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VIA ELECTRONIC SUBMISSION (to InnovationCaucus@mail.house.gov)

Representative Mike Kelly
1707 Longworth House Office Building
Washington, DC 20515

Representative Markwayne Mullin
1313 Longworth House Office Building
Washington, DC 20515

Representative Ron Kind
1502 Longworth House Office Building
Washington, DC 20515

Representative Ami Bera
1431 Longworth House Office Building
Washington, DC 20515

Re: Health Care Innovation Caucus Request for Information

Dear Representatives Kelly, Kind, Mullin, and Bera:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to provide comments in response your request for information (RFI) on value-based payment arrangements and technology and health IT.

The 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.

Overall, as an organization our osteopathic family medicine physicians practice in a variety of settings, including solo, small, group, rural, Native American Indian healthcare, and alternative payment models (APM) and Advanced APMs (A-APMs). Generally, we are supportive of efforts to transition the healthcare system toward value-based care. Value-based care emphasizes wellness, prevention, and avoiding unnecessary resource use, which are at the core of our osteopathic philosophy and training. However, there are several barriers to successful implementation of APMs that disproportionately impact primary care physicians, especially those practicing in solo, small, or rural practices.

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 Debbie Sarason, Manager, Practice Enhancement and Quality Reporting at (847) 952-5523 or debbies@acofp.org.

Sincerely,

Duane G. Koehler, DO, FACOFP *dist.*
ACOFP President 2018-2019

1. Value-Based Arrangements and Provider Payment Reform

ACOFP appreciates the Caucus's recognition of the critical need to sustain the transformation from a volume-driven system to one that rewards value and outcomes. We agree that there must be a marketplace of multiple payment models and offer our support in pursuing a legislative agenda that encourages innovative ideas to improve health care quality and lower costs. Most importantly, ACOFP supports efforts to redesign how care is delivered and would urge the Caucus to focus on supporting access to family medicine and primary care services.

The value of primary care is well-documented. Studies have shown 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 study, *Contribution of Primary Care to Health Systems and Health*,[3] primary care: (1) increases access for vulnerable 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.

Despite primary care's proven success in improving outcomes and lowering costs, there are few value-based arrangements (VBAs) that accurately assess or calculate the savings attributable to increased access to primary care. For example, Comprehensive Primary Care (CPC) model provided a capitated payment for non-visit based care management fees, which averaged $17.50 per beneficiary per month. The CPC model resulted in some positive outcomes, including reduced emergency department utilization, fewer hospitalizations, and improved patient satisfaction. Further, Medicare expenditures grew more slowly for CPC participants than for the comparison group.[4] We recognize that there were minimal savings associated with CPC but highlight that the value of family medicine is in the long-term prevention of chronic conditions and for population health-related measures. Specifically, the management of chronic diseases and ensuring patients have continued access to preventive services is critical to containing long-term cost growth, which was not reflected sufficiently in CPC.

ACOFP commends the Centers for Medicare & Medicaid Services (CMS) for continuing its efforts to expand access to primary care services but believes there is much more that can be done. Many of the existing models are complex, do not fully capture the value of family medicine, and do not account for other cost drivers in the health care sector. Further, ACOFP believes rural providers face unique challenges that must be accounted for and addressed in future models. We fully believe that innovative Value-Based Arrangements (VBAs) and provider payment reform must be studied and designed with access to primary care in mind. Appropriately designed models that leverage the strengths of family medicine will result in significant cost savings and help to slow the growth of health care costs.

Participation in Value-Based Payment Arrangements and Models

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[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, Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report available at https://www.mathematica-mpr.com/our-publications-and-findings/publications/evaluation-of-the-comprehensive-primary-care-initiative-fourth-annual-report.

ACOFP represents osteopathic family medicine members, nearly 40 percent of whom participate in APMs and Advanced APMs. Our members participate in formal CMS demonstration projects, including, Comprehensive Primary Care Plus (CPC+), and Next Generation ACO's, as well as other alternative payment arrangements, such as Direct Provider Contracting Model (DPC). Based on ACOFP's firsthand experience, we have observed the benefits and challenges of such models.

Successful Value-Based Arrangements and Models

ACOFP has found that VBAs are most successful when they are flexible, enable physicians to provide feedback throughout the process, protect the patient-physician relationship, and are formed in a way that accounts for the unique situation of the physician – including solo, small, and rural practice providers. Further, VBAs that identify, address, and when appropriate remove unnecessary burdens of reporting requirements often have better participation rates. Robust participation is critical to ensure the impact of a VBA is not skewed or inappropriately extrapolated in a manner that would misstate how it might impact various patient populations.

