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March 1, 2019

VIA ELECTRONIC SUBMISSION

The Honorable Lamar Alexander
Chairman, Senate Committee on Health, Education, Labor, and Pensions
Washington, DC 20510

The Honorable Patty Murray
Ranking Member, Senate Committee on Health, Education, Labor, and Pensions
Washington, DC 20510

RE: Addressing America's Rising Health Care Costs

Dear Chairman Alexander and Ranking Member Murray:

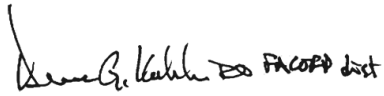
On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Senate Committee on Health, Education, Labor, and Pensions request for information on addressing America's rising health care costs (the RFI).

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 the Committee's interest in addressing rising health care costs and believe that primary care physicians can and should play a significant role in these efforts.

Overall, as an organization our osteopathic family physicians practice in variety of settings, including in solo, small, group, rural, Native American Indian healthcare, and alternative payment models. Every day, our members provide primary care services to patients all across the country in these different settings. We understand the critical importance of primary care services and have witnessed the alarming shortage of family physicians our country faces. We strongly believe that primary care must be leveraged to improve outcomes and reduce costs.

Our full comments are detailed on the following pages. Thank you for the opportunity to share these 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,



Duane G. Koehler, DO, FACOFP *dist.*
ACOFP President

The Value of Primary Care Services

Studies have established that increased access to primary care is more likely to result in preventive services and treatment for medical conditions before they become chronic and costly to treat.[1, 2] As demonstrated in the 2005 Barbara Starfield primary care study *Contribution of Primary Care to Health Systems and Health*,[3] primary care: (1) increases access for deprived population groups; (2) contributes to the quality of clinical care; (3) leads to improved prevention; (4) leads to early management of health problems and corresponding improved health and reduced costs; (5) leads to more appropriate care; and (6) reduces unnecessary or inappropriate specialty care. This study illustrates primary care's importance, and we believe demonstrates that primary care should be emphasized in future work to address rising health care costs.

ACOFP also has long supported efforts to redesign how health care is delivered, especially in terms supporting access to family medicine and primary care services. Our members recognize the importance of value-based care as evidenced by the 40 percent of our members participating in accountable care organizations (ACOs) and Advanced Alternative Payment Models (APMs). ACOFP members have firsthand experience of the reality of implementing value-based arrangements, including ACOs. Moreover, while primary care services alone can reduce costs and improve care, new studies[4] have also shown that primary care is a key contributor to successful ACOs. Unfortunately, ACOs and Advanced APMs do not sufficiently value the delivery of primary care services and are administratively burdensome for solo, small, and rural area primary care practices.

Critical Steps Needed to Increase Access to Primary Care Services

According to a November 2013 HRSA report, the United States faces shortages of 20,400 primary care physicians by 2020[5]. By 2025, the United States is expected to require nearly 52,000 additional primary care physicians to treat the aging population and account for the additional consumption of resources during the projected 565 million primary care office visits.[6] At its January 2018 meeting, the Medicare Payment Advisory Commission (MedPAC) also highlighted its concerns about primary care as it relates to Medicare. Specifically, MedPAC staff noted that the physician fee schedule is not oriented towards primary care services, compensation for primary care is substantially less than other specialties, and typical primary care services (evaluation and management) are labor-intensive. MedPAC staff expressed concern that these factors have decreased the pipeline of future

[1] A. B. Bindman, K. Grumbach, D. Osmond et al., "Primary Care Receipt of Preventive Services," Journal of General Internal Medicine, May 1996 11(5):269–76

[2] L. A. Blewett, P. J. Johnson, B. Lee et al., "When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services," Journal of General Internal Medicine, Sept. 2008 23(9):1354–60

[3] B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," The Milbank Quarterly, Vol. 83, No. 3, 2005: 457-502

[4] *See,* Y. Jabbarpour, M. Coffman, A. Habib et al., "Advanced Primary Care: A Key Contributor to Successful ACOs," August 2018. Available at https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf.

[5] HRSA Bureau of Health Professions, "Projecting the Supply and Demand for Primary Care Practitioners Through 2020," November 2013. Available from: https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projectingprimarycare.pdf

[6] S.M. Patterson et al., "Projecting US Primary Care Physician Workforce Needs: 2010-2025," Ann Fam Med, November/December 2012 10(6):503-509

primary care physicians.[7] During this meeting, MedPAC Chairman Francis Jay Crosson noted that there is a "fair likelihood" that the primary care physician pipeline is in trouble. Chairman Crosson further stated, "we could find a situation in a few years where a significant number of Medicare beneficiaries who want to see a physician for primary care services are unable to do that because [the primary care physician] is not there."[8] In order to address this shortage and to ensure patients continue to have access to primary care physicians, we offer several recommendations.

