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January 17, 2020

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS Solicitation of Feedback on EO #13890

Dear Administrator Verma:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on President Trump's Executive Order (EO) entitled, *Protecting and Improving Medicare for Our Nation's Seniors* (EO #13890).

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 health care system by improving health care delivery and outcomes and ensuring that patients receive high-quality care.

We appreciate and support the goal of protecting and improving the Medicare program. We also appreciate efforts to reduce paperwork requirements for physicians. It is critical the Medicare program is prepared to care for our nation's seniors, especially as the number of Medicare-eligible individuals rise. The EO contains forward-leaning proposals to increase choice for seniors that will drive down costs for the program and beneficiaries. However, we are concerned that Section 5 of the EO contains broad language that will inadvertently raise costs for Medicare and place patients at risk while doing little to reduce physician burden.

We believe implementing the EO could have serious impacts on patient care and the primary care physician profession. Primary care physicians deliver the highest quality care for America's seniors because of their extensive training and education. Equalizing payments among primary care physician and non-physicians will not solve the systemic issues the EO is attempting to address. Conversely, appropriately valuing primary care physician services can ensure patients continue to have access to high-quality, physician-led primary care. We urge CMS to carefully consider our comments when implementing the EO to ensure beneficiaries will continue to have access to high quality primary care physicians.

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,

Robert C. DeLuca, DO, FACOFP *dist.*
ACOFP President

The EO on *Protecting and Improving Medicare for Our Nation's Seniors* takes an innovative approach to lowering health care costs for our seniors while ensuring the long-term sustainability of the Medicare program. We agree that alternative payments linking payment to value, increasing choice, and reducing regulatory burdens on providers has the potential lower costs for seniors and protect Medicare. However, we have significant concerns regarding Section 5 of the EO. Specifically, we are concerned with the language that relates to physician supervision and reimbursement for non-physician services. In addition, we are concerned that Section 5(b) could be misinterpreted in a way that would reduce reimbursement for primary care physicians, further limiting beneficiary access to primary care physician services. We outline our specific concerns below and recommend changes that align with the EO's overall goal to ensure fiscal responsibility and drive innovation in the program without risking patient safety.

1. The Unmatched Credentials of Physicians

The path to becoming a physician is long, typically requiring 11 to 14 years of education, testing, and training. In addition to a four-year undergraduate degree, physicians must successfully complete the Medical College Admission Test, complete hundreds of hours of lectures and training, and complete two years of rotations in a variety of care settings, including community hospitals, large medical centers, and physician offices. Students must have superb academic credentials, perform at a high level during clinical rotations, and excel at the training designed to ensure patients receive the highest quality care. All of this activity, however, comes at a significant cost and student debt. The median medical school debt in 2018 was $200,000.[1]

After successfully completing medical school, a student must then begin postgraduate residency. Residency includes thousands of hours of training over the course of three to seven years. During this time, physicians gain expertise and advanced clinical skills for a wide range of patient conditions to sharpen and perfect their practice. Additionally, a physician must pass rigorous examinations in order to receive their medical license, and once licensed, an overwhelming majority of physicians must participate in continuing medical education and complete comprehensive board certification examinations throughout their career. A family physician will spend approximately 18,900 more hours on education and training than other mid-level health providers.[2] The education, training, and commitment to continued learning during a physician's career are representative of the significant and unmatched credentials of physicians and the profession's rigorous requirements that ensure patients obtain the highest quality health care.

Decades of evidence has shown that physicians are better positioned to deliver high quality care because of their demanding education and professional training requirements. Further, osteopathic physicians are specially trained to deliver comprehensive primary care rather than sporadic and emergency care provided by non-physicians in urgent care settings or via telemedicine.

