AMERICAN OSTEOPATHIC ASSOCIATION

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July 11, 2024

The Honorable Sheldon Whitehouse
United States Senate
530 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, M.D.
United States Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senators Whitehouse and Cassidy

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation of your interest in reforms that can help drive a transition to value-based payment. If implemented correctly, this transition will better serve patients while also ensuring physicians are adequately paid for their services.

The AOA has repeatedly endorsed payment models that are designed with a focus on patient-centered longitudinal care, with an emphasis on team-based coordination between primary and specialty clinicians. However, transitions to value-based payments must account for the unique needs of different specialties, practices' current capacities, and the ways physicians deliver care – particularly in rural areas. As a result, we firmly believe that the establishment or expansion of alternative payment models, including a potential hybrid payment approach for primary care, should:

- Be optional and ensure that physicians can participate in models or initiatives that meet the needs of their specialty, practice setting, and patient population;

- Recognize the underfunded state of the physician fee schedule and challenges created by inadequate payment rates and lack of inflationary updates;

- Be implemented in a manner that does not result in reduced payment across the physician fee schedule, and more importantly, in net payment reductions for model participants (before accounting for risk bearing or quality adjustments); and

- Supports appropriate investment for practice transformation and quality improvement.

As payment rates for office-based physicians become increasingly unsustainable, and the Medicare program faces a looming workforce shortage, it is essential that reforms directly address these issues and conform to the above parameters. While the AOA greatly appreciates your recognition of these issues, and interest in addressing many of the challenges facing primary care, we also want to highlight serious concerns the AOA has with the *Pay PCPs Act,* as currently written. It is with this perspective that we share feedback on the legislation and Request For Information (RFI).

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Hybrid Payments for Primary Care Providers:

While the AOA strongly supports payment policies that ensure patients can receive the primary care services they need, and that physicians are paid adequately for their services, reforms cannot come at the expense of other specialties, the patient-physician relationship, or physicians' ability to sustainably operate their practice. The AOA has long supported increased investment in primary care, and utilizing a whole-person, patient-centered approach to ensure overall patient health. The United States has significantly lower rates of patients reporting a longstanding relationship with a primary care physician.[1] At the same time, evidence shows that longitudinal relationships, which are integral to both the philosophy of osteopathic medicine and delivering high-quality care, lead to better management of chronic conditions and improved patient outcomes.[2] However, for a payment model to successfully improve access to comprehensive care, it must be designed in a manner that supports appropriate payment for the services it entails. Before addressing specific questions within the RFI, it is important to highlight fundamental concerns that the AOA has with the proposed per-beneficiary per-month (PBPM) hybrid payment model under the *Pay PCPs Act*.

1. **Prospective payments should support enhanced payment for primary care services and should not be subject to budget neutrality requirements under the physician fee schedule.** Developing enhanced payments within the budget neutral construct would result in payment reductions for all services in the fee schedule. In particular, further reductions in payment for evaluation and management (E/M) services would exacerbate access challenges to other office-based specialties which are also struggling with inadequate payment (e.g. psychiatry, infectious disease).

2. **Overall payment must be net-positive relative to current fee-for-service (FFS) payments, ensure revenue stability, and account for high-cost services.** There are a broad range of services primary care physicians provide to ensure patients can conveniently and affordably access the care they need. Delivery of these services often requires substantial investment expenses far beyond what would be covered under a typical E/M service, chronic care management, or virtual check-in. This can include purchasing equipment for certain preventive screenings (e.g. bone density scan machines for osteoporosis screening); maintaining supplies for wound care; stocking vaccines; or purchase, storage, and administration of high-cost medications (e.g. HIV medications and PrEP). If payments outside of the prospective payment bundle are paid at reduced FFS rates, this may discourage practices from offering comprehensive care, exacerbate financial challenges primary care physicians face, and necessitate referrals to other providers, which will increase costs to the Medicare program over the long term.

3. **Payment must support small and independent practices in making necessary investments to transition to an advanced alternative payment model (APM).** Transitioning to a hybrid payment model will require substantial changes to how practices operate and manage revenue. Additionally, for the vision of this proposed payment model to be realized, practices will also need to make investments in providing care coordination and management services. This entails hiring additional full-time employees and investing in technical infrastructure. Other APMs account for these costs through

[1] Gumas ED et al. "Finger on the Pulse: The State of Primary Care in the U.S. and Nine Other Countries," March 28, 2024. The Commonwealth Fund. Accessed online at: https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries.