Increasing the Number of Primary Care Physician Residency Positions to Reflect Workforce Needs

There is an urgent need for additional primary care physicians, which begins with systemic changes to re-establish the pipeline. For the reasons described, we believe it is especially relevant and extremely urgent to reform the graduate medical education (GME) program to more accurately reflect workforce needs. Unfortunately, the critical state of the primary care pipeline is not a new issue. The Health Resources and Services Administration Council on GME issued a Report to Congress in December 2010 that highlighted the critical need to advance primary care. COGME noted that "[GME] is central to the development of the workforce. Federal policies are needed to redesign GME to meet existing challenges." Therefore, we strongly encourage the Congress to work with family physicians and the Council on GME to support and stabilize the primary care physician workforce.

In 2014, 52.2 percent of the 884.7 million office visits were made to primary care physicians,[9] and it is expected that there will be significant shortages of these physicians. We therefore believe it is imperative that GME funding be allocated based on workforce needs. Specifically, we recommend that primary care residency positions (including family medicine) account for 50 percent of total residency positions. It has been nearly a decade since the Council on GME submitted its report, and despite efforts to increase access through the use of mid-level providers, the shortage persists today. Furthermore, while we recognize the importance of nurse practitioners (NPs) and physician assistants (PAs), the most effective and efficient care is delivered through a team-based approach led by physicians. Expanding scopes of practice or increasing the NP and PA workforce is not the "silver bullet" to the primary care physician shortage.

Supporting Community-Based Primary Care Residencies

As you know, there are inequities in the geographic and socioeconomic distribution of physicians. This maldistribution is especially prevalent among primary care physicians. Physicians are more likely to practice near the location they completed their residency training.[10] However, these residency positions are mostly available in the hospital setting, and not in the rural and underserved

[7] Rebalancing the physician fee schedule towards ambulatory evaluation and management services (presentation). Available from: http://www.medpac.gov/docs/default-source/default-document-library/rebalancing-fee-schedule-towards-e-m_jan-2018_public.pdf?sfvrsn=0

[8] Rebalancing the physician fee schedule towards ambulatory evaluation and management services (transcript). Available from: http://www.medpac.gov/docs/default-source/default-document-library/jan-2018-meeting-transcript.pdf?sfvrsn=0

[9] Rui P, Hing E, Okeyode T. National Ambulatory Medical Care Survey: 2014 State and National Summary Tables. Available from: http://www.cdc.gov/nchs/ahcd/ahcd_products.htm

[10] Laff, Michael. Reports Highlight the Importance of Residency Training in Underserved Areas. American Academy of Family Physicians website. http://www.aafp.org/news/education-professional-development/20150218gmetraining.html. Published February 18, 2015.

community settings where the need for primary care physicians is highest.[11] The Teaching Health Center (THC) GME program has been successful in increasing the number of primary care physicians in rural and underserved areas and is a key component that must be supported.[12] We thank the Committee for its efforts to reauthorize and provide stable funding for the THC GME program and offer our support.

ACOFP is also proud of our osteopathic training, which focuses on holistic care. Subsequently, osteopathic family physicians receive additional training that enables them to provide both effective preventive treatment and certain office-based procedures. This is especially critical in rural areas where there may not be hospitals nearby. This also serves as a cost-control function as osteopathic family physicians are able to provide certain services in lower cost care settings. We believe that this is a key and unique feature of osteopathic medicine and will be an important tool in addressing rising health care costs.

Incentivizing Primary Care Careers

Ensuring residency slots for primary care are available is the first step to re-establishing the primary care physician pipeline. However, this effort must be supported with incentives that encourage medical students to pursue primary care physician careers. ACOFP believes it is critical to provide incentives for physicians practicing in rural and underserved areas. This could be achieved by significantly increasing the federal government's commitment to loan forgiveness programs and federal health program reimbursement that more appropriately reflects the value of primary care.

As previously described, the value of primary care physicians is their ability to treat and manage chronic care, provide preventive services, safely and effectively perform certain procedures, and coordinate care. All of these services are critical in controlling unnecessary downstream health care costs, such as avoidable specialty care, inpatient admissions, and emergency department use. We need more primary care physicians.

With regards to student loans, the ever-increasing burden of student loan debt faced by new graduates steers them away from the specialty of family medicine. While medical schools have gone to great lengths to absolve their students of this incredible financial burden, we believe the federal government has a critical and essential role to play. Specifically, we suggest that the federal government subsidize student loan interest for students who choose to practice family medicine. This would significantly reduce the financial burden and further incentivize medical students to pursue a career in family medicine.

