AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 13, 2024

The Honorable Brett Guthrie
Chairman
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

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 share the family physician perspective in response to today's hearing titled "Checking-In on CMMI: Assessing the Transition to Value-Based Care."

The Center for Medicare and Medicaid Innovation (CMMI) was created by the Affordable Care Act (ACA) in 2010 to test new payment and service delivery models that could improve care quality and efficiency for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. In contrast to traditional fee-for-service (FFS) payment, value-based payment (VBP) arrangements, such as population-based payments or accountable care organizations (ACOs), better support and encourage physicians to deliver a more comprehensive set of services, such as care coordination and addressing health-related social needs (HRSN), through prospective payment and flexibility. These types of arrangements invest in the longitudinal, continuous relationships primary care physicians have with their patients in ways that FFS has not historically and enable practices to tailor care to better support patients.

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. We strongly believe well-designed APMs 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.

Elevating primary care is central to CMMI's strategy and, while progress is slower than many of us would like, it has had a meaningful impact on accelerating the transition to value-based payment and increasing the adoption of APMs. The AAFP believes CMMI is integral to this transition and that there are opportunities for Congress to better enable and encourage to the Innovation Center to use other markers of success for primary care APMs.

Value of CMMI Demonstrations

Early CMMI demonstrations have better informed our understanding of what does and doesn't work in primary care APMs, providing lessons learned and driving model improvements in

later demonstrations. For example, the Accountable Care Organization Investment Model (AIM), a former primary care and population management model administered by CMMI, offered advance payments to accountable care organizations (ACOs) to fund practice transformation. The model demonstrated savings and reduced inpatient admissions, readmissions, post-acute care utilization and emergency department visits while maintaining quality. The success of AIM led to permanent changes to the Medicare Shared Savings Program (MSSP), incorporating advanced investment payments (AIP) to support physician participation in new ACOs. In 2022, MSSP saved Medicare $1.8 billion, making it the sixth year in a row that the program generated savings while producing high-quality performance results.[i]

Some learnings from early CMMI primary care models are APMs that provide upfront or advanced payments, multi-payer alignment, robust data sharing infrastructure, and technical assistance are enablers of success. Primary care physicians still face significant barriers to entering and sustaining participation in VBP arrangements. Practices must comply with an ever-increasing number of federal and state regulations, negotiate contracts with multiple payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs – all while doing their primary job of taking care of patients. This creates an immediate and high barrier to entry, particularly for independent practices that don't have the upfront capital or resources.

This is why models that provide upfront, reliable payments – especially across payers and in conjunction with other supports such as access to data – have proven to be more effective at supporting primary care practices' participation and success in improving outcomes and achieving savings longer-term. For example, practices participating in Comprehensive Primary Care + (CPC+) not only received population-based, per-member-per-month (PMPM) payments, but CMMI provided them with a robust data dashboard and other technical assistance that enabled new practices to join the model and successfully reduce emergency visits and hospitalizations. CMMI also partnered with state Medicaid agencies and commercial payers to drive alignment across payers in CPC+ regions, which in turn provided practices with greater financial support across their contracts, improved data and information sharing in many regions, and accelerated care delivery innovations.

In December 2023, the final CPC+ evaluation report was published, which showed participating practices reduced outpatient ED visits, acute inpatient hospitalizations, and acute inpatient expenditures.[ii] Independent, physician-owned practices in CPC+ successfully reduced acute hospitalizations and inpatient expenditures while hospital- and system-owned practices increased acute inpatient expenditures across both CPC+ tracks and either reduced acute hospitalizations at a lower rate than independent owned practices (Track 1) or increased acute hospitalizations (Track 2).

By the end of CPC+, practices had used the prospective payments they received as part of the model to invest in care delivery transformation that would not have been possible if FFS was their only source of revenue. These practices reported that they:

- Provided patients with after-hours access to a physician or other clinical staff member who has real-time access to the practice's EHR;
- Used designated care managers, typically on-site staff who are nurses or medical assistants, to deliver longitudinal care management services;
- Increased the use of behavioral staff to offer behavioral health counseling at a higher rate than comparison practices;
- Co-located a pharmacist at the practice site to support comprehensive medication management; and

- Convened and collected feedback from patients during Patient and Family Advisory Council (PFAC) meetings.

The Academy is also encouraged by CMS' recent announcement of a new model, ACO Primary Care Flex, which will heed some of our existing recommendations and provide low revenue ACOs participating in MSSP with a one-time upfront shared savings payment and a prospective PMPM payment. CMMI's forthcoming Making Care Primary (MCP) model, which is set to launch in July, also builds upon lessons learned from CPC+ and Primary Care First (PCF) and provides participants who are new to value-based care with upfront payments to develop infrastructure and build advanced care delivery capabilities. CMMI is also working with state Medicaid agencies and other payers in the selected states to align MCP and state programs, helping facilitate the multi-payer alignment that has contributed to successful aspects of earlier models.

Additionally, early CMMI models have shown the importance of meeting practices where they are, rather than electing a "one-size-fits-all" approach to practices entering VBP. For example, MCP will integrate this philosophy by providing three tracks to practices that each focus on goals aimed at creating pathways to enter value-based payment.

Goals for CMMI Model Design and Evaluations

A September 2023 report from the Congressional Budget Office (CBO) projected CMMI would increase net federal spending based on the Center's activities during the first decade of operation. However, the benefits of the aforementioned and other models, including ACOs, are widespread and are not accounted for in the CBO report. The model evaluations CBO relied on for this report were for brief model tests and focused on aggregate, national results. **The AAFP has long noted CMMI model evaluations are likely unable to capture the full benefits of primary care, including the long-term impacts of improving access to and quality of primary care services.**

For example, improving access to and utilization of preventive services is likely to increase total cost of care in the short term, while reducing spending and use of costly services in the long-term as illness is avoided or treated earlier. This is particularly true as the Innovation Center expands its focus on health equity and caring for patients with both complex clinical and social needs. Evaluations capture short-term costs but not long-term gains.