[2] Jennifer Arnold, "Fostering Long-Term Doctor-Patient Relationships to Improve Outcomes," Duke Health, January 17, 2017.

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advance investment or infrastructure payments, which would be necessary under this proposed payment model to succeed.

4. **Payment must be sustainable over the long term.** In order for payments to be sustainable, they must keep pace with the cost of practicing medicine and be updated based on inflation, as measured by the Medicare Economic Index.

Overall, for the PBPM hybrid payment model to succeed, it must avoid the challenges entrenched in our current FFS system. As you note in the RFI, CMS has begun efforts to test various prospective payment approaches for primary care through the Making Care Primary (MCP) and ACO Primary Care Flex (ACO PC Flex) Models. Overall, the AOA believes that enhanced, stable per-beneficiary payments can support the delivery of comprehensive care. However, the success of these models depends in their implementation, and there is a range of payment models that have a proven track-record of driving high-quality care and savings to the Medicare program. Many primary care practices have decided to join accountable care organizations (ACOs) and participate in the Medicare Shared Savings Program (MSSP). Under these programs, physicians will continue to bill under FFS but are accountable for overall patient costs by taking on risk for losses and savings. Regardless of the approach adopted, physician payment must be sufficient to support long-term participation and delivery of comprehensive care. With this in mind, we offer the following responses to specific questions within the RFI.

What methodology should be used to determine the "actuarily equivalent" FFS amount for the purpose of the hybrid payment? Should hybrid payment rates be based on historic averages across the entire FFS population? If so, are there risks that providers will receive an inappropriate payment rate for certain unusually high- or low- utilizing beneficiaries?

In general, the AOA is concerned with the proposal of total payments being "actuarily equivalent" to FFS amounts that is based on total claims for services provided in a given timeframe. In order for payments to support comprehensive primary care, payments should reflect an enhancement over current rates. Additionally, payment amounts must be appropriately adjusted based on a physician's geographic location and patient population, as this will influence the cost of delivering individual services as well as overall utilization. Appropriate risk adjustment should account for variations in beneficiary utilization based on the health status of the population the provider is treating.

What factors should Congress be considering when setting risk adjustment criteria? Should beneficiaries on Medicare Advantage be considered as part of the calculation or should Congress limit the pool to FFS only?

Ultimately, risk adjustment methodology must account for a broad range of factors, including social risk factors, diagnoses and patient complexity, income/dual eligibility status, and other factors. While looking to Medicare Advantage (MA) for data on patient diagnoses and utilization may be useful in geographic settings with high-penetration of dual-eligible special needs plans (D-SNPs) or chronic condition special needs plans (C-SNPs), MA data may be less useful for the broader population. AOA strongly urges caution in using MA data for risk adjustment purposes based on current lack of transparency of MA data, inappropriate coding practices by plans, and favorable selection within many MA markets. It is important to highlight that outside of D-SNPs and C-SNPs, the average MA beneficiary tends to have better health status than the average FFS beneficiary, with many patients who have high-cost, chronic conditions choosing FFS or switching to FFS

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after initially enrolling in MA.[3] This trend may be driving overpayment to MA plans, and if MA data is used for risk adjustment, it is important that its use does not further exacerbate underpayments to physicians participating in the hybrid payment model.

> *The legislation proposes to allow the Secretary to define quality measures for hybrid payments and suggests four which may be pursued: (1) patient experience, (2) clinical quality measures, (3) service utilization, including measures of rates of emergency department visits and hospitalizations, and (4) efficiency in referrals, which may include measures of the comprehensiveness of services that the primary care provider furnishes. Are these quality measures appropriate? Which additional measures should Congress be considering? What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?*

APMs, such as the hybrid payment model for primary care, will struggle to attract participants and deliver improvements to quality of care if they hold physicians accountable for a broad and complex range of services while continuing to underpay physicians for patient utilization of those complex, high-value services.