ACOFP also believes that incentivizing physicians to pursue careers in primary care requires supporting practice transformation and fully supporting solo, small, and rural primary care practices. As the population ages, there are increasing burdens to treat more complex patients and to meet federal requirements (such as the use of certified electronic health record technology). Primary care physicians often do not have the funding or capacity to invest in critical infrastructure. In addition, these burdensome requirements, especially those associated with electronic health records (EHRs), are directly and adversely impacting physician wellness. A recent study in the Journal of the

[11] Ku, Leighton et. al. Teaching Health Centers: A Promising Approach for Building Primary Care Workforce for the 21st Century. http://publichealth.gwu.edu/pdf/eIR/GGRCHN_PolicyResearchBrief_40.pdf Updated March 10, 2015.
[12] Regenstein, Marsha et. al. The Cost of Residency Training in Teaching Health Centers. N Engl J Med. 2016; 375:612-614. DOI: 10.1056/NEJMp1607866

American Medical Informatics Association indicates that EHR burden is associated with "physician burnout," especially for primary care physicians.[13] Burnout can lead to poorer quality care, lower levels of satisfaction (for both patients and physicians), and drive physicians out of practice. Ultimately, the current EHR burden creates greater limitations for patients to access their primary care physicians. Therefore, we believe improving financial support to aid in practice transformation, including less burdensome technology and documentation requirements, will be critical to ensure primary care physicians can leverage telehealth and other emerging technologies to provide more primary care to more patients.

Finally, in terms of reimbursement, we are concerned that recent proposals by the Centers for Medicare & Medicaid Services will have an adverse impact on primary care physicians. Specifically, the finalized changes to the evaluation and management (E/M) coding will actually increase burdens on primary care physicians and reduce overall reimbursement. This moves in the opposite direction of how the health care system should be evolving.

Supporting Innovative Primary Care-Focused Value-Based Arrangements and Models

As previously described, 40 percent of ACOFP's members participate in some form of value-based arrangement or model. This includes Centers for Medicare & Medicaid Services (CMS) demonstrations (e.g., the Comprehensive Primary Care Plus model, the Next Generation ACO Model) as well as innovative models available in the private sector (e.g., the Direct Primary Care (DPC) model). We support the transition toward value-based care as we believe this aligns with the goals and value of primary care services. However, there are many challenges and barriers to primary care physician participation in such models and arrangements.

ACOFP has identified that one of the most significant challenges to physician APM participation is the required upfront investment in care redesign. Further, many APMs rely on retrospective payments, which can lag as much as a year behind the actual date of service. This arrangement and model structure make it virtually impossible for solo, small, and rural physicians to meaningfully participate in care redesign or to transition to value-based care. In order to promote family physician participation in these value-based arrangements, we recommend models designed around per beneficiary per month payments with risk and gain sharing associated with quality outcomes within the primary care physician's control (e.g., management of chronic diseases, medication counseling and adherence, reduction in unnecessary emergency department or specialty care use). Another way to increase family physician participation is to integrate the use of primary care services in existing and new specialty demonstrations. We strongly believe that primary care physicians should "quarterback" care. Thus, coordination between the primary care physician and other specialists should be an essential quality metric of demonstrations.

Furthermore, we especially support the DPC model, which has been effective in not only supporting primary care physicians by reducing burdens, but has also expanded access for patients across a variety of geographic settings. We urge the Committee to continue to focus on ways to support the DPC model, including the *Primary Care Enhancement Act*, introduced by Senator Bill Cassidy in the last congressional session. We believe supporting the DPC model is important to protecting and supporting access to primary care services.

[13] Rebekah L Gardner, Emily Cooper, Jacqueline Haskell, Daniel A Harris, Sara Poplau, Philip J Kroth, Mark Linzer; Physician stress and burnout: the impact of health information technology, Journal of the American Medical Informatics Association, Volume 26, Issue 2, 1 February 2019, Pages 106–114 (published 5 December 2018), https://doi.org/10.1093/jamia/ocy145

Conclusion

ACOFP thanks the Committee for soliciting feedback and comments on this important issue. We strongly believe that primary care physicians are critical to reducing health care costs by focusing on preventive services and reducing avoidable and high cost downstream utilization. In order to fully support primary care physicians, systemic reform is needed. ACOFP believes and urges the Congress to pursue solutions in line with our recommendations. We offer our support and welcome the opportunity to provide additional details or discuss these issues further.