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October 25, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Ami Bera, MD
U.S. House of Representatives
Washington, DC 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
Washington, DC 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Burgess, MD
U.S. House of Representatives
Washington, DC 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
Washington, DC 20515

The Honorable Brad Wenstrup, DPM
U.S. House of Representatives
Washington, DC 20515

The Honorable Bradley Schneider
U.S. House of Representatives
Washington, DC 20515

The Honorable Mariannette Miller-Meeks, MD
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider and Miller-Meeks:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on your Request for Information (RFI) regarding the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and associated payment mechanisms. 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.

We believe that MACRA, including the Quality Payment Program (QPP), is in need of reform to ensure that its intent of promoting value-based care is actually carried out. This is especially critical for family physicians—many of whom are in small, solo and independent practices and have been burdened by its implementation. We believe addressing these issues will help achieve the goal of MACRA, which is to promote high-quality patient care and lower healthcare costs.

Comments on the Implementation of MACRA and Associated Payment Mechanisms

1. **The effectiveness of MACRA**

MACRA established a system to score physicians on four measures—quality, cost, promoting interoperability and improvement activities—which is then used to adjust physician payments. We are concerned about the disproportionate impact this system is having on physicians in small, solo and independent practices. The National Academies of Sciences, Engineering and Medicine published a report entitled, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* ("NASEM Report"), which notes that "[e]merging evidence indicates that schemes such as [the system established by MACRA] systematically disadvantage smaller practices and those that care for more disadvantaged patients."[1]

[1] National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

MACRA established the QPP, which consists of the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). ACOFP believes that these programs should incentivize primary care, which has been shown to improve overall health outcomes of patients and reduce healthcare costs. Many studies show dramatic benefits in geographic areas that have higher primary care provider use and primary care providers per capita.[2] A retrospective literature review by Dr. Barbara Starfield found that overall health is better in areas in the United States with more primary care providers.[3] Areas with higher ratios of primary care providers 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.[4] In addition, areas with higher ratios of primary care providers per capita had lower healthcare costs than other areas, possibly due to better preventative care and lower hospitalization rates.[5] This contrasts with areas where there are higher numbers of specialists—characterized by more spending, but worse health outcomes.[6]

The implementation of MACRA has not been effective in incentivizing primary care; instead, it has created burdens that family physicians have to navigate to ensure they can continue to care for their patients. Many ACOFP members have encountered difficulties with MIPS and have found the program overly burdensome, confusing and not linked to patient care.

Our members have also spent considerable time keeping up with annual updates and policy changes since the program was implemented. Specifically, our members have had to implement practice changes to comply with the myriad of MIPS requirements. Small, solo and independent family physician practices have been particularly frustrated with the program, since they have limited resources to meet the many requirements of MIPS. Family physicians have also been forced to make significant practice changes and investments in electronic health record (EHR) systems to ensure they are complying with MIPS. While larger entities may be equipped to make these necessary investments, small, solo and independent practices are particularly disadvantaged when such changes are needed, adversely impacting their ability to succeed under new programs.

With respect to APMs, we appreciate recent efforts to establish new primary care-focused models, like Primary Care First and ACO REACH. However, many small, solo and independent practices are unable to meaningfully participate unless incorporated into larger entities. This forces many of our members to make difficult choices regarding their ability to practice autonomously or pivot more directly into important healthcare delivery reform efforts.

Despite clear evidence that primary care physicians are a critical asset for high-quality healthcare for their patients, family physicians are faced with limited opportunities to participate in APMs and MIPS program requirements that are overly burdensome, confusing and not directly linked to patient care. Implementing changes that reduce physician burden and the creation of models that truly enable participation of practices of all types are key to ensuring the effectiveness of MACRA and are critical for all physicians—especially family physicians—to ensure they can provide high-quality care.

2. Regulatory, statutory and implementation barriers that need to be addressed for MACRA to fulfill its purpose of increasing value in the U.S. healthcare system

The biggest barrier family physicians have faced as a result of MACRA is the administrative burden required in order to comply with QPP requirements. Family physicians were already overburdened with Medicare reporting requirements, and MACRA created additional burdens that have especially impacted small, solo and independent practices. These practices have had to make investments and implement practice changes to comply with MIPS, and these additional administrative requirements have forced them to divert limited resources away from patient care. Given the burden MACRA has created

[2] Shi L. The impact of primary care: A focused review. *Scientifica (Cairo)*. 2012. doi:10.6064/2012/432892.
[3] 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.
[4] *Id.*
[5] *Id.*
[6] *Id.*

for family physicians, it has not fulfilled its purpose of improving health outcomes and health status or reducing healthcare costs.