Under many current Center for Medicare and Medicaid Innovation (CMMI) models that provide prospective per-beneficiary payments, participants still bill Medicare FFS to ensure that the program can track the services rendered and overall utilization, regardless of whether CMS pays the individual services. Shifting to a PBPM approach would likely not alleviate burden associated with billing, and the most substantial impacts to burden reduction are achieved through reducing and streamlining quality reporting. However, for this to be achieved, the program must avoid key pitfalls of existing quality measurement programs, such as Merit-Based Incentive Payment System (MIPS).

Physicians in small and rural practices consistently receive below-average MIPS scores, demonstrating that practice size and resources are better indicators of MIPS performance than patient outcomes. This is largely because physicians have to report a significant number of measures, can't track their performance in real-time, engage in meaningful quality improvement, and must perform based on measures that are poorly designed or not clinically relevant. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.[4]

Small practices face four significant barriers to entry into APMS. First, they tend to lack the staff and technical infrastructure required to effectively participate in most quality-based models. Second, thin margins preclude them from being able to take on additional risk or make the significant financial investments needed to effectively participate in APMs. Third, small practices within AOA's membership report significant concerns regarding onerous quality reporting that takes time away from physicians' ability to see patients. Finally, physicians report a fear of failure within the APM model due to inability to track performance in real time and make needed course corrections.

To ensure quality measures under the hybrid payment model actually contribute to high quality care while reducing burden, we advise the following:

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[3] Lieberman et al. "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments." USC Schaeffer Center for Policy & Economics. June 2023. Available here.

[4] Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open. 2020;324(10):984-992*

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- Clinical quality measures used for primary care should align with CMS' universal foundation measures and should not impose additional, overly burdensome measures that would transplant a reporting framework similar to MIPS into a new PBPM model;

- Measure reporting should focus on electronic and claims-based measures that can be determined with less reporting burden from the physician;

- Physicians should be provided with regular feedback on their performance on various measures to ensure that they can improve care quality, and to avoid challenges faced by physicians under MIPS;

- If efficiency of referrals will be a measure for which physicians will be evaluated and receive payment adjustments, total payment under the PBPM model must be sufficient to account for the comprehensive range of services that primary care physicians are trained to provide, allowing them to reduce unnecessary referrals; and

- Use of cost measures should be minimal, as physicians are already responsible for managing overall costs under PBPM models, and cost measures should not hold physicians accountable for factors outside their control.

We urge you to ensure that any quality measurement framework and payment approach developed under this hybrid payment model avoids repeating the challenges created under MIPS, and instead meaningfully drive high-quality care.

> *The legislation allows the Secretary to include four types of service in hybrid payments: (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management (E/M) visits, regardless of modality, for new and established patients. Is this list of services appropriate? Will including these services in a hybrid payment negatively impact patient access to service or quality of care?*

While office-outpatient E/M services and care management services form the foundation of primary care services, primary care physicians are trained to comprehensively care for their patients and treat a broad range of conditions. As such, this breadth of services must be accounted for in payment rates, not only paying for the work physicians perform, but also accounting for the substantial investment in practice expense physicians make to be able to provide these services. This includes investments in equipment (ultrasound equipment, bone density scan equipment), stocking supplies for minor procedures (e.g. wound care), or stocking medications that are administered in-office (e.g. injectable HIV medication). The physician work associated with minor procedures outside of E/M visits or chronic care management services must also be accounted for in total payment, such as physicians who provide osteopathic manipulative treatment to patients with chronic pain. The list above also does not account for common counseling and screening services (e.g. screening for alcohol, substance use disorder, or depression), the broad range of services provided in annual wellness visits, remote monitoring services, services to address health related social needs, or the many minor procedures these physicians perform. This list reflects only a handful of examples of services primary care physicians provide, for which they currently receive separate payment.

The AOA is deeply concerned that the services outlined in the *Pay PCPs Act*, which would form the basis of the PBPM payment are insufficient to account for the broad range of services primary care physicians provide,

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especially if overall payment for these services is not enhanced and all services outside the bundle are paid at reduced FFS rates. Ultimately, this will exacerbate the inadequacy of payment to primary care and discourage physicians from participating in the program.