Demonstrating savings in primary care often takes several years as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services, like care management. For example, one family physician who ran a physician-led MSSP-participating ACO in Nebraska shared that although their cost overall was lower than expected for the first three years of participation in the program they did not meet the Medicare shared savings threshold and therefore did not receive any money from Medicare for their ACO efforts. In fact, they did not receive their first shared savings payment for a full five years after their ACO started. His perspective is if they had not received PMPM payments for their Medicare population through the CPC+ program and their largest commercial contract, they likely could not have sustained their efforts and achieved this success.

Because of how long it can take for savings to manifest in primary care, the Academy has advocated for longer CMMI model test periods. We believe that the success of early models – according to the current CMMI evaluation criteria – was hindered due to relatively short model test periods. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. Currently, federal statute only allows CMMI to expand

models that reduce health care spending and maintain quality, or improve performance on quality metrics without increasing spending.

That statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. As the CMS evaluation of 21 models noted, the tested primary care models served large panels of relatively healthy, mostly low-cost Medicare beneficiaries and focused on preventing disease and improving care coordination.

It can be more costly on the front-end of models to get practices to participate, particularly those that require more significant resources and supports to get a foothold in VBP. Things like one-time advanced payments may often be balanced out by savings on the backend, but it requires enough test time for those to actually be realized and sustained. Longer time windows for investments in care coordination, staffing, clinical workflow redesign, health information technology, and data analytics, as well as greater engagement of primary and specialty care providers, may be needed to reduce spending in primary care models.

The challenge of short model test periods has been one of the lessons learned by CMMI, and they have been incorporating that recognition into newer model announcements. For example, CPC and CPC+ were four- and five-year models, respectively. Similarly, Next Gen ACO was five years and AIM was four years. However, new and forthcoming models like States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model will be eleven years and MCP will be ten and a half years.

The CBO report also fails to account for improvements in quality, which is one of the statutory requirement models can meet for expansion. Excluding quality from this report, particularly as CMMI has renewed efforts to evaluate quality within and across their models, narrows the lens and does not provide a full picture of the Innovation Center's impact over time. As part of its strategic refresh upon reflection of its first decade, CMMI has explicitly stated it's strengthening it's focus on quality through a new Quality Pathway, which will use quality priorities to better inform future model evaluations and the potential for expansion based upon quality.

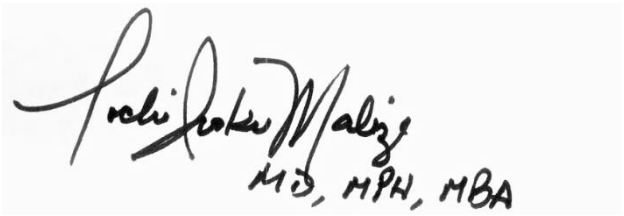
CMMI models have had impacts across and within markets that are not captured in CMMI's evaluations. To date, little is known about the impacts of multi-payer participation in CMMI's primary care portfolio although some regions have done their own independent analyses. Understanding differences in regional performance, including contributing factors to challenges and successes, is critical to fully interpreting the success of past and future models. CPC+ spurred the creation of similar primary care alternative payment models in Medicaid and commercial plans across the country – many of which continue to operate today even though CPC+ has sunset. However, CBO notes in the report that it is unable to capture these downstream impacts.

Further, the CBO report does not take into account Medicare savings (or those accrued in other lines of business) that we know have been achieved in MSSP – the only nationwide value-based payment model. As of January 2024, SSP ACOs include over 634,000 participating clinicians who provide care to almost 11 million people with Medicare.[iii] Recent MSSP results emphasize that primary care-led alternative payment models most effectively achieve cost savings. One New York Times report noted that Medicare spending is about $3.9 trillion dollars lower than previous projections expected, with changing clinician behavior and cost consciousness being one explanation.[iv] This report indicates the potential impacts of the MSSP program and the value movement overall may have had significant effects on Medicare spending that aren't captured by CBO.

As the Subcommittee examines the Innovation Center's progress, we believe there are opportunities to build upon and improve the original statute to better support CMMI's role in accelerating the transition to value-based payment. Specifically, **Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs**, such as whether they successfully bring new physicians into value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, evaluate models both nationally and regionally. These additional criteria would allow CMMI to continue testing models that show early markers of success and iterate upon them to meet current patient, clinician, and market needs.

Thank you for continuing to focus on the importance of transitioning our health care system away from prioritizing volume over value. We look forward to working with Congress to better support CMMI's integral role in this meaningful shift, particularly within primary care. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,



Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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[i] Centers for Medicare and Medicaid Services, "Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care." August 24, 2023. Available online at: https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion2022-and-continues-deliver-high

[ii] Centers for Medicare and Medicaid Services, "Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Report." December 2023. Available online at: https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpcplus-fifth-annual-eval-report

[iii] Centers for Medicare and Medicaid Services, "Press Release: Participation Continues to Grow in CMS' Accountable Care Organization Initiatives in 2024." January 29, 2024. Available online at: https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024

[iv] Sanger-Katz M, Parlapiano A, and J Katz. "A Huge Threat to the U.S. Budget Has Receded. And No One Is Sure Why." *The New York Times*. September 4, 2023. Available online at: https://www.nytimes.com/interactive/2023/09/05/upshot/medicare-budget-threat-receded.html