The disparity in reimbursement between physicians and non-physicians is one of practicality and value, with physicians trained to provide higher levels of health care services than non-physicians. We recognize that non-physicians play a critical role as part of physician-led care teams, but physicians are physicians because they received unmatched education and training in the furtherance of patient safety and higher quality. We value our non-physician team members, but

[1] Ken Budd, "7 Ways to Reduce Medical School Debt." Association of American Medical Colleges. Website Accessed December 31, 2019 at https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt

[2] Primary Care Coalition. "Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners." Texas Academy of Family Physicians, Texas Pediatric Society, and the Texas Chapter of the American College of Physicians. Accessed January 15, 2020 at https://tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf

ultimately, the conditions to participate in Medicare as a physician are fundamentally different from those of non-physicians, reflecting the differences in care delivered.

2. Addressing Administrative Burden for Physicians

ACOFP applauds the White House and the Department of Health and Human Services (HHS) for their attention to physician administrative burden. The Centers for Medicare & Medicaid Services' (CMS) Patients Over Paperwork Initiative has eliminated countless hours of administrative burden and allowed physicians to devote more time to treating patients. The EO correctly focuses on reducing administrative burden; however, we are concerned that the proposals pertaining to scope of practice are overly broad attempts to reduce administrative burden at the expense of patient safety and increased program spending. In addition, we disagree that revising scope of practice rules are a component of physician administrative burden. Rather, scope of practice issues should not be characterized as part of an initiative to reduce physician burden. We understand that many states have tailored their physician supervision and scope of practice laws to best meet their state's unique needs. We also appreciate CMS' policy principle to defer to state authorities regarding scope of practice laws, which was reiterated in the recent Calendar Year 2020 Physician Fee Schedule final rule. We agree that states are best suited to oversee physicians and medical professionals within their borders, but we believe this is because states are better positioned to put supervision requirements in place that most appropriately balance access and high quality care. ACOFP is hopeful that CMS will continue to follow this principle as it implements the EO's language on scope of practice.

Administrative burden primarily comes in the form of utilization management tools (e.g., prior authorization or step therapy) or electronic medical record (EMR) and documentation requirements. HHS and the White House should focus on reducing administrative burden that truly inhibits physicians' ability to treat patients. Therefore, we urge the Administration to: (1) work with Congress or take regulatory action to standardize prior authorization requirements across all payers and reimburse physicians for time spent on prior authorization; (2) improve EMR interoperability and functionality; and (3) evaluate and revise existing unnecessary documentation requirements in federal health care programs. We believe that focusing on these initiatives would be better aligned with the goal of reducing burdens to protect and improve Medicare.

3. EO Impact on Patient Safety and Care Delivery

Physician-led care teams are the gold standard for care delivery – non-physician led care teams are not equivalent. We fear the EO may be interpreted in a way that could allow health care professionals with less training and expertise to take the place of the family physician and risk patient safety. This will neither protect nor improve care for our seniors. Further, if seniors do not have access to the higher level of health care services only physicians can provide, this will continue to jeopardize the fiscal sustainability of the Medicare program. Costs will rise when a patient must undergo multiple visits or be hospitalized because they did not receive physician-led care at the outset. Also, as costs rise in fee-for-service Medicare, costs will increase for Medicare Advantage (MA) plans as MA organizations base their spending on Medicare fee-for-service spending.

We also believe that mandating pay parity between physicians and non-physicians will drive up costs in the form of higher payment rates for many non-physicians. This could lead to a decrease in access to affordable, high-quality care for beneficiaries. As more non-physicians are eligible for higher payment rates, the overall cost of care will increase. Costs will increase, and beneficiaries will be forced to pay more out of pocket. In addition, simply raising payment rates is not an evidence-based approach that CMS should employ. It is a "band-aid" fix that will limit beneficiaries' access to the

highest quality primary care available. Instead, CMS should focus on addressing the primary care physician shortage issue to ensure beneficiaries have access to the best possible care and enjoy the highest quality of life.

