AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 12, 2024

The Honorable Sheldon Whitehouse
United States Senate
530 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Whitehouse and Cassidy:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership to meaningfully examine and consider reforms to how we pay for primary care delivered to Medicare beneficiaries through the release of legislation, the *Pay PCPs Act* (S. 4338), and an accompanying request for information (RFI).

The AAFP agrees wholeheartedly with the RFI's opening sentiments that primary care is the bedrock of our health care system and that the existing payment structures fail to recognize it as such. As you also note, much of the work and value that primary care physicians, including family physicians, provide is either poorly compensated or uncompensated altogether.

Family physicians provide continuous, comprehensive person-centered care, including health maintenance and preventive services, to patients across the lifespan regardless of age, gender-identity or type of problem. Through enduring partnerships, family physicians help patients set health goals, prevent, understand, and manage illness, and navigate an increasingly complex health care landscape. The defining features of primary care are continuity, coordination, first contact, and comprehensiveness.[i]

Evidence continues to affirm that longitudinal, relationship-based care delivered by primary care physicians and their teams, leads to better control of chronic conditions, fewer emergency department visits and hospital stays, and improved health outcomes.[ii,iii] Unfortunately, our health care system underinvests in these trusted relationships between primary care physicians and patients. Only five to seven percent of total health care spending in the United States is on primary care.[iv] Primary care spending decreased for all payers between 2019 and 2021 with Medicare being the most pronounced with a 15 percent drop.[v] While some of this decrease could be due to a drop in office visits during the pandemic, it is also important to consider that the reduction could be driven as much by higher overall spending (the denominator in this calculation) that could have been avoided with a greater investment in primary care.

While there are many factors that have contributed to the current state of primary care underinvestment, we highlight the following areas within the Medicare Physician Fee Schedule (MPFS) that the AAFP believes are significant culprits:

1. Fee-for-service (FFS) payment is designed to pay for discrete services in ways that favor procedural service delivery.

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2. FFS is incompatible with the continuous, comprehensive nature of relationship-based primary care.
3. Budget neutrality requirements are unreasonably outdated and should not be narrowly focused only on physician services.
4. The lack of an inflationary update means payment has not kept pace with the inflationary costs of running a practice.

1. Primary care is undervalued relative to other specialties in the MPFS. In general, the MPFS values procedural services delivered by other specialists higher than it does office visits and other cognitive services, which are most frequently delivered by primary care physicians. Primary care and other cognitive services have been passively devalued over time as many new procedural codes with higher values have been added.[vi] The AAFP has long called for realignment of Medicare payment to reflect more equitable payment for services provided by family physicians and other primary care physicians, including changes such as increased recognition of both direct and indirect resource use associated with valuation of practice expense and a more equitable approach to the valuation of more cognitive care, such as evaluation and management (E/M) services relative to procedural services.

This devaluation has led to lower compensation for primary care physicians, despite the vital role they play in managing chronic conditions and coordinating patient care across the complex health care landscape. This relative inequity persists despite the fact evidence has shown that primary care office/outpatient E/M visits are more complex and comprehensive than those delivered by other specialties.[vii]

2. FFS is designed to pay for the delivery of discrete services – not the comprehensive nature of primary care service delivery. Physicians must submit unique codes for every service provided – documenting both what they did and why they did it. This is incompatible with the continuous, comprehensive nature of primary care, which spans everything from basic preventive services to more complex services involving chronic care management, integrated behavioral health, and care coordination. For patients with chronic conditions, these discrete services may include patient education, care planning, and managing medications, all of which are ongoing and continuous processes. Each of these services must be individually documented to justify payment for typical, comprehensive primary care, even though these services are all essential aspects of high quality primary care delivery.

A 2009 study found that physician practices collectively spend about $30 billion a year alone on administrative costs related to billing and coding.[viii] One can assume that, when adjusted for inflation today, that number is significantly higher. Every billing code has its own accompanying rules (some associated with the code set(s) and others created by Medicare and other payers) that govern when they may be reported either independently or in conjunction with other codes.