DPC is an example of a successful VBA. Specifically, DPC enables primary care physicians to offer critically important family medicine services at a flat rate without having to go through the various reporting and billing burdens imposed by insurers. By removing unnecessary administrative red-tape, DPC family physicians can spend more time with more patients, increasing access to the family medicine services, often at a lower out-of-pocket cost for patients. Further, DPC supports improved continuity of care and strengthens the patient-physician relationship.

Barriers that Limit the Full Potential of Innovation

CMS has recognized that there must be additional options for physicians to participate in APMs. While several models provide an avenue for participation, the evaluation and assessment of these models have uncovered various challenges and avoidable burdens on physician participation. ACOFP believes there are four significant barriers: (1) lack of physician time required for administration and reporting to ensure ongoing stakeholder engagement and interaction; (2) unnecessary regulatory burdens; (3) model design limitations; and (4) financial barriers. These barriers are more acutely felt by the solo, small, and rural family medicine practices who comprise 40 percent of ACOFP's membership.

Stakeholder Engagement

ACOFP believes that to ensure continued participation in new models, stakeholders must have defined opportunities to provide feedback and input, not just in the design phase, but also during development and throughout model implementation. ACOFP believes any model should include interim evaluations, reports, and updates so that participants can monitor progress, identify issue areas, and adjust as needed. In addition, the existing CMS models have significant delays in data sharing. For example, the Merit-based Incentive Payment System (MIPS) operates on a two-year delay, where a participant's performance will be reflected in payment adjustments two years later. At times, the lag in data delivery has negatively impacted physicians' ability to adapt and improve care for their patients. It is critical that these outcomes data be shared with physicians in a timely manner. The data lag has also had adverse effects on reimbursement and the opportunity for solo, small, and rural practices to continue participation. These practices have extremely thin margins, and a delay in receiving appropriate value-based payments is a significant barrier to participation.

Regulatory Burdens

There are several regulations and laws that unnecessarily burden CMS model participants. These barriers inhibit true innovation and care redesign that are needed to improve outcomes while reducing costs. Specifically, requirements to use certified electronic health record (EHR) technology (CEHRT) are not only burdensome, but extremely expensive. Further, participants in different models can face complex or varying legal requirements as CMS has not consistently provided regulatory/legal waivers. This is the case with CPC+ and participation in MIPS. Specifically, our members have faced reporting burdens and are essentially required to perform duplicative work based on participation requirements in MIPS and CPC+.

Model Design Limitations

Regulatory burdens and barriers disproportionately impact solo, small, and rural physicians who would benefit from additional administrative support and alternative tools to provide high quality care. ACOFP believes that to ensure robust provider participation, models must be designed with such solo, small, and rural physicians in mind especially since these practitioners often treat underserved and vulnerable populations.

Solo, small, and rural physicians face unique challenges and barriers. These difficulties were recognized in the Medicare Access and CHIP Reauthorization Act of 2015, as Congress instructed CMS to consider small and rural practices. CMS responded by providing exemptions for certain clinicians practicing in solo or small practices, which were of little value to these physicians. In addition, many of these physicians are excluded from care redesign efforts as models have not been developed to address the barriers they face.

Financial Barriers

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. As noted previously, the MIPS lag is two years. This arrangement and model structure make it virtually impossible for solo and small practices to meaningfully participate in care redesign or to transition to value-based care.

ACOFP believes it is critical that models provide added flexibilities in how services are delivered as well as prospective payments to ensure providers can reasonably rely on payments to sustain care redesign. Considering the family physician's role in not only providing direct medical care, but also as the first line of defense against avoidable acute episodes, we believe it is essential that models recognize and reimburse participants for care coordination services such as, Transitional Care Management, Chronic Care Management, the Diabetes Prevention Program, and telehealth services. ACOFP commends and encourages the Innovation Caucus to continue to develop this type of reimbursement for all Primary Care Physicians as to incentivize preventative care more fully in the current practice of medicine. The monies spent on preventative care coordination, improves patient outcomes, and saves resources downstream.

