AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 2, 2024

The Honorable Vern Buchanan
Chairman
Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member
Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1129 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Buchanan and Ranking Member Doggett:

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 for your bipartisan leadership in identifying how we can further our nation's progress toward delivering value-based care with the Subcommittee's hearing titled "Improving Value-Based Care for Patients and Providers."

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 delivery 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.

Unfortunately, a dearth of widely available primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' successful transition into value-based care.

Improving Fee-for-Service Payment for Primary care

Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits. Yet the United States has continuously underinvested in primary care with only five to seven percent of total health care spending going to primary care.[i] Primary care spending decreased for all payers between 2019 and 2021 with Medicare being the most pronounced with a 15 percent drop.[ii] While some of this

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decrease could be due to a drop in office visits during the pandemic, it is a trend worth noting.

The impact of this long-term underinvestment is evidenced in our nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[iii] A common theme across countries with better health outcomes and lower health care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17 percent of total health care spending for these high-performing nations.[iv]

One of the major factors contributing to this underinvestment is the relative undervaluation of primary care in FFS, the predominant payment model. In general, the Medicare Physician Fee Schedule (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.[v]

This devaluation has led to lower compensation for primary care physicians who specialize in treating the whole person compared to their specialist peers, despite the vital role they play in managing chronic conditions and coordinating patient care across a large team and despite the fact evidence has shown that primary care office/outpatient evaluation and management (E/M) visits are more complex and comprehensive than those delivered by other specialties.[vi] This devaluation is not limited to Medicare. Many other private and public payers peg their payment rates to the MPFS rates or use the relative values in the MPFS to set their rates.

FFS doesn't just underinvest in primary care – it also makes it hard to get paid. Physicians must submit unique codes for each and 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. Each of these services must be individually documented to justify payment for typical, comprehensive primary care, even though these services are all foundational aspects.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs. For example, FFS structures have not historically paid for wraparound patient activities, such as community health workers or care coordination, but these interventions enable family physicians to better address a patient's identified health-related social needs (HRSNs) within their community context. This disadvantages patients who require more support and the physicians who care for them. While Medicare has implemented new codes for some of these services in 2024, such as community health integration and social drivers of health risk assessments, their utilization and effectiveness is not yet known.

The Academy therefore continues to strongly urge Congress to advance legislative solutions that will meaningfully improve fee-for-service payment so that it adequately supports and values the work done by primary care physicians and makes the transition to value-based payment more feasible, particularly for many small and rural practices that have been left behind. Specifically, **we continue to advocate for the implementation of an annual inflationary update for Medicare physician payment based upon the Medicare Economic Index (MEI), which the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474) which do**. 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 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 MEI. Because of inadequate payment, many independent physician practices are forced to sell their practices to hospitals or large health systems, or in some instances, close their doors altogether. This is happening at the same time that hospitals, skilled nursing facilities, ambulatory surgery centers and other Medicare providers receive annual payment increases to account for rising costs.

Reforms to the zero-sum, budget neutral nature of the MPFS are also urgently needed, as these requirements are undermining efforts to invest in primary care. Budget neutrality requirements force the Centers for Medicare and Medicaid Services (CMS) to offset increases or additions anywhere in the MPFS with across-the-board cuts to all services, including those most frequently delivered by primary care physicians. In short, this 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.

The Academy appreciates that this Subcommittee has advanced legislation that would implement incremental budget neutrality reforms, including increasing the budget neutrality threshold, which has not been updated since the fee schedule was created in 1992; correcting the impact of over- or under-utilization assumptions by CMS on the availability of funds; and more regularly updating the direct costs used to calculate practice expense Relative Value Units (RVUs).

Further, on budget neutrality, the AAFP encourages Congress to think of traditional Medicare holistically, rather than as inviolable silos such as Part A and Part B. 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 Congress should consider the total costs of Medicare across the multiple Medicare silos and look for offsets across those silos, not just within Part B or the physician fee schedule.

Reforming the Merit-based Incentive Payment System

Congress tried to provide an on-ramp for more practices to participate in APMs with the passage of MACRA and implementation of MIPS, which was intended to provide clinicians with experience being measured on their performance. The AAFP supported the intent of fostering continuous performance improvements that lead to better outcomes for patients. **Unfortunately, continuous cuts to Medicare FFS payments have inhibited most practices from making the necessary investments that would allow them to successfully move into APMs.** Further, the current design of MIPS, which focuses on individual clinician performance using largely process rather than outcomes measures, does not appear to be driving care improvements as much as it is adding administrative complexities that detract from patient care while unfairly penalizing small and rural practices.