Another barrier is the current framework for defining and measuring healthcare quality. For example, in the NASEM Report, it is noted that MACRA created a federal mandate to assess and pay primary care practices based on quality outcomes; however, there is a lack of consensus on specific outcomes that best match primary care quality.[7] Consistent with recommendations in the NASEM Report, in order to ensure MACRA is properly implemented, we believe it is essential that the Centers for Medicare & Medicaid Services (CMS) work with stakeholders to ensure that consensus is reached.[8] Also, quality measures are imperative to achieve national health objectives, but current quality measurement systems are costly and provide limited return. As the NASEM Report notes, "[r]ather than incentivizing physicians to work harder, value-based payment programs should support physician professionalism."[9] Focusing on establishing relationships with patients and addressing patient priorities is essential to improving health outcomes. We believe that the agency should align its strategy with the NASEM Report to ensure that physicians are supported, and patients receive high-quality care.

An additional barrier includes the lack of transparency of the patient population for whom a physician's assessment of healthcare quality is being based. The Medicare program does not provide a patient roster for physicians to verify that certain patients are, in fact, part of their practice. In many instances, a patient who has been attributed to a physician has received the healthcare services in question from the patient's previous physician. This inaccurate assignment is concerning, because quality assessments therefore can be based on healthcare services that a physician did not provide. In order to ensure fair and accurate assessments of healthcare quality, there must be transparency in which patients are attributed to a physician, as well as a process for corrections to be made.

3. How to increase provider participation in value-based payment models

Currently, there are limited opportunities for family physicians to participate in value-based payment models. Also, as previously noted, when there are opportunities, the incentives available for physicians are overly burdensome or require practices to make difficult decisions in order to participate in such opportunities. By creating more opportunities for physicians to participate in value-based payment models that do not require smaller practices to merge or partner with larger entities, provider participation in APMs would increase and result in better outcomes and health status for patients, as well as lower healthcare spending.

In addition, family physicians are committed to providing patient-focused and relationship-based care to ensure patients receive the individualized care they need, which will lead to better health outcomes. While new models must be created to include smaller practices, these models also must include the appropriate quality measures that focus on providing high-quality primary care to patients. Congress must recognize that high-quality primary care is the foundation for ensuring a high-functioning healthcare system and establishing quality measures that result in better health outcomes for patients is essential in the development of future models in order to increase provider participation.

Furthermore, to increase provider participation in APMs, Congress can focus on reducing administrative requirements for physicians that are overly burdensome and that disproportionately impact small, solo and independent practices. As previously noted, family physicians are already struggling with overburdensome paperwork requirements, and the addition of further administrative burden from value-based payment models acts as a deterrent from participation. For example, many of the APMs established by the CMS Innovation Center have incredibly complex financial arrangements and methodologies that can be overwhelming for smaller primary care practices. Such practices should not be required to obtain statistical analyses or economic modeling to predict or anticipate how they may be impacted financially by participating in an APM. By limiting burden and simplifying model design elements, family physicians will have more opportunities to participate in APMs.

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[7] *See* National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[8] *See id.*
[9] *See id.*

4. Recommendations to improve MIPS and APM programs

Although CMS is committed to improving provider and patient experiences in the Medicare program through the QPP, many ACOFP members have encountered difficulties with MIPS and APMs and believe further action by CMS is necessary. As previously noted, we believe that MIPS and APMs can be improved by providing more opportunities for primary care physicians to participate in the QPP, especially in APMs. We believe CMS can improve the program in a way that both recognizes the unique characteristics of family medicine practices and rewards them for improved patient outcomes and health status.

In addition, we encourage CMS to take advantage of the opportunity to leverage the QPP to increase the utilization of high-quality primary care. High-quality primary care is critical to ensure a high-functioning healthcare system. Access to high-quality primary care is essential for individuals to receive preventative care and avoid poor health outcomes. Furthermore, primary care provides comprehensive, person-centered, relationship-based care that focuses on the needs of patients. Family medicine plays a critical role in the provision of primary care, which ensures improved patient outcomes and reduced healthcare costs. CMS should recognize and take steps to account for such improved outcomes and reduced costs to better incentivize primary care services to prevent unnecessary or avoidable high-cost services and downstream healthcare utilization.

We also emphasize that reducing provider administrative burden is a key change that must be implemented. Reducing burdensome administrative requirements will allow physicians to devote more time and resources to treat patients.

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