Despite efforts to introduce new, more comprehensive codes (e.g., Chronic Care Management and Transitional Care Management) designed to overcome the incompatibility of FFS with the comprehensive nature of primary care, the challenges associated with FFS documentation persist and uptake of these more comprehensive codes has been low. Researchers who have examined the lack of uptake suggest that implementing additional FFS codes is likely not the most effective solution.[ix]

3. Reforms to the zero-sum, budget neutral nature of the MPFS are also urgently needed, as these requirements undermine efforts to invest in primary care. Existing budget

neutrality requirements force CMS to offset increases or additions anywhere in the MPFS with a conversion factor reduction which means across-the-board cuts to all services, including those most frequently delivered by primary care physicians. The $20 million threshold that triggers these adjustments has not been increased since the MPFS was established in 1992. In short, this policy environment means Medicare cannot appropriately pay for all the services a patient might need, and it perpetuates inequities in the fee schedule, which bleed into and impact the success of primary care practices in VBP arrangements and outside of Medicare.

To achieve meaningful reform, the AAFP has encouraged Congress to think of traditional Medicare holistically when considering budget neutrality, rather than as inviolable silos of Part A and Part B services. Eliminating waste and anachronistic policies across all of Medicare may serve to yield the offsets necessary to invest in comprehensive physician payment reform. Just as Medicare expects Medicare Advantage plans, some Center for Medicare and Medicaid Innovation (CMMI) models, and even physicians (in terms of the cost category of the Merit-based Incentive Payment System or MIPS) to think of total cost of care, so should Congress consider the total costs of Medicare across the multiple Medicare silos, not just within Part B or the physician fee schedule.

4. Physician payment has failed to keep pace with inflation, meaning that practices are struggling to cover the rising costs of employing their staff, leasing space, and purchasing supplies and equipment - let alone make investments to transition into new payment models. Even the nominal positive updates to the MPFS conversion factor eventually envisioned by the Medicare Access and CHIP Reauthorization Act (MACRA) are well below the inflation in costs to run a medical practice as measured by the Medicare Economic Index (MEI).

While the AAFP has and continues to advocate in support of prospective, risk-adjusted population-based “per member per month” (PMPM) payments for continuous, comprehensive care delivered by primary care physicians and their teams across all payers, **we strongly believe that comprehensive, foundational reforms to the MPFS are needed for the benefits of a hybrid primary care payment to be realized.** These MPFS reforms include:

- Providing an annual inflationary update based on the MEI,
- Improving FFS primary care payment rates with updated approaches to valuation of both practice expense and work relative value units (RVUs), and
- Reforming budget neutrality requirements.

These reforms to the underlying MPFS are especially critical when considering the impact the MPFS has well beyond the Medicare program as most private and public payers peg their payment rates to the MPFS rates or use the relative values in the MPFS to set their rates.

The Academy shares your vision of providing a well-designed, operationally feasible payment option that meaningfully invests in primary care physicians and the care of their patients and understands the current iteration of this legislation is intended to be a starting point. The AAFP sincerely appreciates the opportunity to provide the below feedback, and as noted above, **we believe there are significant underlying issues in the MPFS payment structure and operational concerns with the proposed hybrid payment approach that must be resolved before proceeding with legislation.**

Hybrid payments for primary care providers:

AAFP Response: The Academy agrees that hybrid payments allow primary care clinicians to innovate and more easily integrate diverse care activities to meet their patients' unique needs, improve care quality and reduce costs. **However, as we note above, implementing a truly effective and impactful hybrid payment within the context of the MPFS requires additional reforms to the underlying FFS payment structures to happen first.** As a starting point, we believe Congress must pass legislation providing an annual inflationary update for physician payment based upon the MEI.

As noted in our introductory comments, reforms to the budget neutrality requirements unique to physician services are urgently needed. Even with these reforms, whether or not the implementation of a hybrid payment for primary care triggers a budget neutrality adjustment will depend upon the payment methodology and amount provided in the PMPM payment. **If this proposal is intended to more accurately value the work of primary care physicians that is currently either poorly compensated or uncompensated altogether within the MPFS, it must include increased investments.** We agree the payment mechanism (i.e., prospective or retrospective) is important. This was evident, for example, during the pandemic when primary care practices receiving prospective payments were able to respond accordingly, versus practices receiving only retrospective fee-for-service payments that depended entirely upon the volume of services provided. However, the actual amount of investment is what's most important. **Therefore, absent broader budget neutrality reforms, we believe a hybrid payment within the MPFS must be done outside of current budget neutrality constraints.**

The Academy also strongly urges any patient cost sharing responsibilities associated with a PMPM be fully waived while ensuring physician practices are "made whole," meaning they are paid the full allowed amount they would otherwise receive if patient cost sharing were applied. This would increase Medicare's payment responsibility, thus likely triggering a budget neutrality adjustment. This is an additional reason the AAFP firmly believes a hybrid payment for primary care cannot be subject to existing budget neutrality requirements.