Beyond the technical concerns and costs associated with participation, the *Pay PCPs Act* relies upon outdated and unsustainably low FFS payments as the basis for hybrid payments. As noted above, any quality-based payment model will struggle to deliver improvements to quality of care if it continues to underpay physicians for patient utilization of complex, longitudinal services. Since 2001, physician payment under Medicare has declined 29% when accounting for inflation.[5] Reversing this trend would not only provide stability to independent physician practices facing unique economic challenges, but would align with the recommendations from the Medicare Payment Advisory Commission (MedPAC) for Congress to update the base physician payment and enact add-on payments for services delivered to low-income beneficiaries to protect patient access.[6] Without sustainable and predictable updates to physician payment under FFS that accurately reflects the cost of services provided, it will be impossible to successfully implement a PBPM hybrid payment model that delivers improvements to patient access and quality of care.

With those concerns in mind, the *Pay PCPs Act* must be amended to address both the necessity of allowing physicians to choose how they practice and the inadequate basis for payment under the legislation.

Cost Sharing Adjustments for Certain Primary Care Services:

The AOA appreciates the recognition, in the *Pay PCPs Act,* of how out-of-pocket costs strongly influence patients' decisions on whether to seek care and how it may discourage patients from seeking preventive primary care, despite its importance to long-term health and well-being. While the concept of reducing beneficiary cost sharing may encourage patients to seek out primary care services, we would like to emphasize that any reduced payments to physicians through changes to cost sharing should be made up by the Medicare program to ensure that physicians are made whole on the costs of delivering care.

Considering the state of inadequate Medicare payment, and the steep financial challenges practices across the country face, physicians are not in a position where they can sustainably absorb the cost of reduced cost sharing, and any policy changes should not result in a net payment reduction to physicians.

Technical Advisory Committee:

The AOA strongly supports the RVS Update Committee (RUC) as the entity best suited to provide recommendations to CMS on the relative values of physician services, as well as their cost inputs, and does not support the establishment of a federal panel or advisory committee that would serve as a substitute or alternative source of recommendations to CMS. As defined under law, physician payment is based on three primary components: physician work, practice expense, and malpractice liability insurance expense. Physician work is determined based on the time, intensity, and complexity of individual services physicians provide. The relativity of each of these components of physician work, as well as the direct cost inputs for services across settings, cannot be appropriately determined without direct physician input.

[5] American Medical Association. "Medicare Updates Compared to Inflation in Practice Costs." March 2024.
[6] MedPAC. "March 2024 Report to the Congress: Medicare Payment Policy." March 15, 2024.

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The AOA is not confident that any alternative to the RUC would account for input from physicians across the 125+ medical specialties, and from these specialties, physicians practicing across a range of settings, from small and rural practices to large multi-specialty groups to hospital-based physicians. Moreover, as written, the legislation would limit the technical advisory committee to only 13 members to represent all medical specialties and would allow entities such as the Departments of Veterans Affairs and Defense to have input on Medicare payment policy, despite Medicare payment policies having no relevance to care provided within the VA or Defense healthcare systems, and vice versa.

As a result, the AOA firmly believes that the RUC is the entity best situated to make recommendations regarding resource inputs for services. The RUC is comprised of volunteer physicians across specialties that work to evaluate the value of services based on a system of relativity, utilizing survey data generated by physicians in active practice who render a given service. The RUC process generates granular data to describe the physician time, work relativity, clinical staff time, medical supplies and medical equipment used in providing services to patients.

The AOA also supports the reestablishment of CMS' RUC Refinement Panel process which was discontinued in 2016. This process served as a relative value appeal process to provide independent review of values and ensure that values adopted by CMS reflected the practice of medicine. For the 25 years it was in place, CMS convened the Refinement Panel comprised of representatives across Medicare carriers to carefully review public comments, hear testimony from practicing physicians, and recommend refinements to relative values. The AOA believes that continuing to rely on the RUC's input, while also reestablishing this panel for appeals within CMS, will ensure integrity of CMS' rate setting process.

Input from practicing physicians and clinical physician leadership via the RUC process is essential to the process of valuing services because these individuals are in the field and intimately understand the inputs for the services they provide to patients. There is no other entity that collects data with the level of detail and broad specialty input as compared to the RUC, and thus equally capable of assessing the value of services.

Again, thank you for the opportunity to submit a formal response to the Request for Information on this legislation. Should you have any questions or if the AOA can be a resource, please contact AOA Vice President of Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

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