Congressional Assistance to Develop, Test, and Improve Innovative Models

ACOFP believes that one of the overlooked consequences of the barriers to VBA participation is that patients are also excluded from participation. We believe it is critical to ensure that new models do not limit patient access to needed care and to innovative models that have demonstrated improved outcomes at reduced costs. Specifically, ACOFP believes that new models must be developed that appropriately capture the value of family medicine. The primary benefits of family medicine are: (1)

primary care physicians have longstanding relationships with patients and their families; and (2) overall costs are lowered through preventive services and reduced use of unnecessary specialty or emergency care.

We believe it is important to review the current studies on the value of family medicine and quantify its benefit. While we recognize the economic difficulties in calculating and valuing avoided adverse outcomes, we believe it is important to both review and estimate current savings so that CMS can better develop new models. When there is a better understanding of potential savings, this could create new opportunities for models that appropriately incentivize family medicine. Specifically, addressing financial barriers to enable solo, small, and rural providers to implement proven care redesign will be critical to ensuring all patients have access to better care at lower costs.

Issues Impacting Rural Physicians

While our comments generally apply to all ACOFP members, we urge the Caucus to specifically consider the issues associated with VBAs that impact rural physicians. Requirements associated with the Promoting Interoperability (PI) program and are especially challenging for rural family medicine practices that do not have access to a broadband connection. ACOFP appreciates the efforts which have been made by CMS to offer Hardship Exemptions to those practices who cannot utilize an EMR in their practice for various reasons. However, this does not solve the problems which contribute to these hardships.

While CMS has taken steps to address administrative burdens to support rural practices (e.g., the Transforming Clinical Practice Initiative and Practice Transformation Network), more assistance is needed from the government to support rural physicians and their patients. We commend the government for offering loan repayment to physicians coming out of residency who are willing to spend two years practicing in a rural setting. More rural recruitment incentives along these lines would benefit overall care for this underserved patient population.

Further, dual eligible individuals pose greater challenges in rural areas as these individuals are often have multiple medical conditions and would benefit from additional focus on their behavioral and social determinants of health. Rural physicians, especially those practicing family medicine, have slim operating margins, and thus less operating capital to adapt to VBAs, learn about best practices, and implement expensive care redesign efforts. While some training avenues exist, it is especially challenging for rural physicians to partake in or benefit from such opportunities.

To ensure rural provider participation, we believe it is critical that future models consider the financial reality facing these physicians and the disproportionate share of Medicaid and dually eligible individuals whom rural physicians treat. As you know, many rural hospitals have closed in the last 10 years due to inadequate funding. Many that remain are old and outdated, there are many safety net hospitals on the brink of closure. Our physicians rely on being able to refer to these hospitals. We recognize CMS's efforts, including its Rural Health Strategy, to ensure rural practices are protected, and we similarly urge the Caucus to ensure there are sufficient opportunities and protections moving forward.

2. Technology and Health IT

ACOFP believes that technology and health IT can significantly improve the effectiveness and efficiency of the health care system. However, to appropriately leverage innovation in technology, there must be broadband connections in all parts of the country. Many of our rural family medicine practice members provide services to individuals without a reliable internet connection. This is a significant challenge, especially in rural areas where patients must travel long distances to receive

preventive care. Further, patients may not have the time or opportunity to go to their primary care provider but could address certain health care issues through remote monitoring or telehealth systems, instead of a costly emergency department visit. Such technology has proven to be extremely beneficial, especially considering the significant family physician shortages that we face.

ACOFP also has identified that many existing EHR systems do not offer sufficient population health management. Many systems were developed prior to physicians and EHR industry fully understanding the value of population health management. ACOFP believes there should be a population health incentive program, like the EHR Incentive Program that would improve upon the existing systems and offer solo, small, and rural practices a pathway to improve their accuracy of patient management. ACOFP believes that a focus on population health, including more education for physicians and other eligible professionals on what it is and how it can improve care will result in more targeted care plans, more effective patient management, better outcomes, reduced long-term costs, and improved patient satisfaction.

3. Conclusion

ACOFP urges the Health Care Innovation Caucus to consider the on-the-ground experience of family physicians and the reality of implementing VBAs. Nearly 40 percent of our members are solo, small, and rural family medicine practices; who are at a significant disadvantage and must be afforded stability and certain protections if they are expected to meaningfully participate in care redesign initiatives and efforts. Despite the barriers that exist to meaningful VBA participation, 40 percent of ACOFP members participate in ACOs or A-APMs to improve care and reduce costs. ACOFP stands ready to work with you as you explore and advance innovative payment models.