Without enactment of these underlying MPFS reforms, the AAFP is deeply concerned this legislation will simply be building upon a broken framework and fail to yield the intended investment in primary care.

Question: *How can Congress ensure we are correctly identifying the primary care provider for each beneficiary and excluding providers who are not a beneficiary's correct primary care provider or usual source of care?*

- *How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?*

- *How should the legislation address beneficiaries who routinely see two or more providers who could each plausibly be the "primary" care provider? For instance, a beneficiary who routinely visits both a family medicine provider and an OBGYN.*

AAFP Response: Fundamentally, the delivery of a primary care service and the provision of comprehensive primary care are not the same thing. The AAFP defines comprehensive primary care as "the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment." Therefore, a clinician who has a longitudinal relationship with a patient but does not deliver

comprehensive primary care should not be considered a primary care clinician for purposes of a hybrid payment model.

The AAFP recognizes the importance of consistent physician-patient relationships and the power of VBP to help codify and reward these relationships by establishing accountability for patients at the physician level. In alignment with the Health Care Payment Learning and Action Network resource on patient attribution which describes "patient self-selection" as the gold standard, the AAFP encourages payers to incentivize or require patients to identify their primary care physician as part of the insurance enrollment process. Many labels describe this patient-led approach to establishing accountability—voluntary alignment, voluntary attribution or self-attestation. Regardless of what it is called, asking patients to express their preference is always a good idea. **To that end, the AAFP would recommend that voluntary attribution be the first method used to assign patients to their self-selected primary care physician.**

As a second step, for those patients that have not voluntarily selected their PCP, Medicare can utilize historical claims data to assign beneficiaries to the primary care physician from whom they have received the highest volume of primary care services within a designated period. This step should include an opportunity for patient verification to ensure the methodology has produced the correct result from the patient's perspective. We believe this step is important to ensure greater utilization of the PMPM beyond what it would be through exclusively voluntary alignment. **If the hybrid payment is only attributed through voluntary alignment, it will likely have much less impact on practices since they will only receive it for the portion of their patients that elect to opt-in.**

Whether patients are voluntarily attributed or assigned based on historical claims data and patient verification, the attribution needs to be prospective and timely, so primary care practices know in advance for whom they are responsible under a hybrid payment methodology. Additionally, Medicare should notify primary care practices of changes in the patient list on a timely and regular basis.

Furthermore, while matching patients to individual physicians is important, attribution methodologies should seek to recognize how other care team members contribute to care delivery and patient outcomes. Methodologies should also account for the unique structure of the primary care organization and whether it is a large group practice, a multi-level health system or a small group/independent practice.

Question*: 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?*

AAFP Response: Given the AAFP's concerns regarding foundational issues embedded in the current MPFS approach to primary care payment, ensuring an "actuarially equivalent" amount becomes a way of codifying the current inequities. Success of hybrid payment is contingent on not only changing the structure but on correcting for the long-term underinvestment in primary care. Considering historic primary care FFS payments as an actuarially equivalent reference point is a non-starter for a successful hybrid payment model.

Question: *What factors should Congress be considering when setting risk adjustment criteria?*

AAFP Response: The AAFP's policy on risk adjustment for primary care payment states risk adjustment methodologies should incorporate clinical diagnoses, demographic factors, and other relevant information such as social drivers of health without exacerbating healthcare disparities or expanding the administrative burden on primary care practices. Social drivers of health should be identified as risk factors and used for risk adjustment of populations.

Question: *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?*

AAFP Response: The AAFP believes performance measures should focus on processes and outcomes that matter most to patients and have the greatest impact on overall health and unnecessary spending. VBP measures and the mechanisms of measurement should be aligned across payers to reduce unnecessary administrative burden. Measures of primary care should focus on the unique features most responsible for better outcomes and lower costs, and under the reasonable control of primary care physicians. The Center for Professionalism and Value in Health Care (CPVHC), through its Measures that Matter to Primary Care initiative, has developed a suite of performance measures that have been tested and validated for use at the individual clinician level and can be applied by different stakeholders, including primary care practices, employers, patients, insurers and health systems. These include the Person-Centered Primary Care Measure and the Continuity of Care Measure.

