Becker ER, Ballard DJ. The financial and nonfinancial costs of implementing electronic health records in primary care practices. Health Aff (Millwood). 2011;30(3):481–489. doi:10.1377/hlthaff.2010.0768.

[9] Sinsky C, Colligan L, Li L, *et al*. Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Ann Intern Med*. 2016;165(11):753–760. doi:10.7326/M16-0961.

[10] Top challenges 2021: #1 administrative burdens and paperwork. Medical Economics website. Published January 15, 2021. https://www.medicaleconomics.com/view/top-challenges-2021-1-administrative-burdens-and-paperwork.

[11] Freeman L. Is your doctor at risk?; Burnout could drive physicians from field, jeopardize patient. *Northwest Florida Daily News*. Published December 1, 2021.