4. Re-Establishing the Primary Care Physician Pipeline

Currently, our country faces a shortage of between 21,100 and 55,200 primary care physicians by 2032.[3] As more primary care physicians are reaching retirement age and the Medicare population grows, it is critical that the primary care physician pipeline is ready to meet the care needs of our seniors. If non-physicians are reimbursed at the same amount as physicians, there will be little incentive for medical students to pursue a career in primary care. Students already are incentivized to choose specialty training (e.g., cardiology, pulmonary medicine) over primary care because of higher reimbursement rates for specialty services and significant costs of becoming a physician. As previously outlined, we are concerned with elements of Section 5 (paragraphs (a) and (c)), which may further exacerbate the physician shortage and threaten the primary care career path.

With respect to Section 5(b), we are cautiously optimistic that this instruction would address one of the major components of re-establishing the primary care physician pipeline. As written, we interpret this as directing HHS to propose a regulation that would ensure appropriate reimbursement, reflecting the value of the service provided and the time spent by primary care physicians and other specialty physicians. As we have previously commented to CMS, the value of primary care is well-documented. Beneficiaries with greater access to stable, coordinated primary care have better outcomes and lower health care utilization. Of greatest importance is the fact that increased access to physician-led primary care reduces unnecessary specialty care, reducing downstream costs that could otherwise be avoided. Therefore, we would support efforts to ensure appropriate reimbursement across primary and other specialty care physicians such that reimbursement more appropriately reflects the value of time patients spend with their primary care physicians.

We are concerned, however, that the broad language of Section 5(b) could be misinterpreted to suggest establishing parity between physicians and non-physicians who are some other "specialist health provider." If implemented incorrectly, primary care physicians could receive even less compensation for time spent with patients. Primary care physicians provide high-quality care to all patients, which includes spending time discussing patient social determinants of health as well as lifestyle and social concerns that are not captured in traditional Medicare billing. Thus, primary care physicians spend more time with patients at lower reimbursements. Subsequently, administrative tasks are often pushed to non-business hours, leading to significant "burn out" among the already limited supply of primary care physicians. A reduction in reimbursement resulting from Section 5(b) would be catastrophic to the current and future primary care physician workforce. As CMS contemplates developing a regulation pursuant to this section of the EO, we urge you to consider the value of primary care and ways to ensure beneficiaries continue to have access to high-quality, physician-led primary care.

We urge the Administration to focus on solutions that will meet the primary care physician workforce demands. CMS can do so by investing the expected resources for implementing Section 5 on physician workforce development initiatives and ensuring appropriate reimbursement for primary care

[3] Stuart Heiser. "New Findings Confirm Predictions on Physician Shortage." Association of American Medical Colleges. Website Accessed December 31, 2019 at https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage

physician services. One approach the Administration could take is to invest in loan repayment and forgiveness programs for physicians choosing a career in primary care. These programs have a long-standing history of attracting talented young physicians to the primary care profession. CMS also could, as we suggest in response to Section 5(b), equalize reimbursement for primary care and specialty care among physicians. This would incentivize greater use of primary care services, which have been proven to reduce unnecessary health care services and improve patient outcomes. Enacting these changes would better achieve the goals of the EO and improve the quality of life for countless seniors. We also appreciate that CMS is currently pursing value-based primary delivery models through the new Primary Cares Initiative and urge you to continue these efforts to ensure more solo, small, and rural practices have an opportunity to participate in value-based models. CMS can bolster physician-led primary care delivery by building on its existing efforts while also following the directives of the EO.

Conclusion

We appreciate the opportunity to comment on non-physician scope of practice and reimbursement policies. We reiterate our recommendations for the Administration to:

- Working with Congress to take regulatory action to standardize prior authorization requirements across all payers and to reimburse physicians for time spent on prior authorization;
- Improve EMR interoperability and functionality;
- Evaluate and revise existing unnecessary documentation requirements;
- Ensure Medicare beneficiaries continue to have access to the gold standard of care – physician-led primary care; and
- Take steps to protect the current primary care workforce and to re-establish the primary care physician pipeline.

We share the same goals as the Administration: to ensure the fiscal sustainability of Medicare while improving the quality of care for our nation's seniors. ACOFP is ready to work with CMS to achieve those goals. Thank you for your attention to and consideration of our comments and recommendations.