The AAFP does not believe MIPS can or will serve as a meaningful transition to APMs as it does not change payment. Alternative payment is a foundational element of value-based payment models. Given that FFS payment of discrete services is inherently incompatible with the comprehensive, continuous, relationship-based nature of primary care, MIPS or any other pay-for-performance

program built upon FFS is limited in its utility to serve as a true mechanism to transition primary care physicians away from FFS. Instead, programs intended to "transition" primary care practices out of FFS are largely compliance programs that increase burden by forcing physicians to report on measures that are not relevant to patient care and outcomes and detract from time that could be spent with patients.

However, despite the challenges and shortcomings of MIPS and absent a viable alternative, we believe there are policy changes Congress could implement to alleviate the administrative costs of reporting to the program, ensure it drives meaningful quality improvement, and assist physician practices in building the necessary competencies to transition into APMs. Specific recommendations to improve MIPS and the Quality Payment Program (QPP) include:

- **Granting CMS the authority to provide credit across multiple performance categories.** MIPS uses four siloed performance categories – all with different measures and reporting requirements. Despite multiple calls for consolidation and cross-category credit, CMS argues that they do not have the statutory authority to alter the program in that regard. One significant step toward reducing burden would be to give CMS the flexibility to provide cross-category credit. For example, a physician who reports a quality measure related to depression screening should automatically receive credit for the corresponding improvement activity.
- **Allowing practices to attest to using certified electronic health record technology (CEHRT) in place of reporting on Promoting Interoperability measures**. The AAFP has advocated for practices to be able to attest to their use of CEHRT rather than requiring multiple burdensome measures, but CMS does not have the authority to offer such an option. Years of policy changes to the legacy Meaningful Use program and now the Promoting Interoperability category have failed to move the needle on health information exchange. It is beyond time to move away from such burdensome requirements – doing so would be an important step toward reducing the burden of the MIPS program.
- **Providing CMS with the authority to modify the qualifying participant threshold through rulemaking to ensure advanced APM participation is attainable.** Existing thresholds set in federal statute are creating barriers for physician practices seeking to move into more advanced models. Providing CMS with the authority to modify the thresholds will help ensure the QPP is facilitating the transition to APMs instead of preventing it.
- **Providing technical assistance, shared learning collaboratives, and data infrastructure to support all primary care practices to transition to APMs.** Primary care's information needs are particularly complex which requires technical capabilities and a reliance on others to fill information gaps, including payers and other clinician organizations. Often, IT departments may be non-existent or staffed by non-IT personnel, posing challenges when implementing new or updated hardware or software, connecting to regional health information exchanges (HIEs), and setting up registries. Additionally, building and understanding reports from an EHR is time-consuming, burdensome, and can be costly if there is a need for custom reports. Safety nets also face additional reporting burden on top of payer reports due to other reporting requirements based on their funding streams (grants, Uniform Data System, etc.).
- **Funding technical assistance programs to support overall adoption of APMs by all practices in all settings.** MACRA provided funding to support small practices with direct assistance through tools and resources to help them navigate the complex MIPS reporting requirements. In response, CMS created the QPP Small, Underserved, and Rural Support (QPP SURS) program which provided small practices in rural and health professional shortage areas with technical assistance at no cost to them. Unfortunately funding for the QPP SURS expired in February 2022 and has not been renewed.

Additional Opportunities to Support the Transition to Value-Based Payment

As discussed during the hearing, primary care physicians – particularly those in rural and underserved communities – 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.

To address this, **the AAFP has called on federal policymakers to increase options for primary care practices to participate in APMs that provide upfront or advance payments and other supports to enable the investments required to be successful**. For example, practices participating in CMMI's Comprehensive Primary Care Plus (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 and accelerated care delivery innovations.

We are encouraged by CMS' announcement of a new model, ACO Primary Care Flex, which will heed our recommendations and provide low revenue ACOs participating in the Medicare Shared Savings Program (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 this month, also builds upon lessons learned from CPC+ and Primary Care First (PCF). It will provide 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.

Witnesses during the hearing also acknowledged that much of the work done by primary care physicians is not captured and paid for by existing FFS billing structures. However, given the complexity and onerous requirements associated with billing many FFS codes, research has concluded that implementing additional, prescriptive codes for every unique service that may conceivably be provided within primary care is likely not the most effective solution either.[vii] This is another reason why the AAFP advocates for prospective, risk-adjusted PMPM payments for the continuous, comprehensive care delivered by primary care physicians.