In considering this proposal, we believe there are important outstanding questions that need to be addressed before moving forward. For example, how would this new quality reporting program interact and align with all the other existing programs that primary care physicians are subject to? What happens if a practice chooses to join an APM, such as a CMMI model or the Medicare Shared Savings Program (MSSP)? Can a practice participating in MSSP receive the hybrid PMPM? How will the hybrid payments in the MPFS impact payments and/or benchmarks in other value-based models? These transition, overlap, and payment policies are important as primary care practices assess the landscape of payment options to decide which arrangements are best suited for their practice and patients over time.

Question*: 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 visits, regardless of modality, for new and established patients.*

- *Is this list of services appropriate?*
    - *Are there additional services which should be included?*

  - *Are there any services which should be excluded?*

- *Will including these services in a hybrid payment negatively impact patient access to service or quality of care?*

AAFP Response: The Academy believes this is an appropriate list of services for inclusion in a PMPM payment when they are delivered by primary care physicians and clinicians in a primary care setting. The AAFP also supports taking a tiered approach to population-based payments that recognizes each practice's capabilities and the unique needs of their patient populations. The AAFP encourages payers to meet practices where they are in terms of the services they can deliver to patients, while providing the necessary supports to eventually enhance their care delivery and move into a more sophisticated arrangement if desired and feasible. Consistent with the AAFP's comments on underlying MPFS reforms above, we strongly believe that population-based payments need to continually be updated based upon inflation and reflect payment increases to the underlying FFS amounts for services captured in a PMPM.

The AAFP has concerns with language in the current legislative text that states "*For such hybrid payments, the Secretary may continue to pay through reduced fee-for-service payments for all other services not specified in paragraph (2) under the Medicare physician fee schedule*…" As written, this language reads as if FFS payments for services not captured in the PMPM (i.e., all services not listed in the above question) could be paid at a lower rate than they would otherwise for clinicians participating in the PMPM. We believe the intent of this language is to allow the above listed services to be paid partially through the prospective payment, but to incentivize delivery of services, allow the rest of the payment to be paid as a reduced FFS payment when clinicians submit HCPCS codes for the services included in the PMPM similar to the flat visit fee methodology in the Primary Care First model.

If this is the goal, **the Academy has concerns with this approach, which requires practices to make up the rest of their revenue by delivering a volume of services**. We believe this approach is misaligned with the intent of hybrid, prospective VBP to promote quality of care over quantity of services. The AAFP understands some stakeholders may have concerns about perceived stinting of care and the idea that receiving a prospective payment would incentivize clinicians to deliver fewer services in order to accrue greater savings. However, clinicians are held accountable for the quality of care provided. This means primary care practices are incentivized to address all a patient's health care needs effectively and early to avoid utilization of more expensive care later, which can negatively impact their performance as reflected in quality and other performance measures. Additionally, because patients ideally choose their primary care physician for purposes of receiving the hybrid payment, those physicians have an incentive to ensure patient satisfaction and avoid patients choosing someone else as their PCP.

Given these concerns, the AAFP would strongly recommend that the specified services be paid fully through a PMPM with a tiered approach as described above. We also believe it is important to clarify that the fee schedule should in no way be reduced for primary care services for primary care clinicians participating in the PMPM.

Cost-sharing adjustments for certain primary care services:

Question: *What is the appropriate amount of cost-sharing to make the hybrid payment model attractive for beneficiaries and providers while constraining negative impacts on the federal budget?*

AAFP Response: The AAFP supports the provision of primary care services to patients without financial barriers, such as deductibles and cost sharing, if the services are provided by the patient's usual source of primary care. This applies to patients regardless of payer or the payment model through which the patient is attributed.

