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March 21, 2018

VIA ELECTRONIC SUBMISSION

Ways & Means Subcommittee on Health
U.S. House of Representatives
1102 Longworth HOB
Washington DC, 20515

Re: ACOFP statement on Implementation of the Quality Payment Program

The American College of Osteopathic Family Physicians (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. Our full statement is included below.

Thank you for the opportunity to share our statement 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

The American College of Osteopathic Family Physicians (ACOFP) appreciates the opportunity to provide this statement to the House Ways & Means Health Subcommittee (Committee) regarding the implementation of the Quality Payment Program (QPP) – including the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (A-APMs) – under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We applaud the Committee for holding a hearing on the implementation of MACRA.

As an organization, our osteopathic family physicians practice in a variety of settings, including solo, small, group, rural, Native American Indian healthcare, Alternative Payment Models (APMs), and Advanced Alternative Payment Models (A-APMs). Generally, we are supportive of CMS' focus on patient-centered, value-based care. Value-based care, which emphasizes wellness and prevention, are at the core of our osteopathic philosophy and training.

Primary Care Physicians (PCPs) should be at the frontlines of care and appropriately integrated within a care pathway. When appropriately empowered, they improve quality of care while reducing unnecessary resource use.

We acknowledge and appreciate recent efforts to reduce provider burden and to simplify various components of the Quality Payment Program (QPP). While we still have some concerns with the program's implementation, we are hopeful that CMS will continue to keep an open mind to suggestions from family physicians, especially where it allows for increased time for patient interaction and reduction of reporting burden.

MIPS Implementation

ACOFP supports movement towards a healthcare system that rewards value over volume. Specifically, we believe that PCPs provide valuable services that often reduce the need for higher cost care. Our comments focus on the need to protect and appropriately value family physicians within the context of the MIPS performance.

1. Resource Use Performance Category

As you know, in the recently passed *Bipartisan Budget Act of 2018* (BBA), Congress provided the Centers for Medicare & Medicaid Services (CMS) additional flexibility with regards to the Resource Use performance category of MIPS. Specifically, CMS now has the regulatory authority to weight this performance category between 10 and 30 percent each year. We appreciate this additional flexibility and believe it helps to address some of the key challenges and barriers that MIPS physicians face.

ACOFP has shared with CMS its concerns about the weighting of this performance category. Specifically, we are concerned that an increase to 30 percent will dramatically impact practitioners by driving the focus away from quality, to resource management. We continue to believe and stress to the Committee that a patient's quality of care must be the priority.

Providing fewer services is not always in the patient's best interest. Spending today for some patients, may lead to savings down the line. If we strive for a true preventive model of healthcare, then this requires spending on prevention. Currently, we are not aware that preventative spending is looked at differently from other spending. The exception to this is avoidable ED visits, and rehospitalizations.

To this end, we have voiced our concerns with the assessment and attribution of costs and how these costs relate to assessing quality. We believe that to protect the availability of preventive services and to appropriately value primary care, primary care services that are medically more effective and efficient should be excluded from the Resource Use calculation.

Measuring primary care costs in a vacuum can skew the analysis of resource utilization and therefore must be considered for the additional value these services provide. For example, chronic care management is a preventive service that can often reduce the need for emergency or higher cost specialty care. We have encouraged CMS to devise a methodology so that costs related to appropriate primary care services do not negatively impact a physician's assessment under this performance category.

<u>For these reasons, we urge continued work to ensure the Resource Use performance category is appropriately measured and weighted and to ensure quality of care is not sacrificed to control costs.</u>

2. Protecting Solo, Small and Rural Practices

Overall, ACOFP supports recent changes to MIPS intended to protect solo/small practices. In its March 2018 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) highlighted the significant reporting burden on physicians - $1.3 billion in the first year. While the burden is felt by all MIPS participants, solo/small practices face significant challenges to meaningful participation.

We believe it is critical for these practices to be assured stability and flexibility as they attempt to participate in MIPS and transition to value-based care. CMS has finalized certain protections across the performance categories, but it is unclear if or whether these protections will continue to be available for participants.

In order to provide stability and certainty, especially for solo/small and practices, we believe it is critical to statutorily require that CMS provide the protections over a longer transition period. Like the changes made in the Bipartisan Budget Act (BBA), we believe it is imperative these protections remain consistent through year five while solo/small practices ramp up to adapt to value-based care.

Specifically, ACOFP supports stabilizing the following protections:

- Continuing to allow MIPS eligible physicians in solo/small practices to report on no more than two medium or one high-weighted Practice Improvement Activity to achieve the highest score for this performance category;

- Awarding three points for measures without a benchmark or not meeting case minimums (20 cases)
- Bonus for additional high priority measures (up to 10 percent of quality category denominator)
- Bonus for end to end reporting (up to 10 percent of quality category denominator)
- Reweighting Advancing Care Information (previously Meaningful Use) performance category to zero and allocating the corresponding weight to the Quality performance category for solo, small, and HPSA practices who do not currently have an EMR system.

We thank the Committee for allowing Rural practices to remain exempt from MIPS reporting as long as they are not receiving Fee-for-Service payment.

Finally, we urge the Committee to consider adjusting low-volume threshold requirements further to exempt more physicians in solo/small and rural practices (rural practices who accept FFS payments, and are eligible for MIPS reporting).

Virtual Groups

ACOFP believes that virtual groups can offer small and solo practitioners an important pathway to achieve success under MIPS. Further, we appreciate that there are no limits on geographic area, specialty, or number of TINs that may form a virtual group. By allowing virtual groups to form naturally, or based on any criteria, we believe this ensures sufficient flexibility for virtual groups to be truly meaningful.

However, we are concerned that because virtual groups must be recertified annually, new or different requirements may be made that would prevent continued participation. In fact, CMS has indicated that such changes could occur through annual rulemaking. This uncertainty poses a significant challenge to practitioners who would look to participate in MIPS through a virtual group. We believe this is another area where the Committee can provide much needed guidance and direction.

Conclusion

ACOFP urges the Committee to consider the on-the-ground experience of family physicians and the reality of implementing MIPS. Solo and small practices 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. ACOFP stands ready to work with CMS and Congress to ensure primary care is appropriately supported and valued, especially in the context of the QPP.