Prospective, reliable payment can be used to better capture and pay for non-medical services like care coordination and addressing HRSN. For example, in evaluations of CMMI's Comprehensive Primary Care (CPC), CPC+ and PCF models, participating practices emphasized that reliable prospective payments were invaluable for budgeting, hiring staff, and providing services otherwise not paid for. Practices used prospective payments to invest in care management programs, coordinate with other clinicians and community-based services, and hire a broader range of staff, including behavioral health clinicians, to deliver more comprehensive care.[viii] As one staff person from a PCF participating practice put it: "You're receiving money on a quarterly basis that helps cash flow of the clinic [for] things that clinics normally do, and that are not reimbursed. Care coordination is not reimbursed, and having those funds upfront is helpful."[ix] The primary difference that afforded practices the opportunity to make these investments is that the payment was *prospective*; while they

are possible to make in traditional FFS, the retrospective payment makes it much more challenging for practices to do so.

Further, additional opportunities for the Subcommittee to improve the landscape of APMs include passing the *Value in Health Care* Act (H.R. 5013), which would make necessary reforms to and incentivize further participation in Medicare APMs. This includes extending MACRA's five percent advanced APM (A-APM) incentive payments – which are currently set to expire at the end of this year – for two more years to continue to encourage the movement to value. The A-APM incentive payments have served as an important tool for attracting physicians to participate in A-APMs, which require significant upfront (and often ongoing) investments in new staff, technology, and other practice improvements. Primary care practices have also used the bonus payments to offset the cost of investing in care delivery transformation that drives success in these models by improving patient outcomes and lowering spending.

While the AAFP strongly urges Congress to extend the existing A-APM incentive payments, we also acknowledge that there are no guardrails in place to ensure they flow to the physicians and clinicians delivering care to Medicare beneficiaries in employed settings. Current A-APM incentive payments are distributed at the organization level and do not have stipulations for how those incentives are shared or flow to the physicians and clinicians delivering care to beneficiaries. This is one reason why independent practices have better outcomes in value-based arrangements, as the resources and incentives flow directly to the practices and care teams delivering the care and are uniquely positioned to be more agile, flexible, and timely in their implementation of care interventions.

In considering a new design for future A-APM bonus payments, we would encourage the Subcommittee to consider policies to ensure individual physicians and clinicians share in the financial rewards that accrue from their performance. To better encourage new participation in A-APMs, bonuses should be structured based on the value of what physicians and clinicians deliver, their impact on health outcomes and patient satisfaction, and both improved and sustained performance.

The *Value in Health Care Act* also gives CMS authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved practices in APMs. Further, it establishes a voluntary track for ACOs in the MSSP to take on higher levels of risk and provides technical assistance for clinicians new to APMs.

In addition to this legislation, the AAFP believes there are additional changes Congress can enact to incentivize more primary care physician-led ACOs or greater primary care physician participation in MSSP. According to CMS data, in 2021, physician-led ACOs in the MSSP achieved net savings that were nearly double that of hospital-led ACOs ($237 per capita in net savings versus $124 per capita net savings).[x] ACOs comprised of 75 percent primary care clinicians or more saw $281 per capita in net savings compared to $149 per capita in net savings for ACOs with fewer primary care clinicians. The data clearly shows primary care is essential to the success of MSSP. As such, Congress should consider the following options to encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers:

- Create a minimum threshold of primary care spending within an ACO to be eligible for shared savings.
- Set a minimum utilization rate of E/M encounters with primary care clinicians to be eligible for shared savings.
- Require ACO rosters to maintain a minimum ratio of primary care to other clinicians.

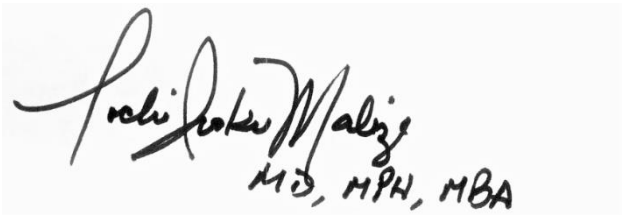
- Require primary care physician representation in the ACO governance structure.

Finally, **Congress should consider providing CMMI with additional flexibility in how it evaluates the success of primary care models**. 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. 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.

The current 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. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. 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 the Subcommittee and your colleagues in Congress to better support 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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