Family physicians often report that their patients decline important care due to cost sharing. Studies have backed up these anecdotes by showing that patient cost sharing requirements are associated with lower utilization of important primary care and preventive services and increased hospitalizations, thus increasing overall health care spending while disincentivizing high value care.[x] Patient cost sharing requirements also hinder uptake of existing Medicare codes such as chronic care management. One study found that MPFS billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients.[xi] The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients. One of the primary reasons family physicians report being unable to bill these codes is because patients don't consent to paying the associated cost sharing amount.

In order to incentivize uptake and have a meaningful impact on both primary care investment and patient care delivery, the AAFP strongly recommends 100 percent of patient cost sharing responsibilities be waived for a hybrid payment. Patients are not used to paying for these services prospectively and, understandably, are unlikely to do so for services that they may or may not receive in any given month.

If waiving the full cost sharing amount for the services included in a PMPM is not feasible, the Academy would suggest waiving the full cost sharing amount of a monthly PMPM fee and having practices continue to submit claims at the time of service for those services included in a PMPM. The FFS payments for these claims would be reduced 100 percent and practices could collect their usual cost sharing amount from patients for services they've actually received based upon the fee-for-service payment. This method is used in recent CMMI primary care models, including Making Care Primary, and would have a much smaller impact on Medicare spending.

Technical advisory committee to help CMS more accurately determine Fee Schedule rates:

Question: *Will the structure and makeup of the Advisory Committee meet the need outlined above?*

AAFP Response: The AAFP has encouraged Congress and CMS to invest resources in additional, supplemental sources of information, especially physician time, rather than relying almost exclusively on the Relative Value Scale Update Committee (RUC). However, the Academy emphasizes that existing budget neutrality constraints and the lack of additional data sources would make it challenging for *any* entity, be it the RUC or another expert panel, to allocate and reallocate payment effectively. **Making recommendations on how to redistribute resources within the fee schedule without new money and absent additional data is unlikely to have any meaningful impact.**

We believe more participation and input from primary care teams and beneficiaries may be helpful to CMS in advancing its goals of improving access to care, moving towards value-based

payment, and improving health equity. However, providing access to helpful data and analyses will be key. Other organizations struggle with finding, analyzing, and presenting data to CMS that may provide a different perspective than that recommended by the RUC, which benefits from dedicated staff and other resources. Since CMS is charged with setting RVUs based on actual resource costs, we believe the lack of access to data and survey capabilities by others contributes to an overreliance on the RUC. **We believe there is value in allocating resources to identify and establish new sources of data or survey capabilities to further inform RVUs, which is a necessary pre-requisite or adjunct to setting up this additional expert panel. Creating an additional expert panel without those resources, new sources of data, or survey capabilities will likely prevent the panel from fulfilling its charge.**

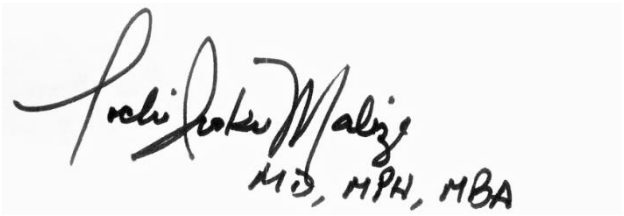
Question: *How else can CMS take a more active role in FFS payment rate setting?*

AAFP Response: CMS may also improve their methodologies by improving access to Medicare and Medicaid data. Disseminating Medicare utilization data earlier would be particularly helpful to immediately understand if the utilization of a service is as anticipated. The first quarter of Medicare claims data should be available by July 1st of each year. A full year of claims data should be available by April each year (example, 2023 data should be publicly available by April 2024). Availability of Medicaid utilization data is also necessary to examine trends in services in the non-Medicare population. The absence of Medicare Advantage claims or encounter data is also problematic, since the number of patients in this program has increased. CMS should share recent Medicaid claims data and investigate mechanisms to collect and share Medicare Advantage encounter information.

In closing, the Academy reiterates our strong belief that well-designed APMs can provide primary care a path out of the under-valued and overly burdensome fee-for-service payment system that exists today and, in turn, will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways. However, because of the impact that the existing FFS structure and payment rates would have on this proposal, the AAFP urges you and your colleagues in Congress to prioritize advancing necessary reforms to modernize FFS payment for primary care before proceeding with a hybrid primary care payment in the MPFS. We look forward to working with you to pass such reforms.

Thank you again for the opportunity to provide this feedback. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,



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American Academy of Family Physicians, Board Chair

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