AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance

On

"Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B"

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Dear Chairman Wyden and Ranking Member Crapo:

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 both how we care for chronically ill patients and how we pay physicians for delivering said care under Medicare Part B fee-for-service, known as traditional Medicare.

Management of, and payment for, chronic care services is one of the most pressing issues facing our nation's seniors and the physicians who care for them. Nearly 95 percent of adults 60 years and older have at least one chronic condition, and nearly 80 percent have two or more.[i] This is only projected to get worse in the coming years as the number of adults 50 years and older with at least one chronic disease is estimated to increase by almost 100 percent from 71.522 million in 2020 to 142.66 million by 2050.[ii] Effectively meeting the current and future needs of our patients with chronic conditions requires our nation to better leverage primary care as the foundation of our health care system. However, our current fee-for-service payment structure favors and incentivizes work that is done to a patient, rather than done with and for them.

Our failure to invest in and uplift the true value of primary care is impacting patients every day. Our current physician workforce skews heavily toward non-primary care specialists, and we have fewer primary care physicians relative to the population than in other countries. This is having severe impacts on patient access. In a recent comparison of primary care access across ten peer countries, U.S. adults were the least likely (43 percent) to have a longstanding relationship with a primary care clinician and a growing number of adults have reported not having any usual source of care over the past decade.[iii] At the same time, three-quarters of U.S. adults (73 percent) say the health care system is not meeting their needs.[iv] This data is telling. People are losing their trusted relationship with a primary care physician and, in turn, their trust in the health care system.

Evidence makes clear that this type of longitudinal relationship primary care physicians foster with their patients leads to better control of chronic conditions, fewer emergency department visits and hospital stays, and improved health outcomes.[v,vi] Unfortunately, traditional Medicare underinvests in these trusted relationships with patients. Low primary care payment rates in a system that rewards volume over value means physicians are pressured to see as many patients as possible. Meanwhile, overwhelming administrative burden takes time away from delivering patient care and often requires physicians to spend hours outside of the office doing documentation.

These factors are leading current primary care physicians to leave the field and, when combined with the burden of student loan debt, dissuading medical students from pursuing primary care specialties like family medicine. At a time when Americans have more chronic conditions than ever, we should be making strides to embed primary care physicians in every community. Instead, we've created a policy framework that is actively driving prospective physicians away from primary care and perpetuating nationwide workforce shortages.

Decades of systemic underinvestment in primary care and prevention have led to poorer population health and a greater emphasis on rescue medical care, rather than health care. We as a nation have worried about increased upfront spending and implemented policies that have wrongly steered people away from high-value, low-cost services like preventive screenings and primary care office visits. By failing to invest more upfront dollars in primary care, we're paying

an even higher price. We're spending more than ever on health care costs, both as a nation and as consumers, because we have sicker patients receiving later diagnoses and utilizing expensive settings like the emergency room and hospital as their "usual source of care." Establishing a health care system that prioritizes primary care will, among many other things, require a meaningful overhaul of physician payment that will take time. It is with this end goal in mind that the AAFP offers the following feedback, considerations, and policy recommendations in response to the Committee's white paper.

Addressing Payment Update Adequacy and Sustainability:

The Committee will explore how to provider greater predictability in the conversion factor (CF) statutory update schedule while also maintaining responsible stewardship over the Medicare program and taxpayer dollars.

1. *As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?*

AAFP Response: The Academy's policy supports adjustments to the conversion factor based on the Medicare Economic Index (MEI) or another fair representation of physicians' costs of delivering care. Therefore, we have supported and continue to call for an annual inflationary update to Medicare physician payment based upon the MEI. This is one of the most tangible and impactful actions that the Committee can take to uplift all physicians and stem the growth in health care consolidation by giving independent practices a fighting chance at keeping their doors open.

2. *Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?*

AAFP Response: AAFP policy supports the use of a single conversion factor, if a conversion factor exists, for all physician services under the Medicare Physician Fee Schedule, except for purposes to achieve specific public policy goals. If Congress determines that encouraging physician involvement in A-APMs is a sufficiently important public policy goal, then the AAFP would support differential conversion factors as one means to further that goal. That said, differential conversion factors are probably not the most effective means to achieve such a public policy goal, and our perception is that the current differential set to go into effect in 2026 is likely too small to achieve the desired goal.

3. *What targeted policies should Congress consider pursuing to offset the costs associated with an alternative CF framework?*

AAFP Response: About one-third of the $4.5 trillion America spends on health care per year is wasted.[vii] That is, it does not result in high quality care being delivered to patients. High health care costs and a fee-for-service payment structure have incentivized utilization of more expensive and low value services in lieu of prevention, primary care, and early intervention. Meanwhile, non-patient care related buckets such as administrative burden eats up significant financial resources. 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.

Admittedly much of this waste happens across other payers and sectors of health care that sit

outside the scope of this white paper. However, as one of the largest payers, Medicare can (and does) set trends for the rest of the industry and the federal government has the authority to address and rein in costs across other payers. The Academy would encourage the Committee to look at several potential policy avenues for eliminating waste and funneling those funds toward actual patient care. For example:

- Site of service payment differentials, such as facility fees, allow hospitals to charge significantly more for a service than physician's offices can, even if it is delivered off-site in an outpatient setting. These payment differentials contribute to increased health care spending despite no demonstrated differences in the quality of patient care and outcomes. They directly reward hospitals financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings. Meanwhile, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[ix]

  Medicare's increased payments for services performed in hospital outpatient departments (HOPDs) do not just impact the Medicare program and beneficiaries, however. Private health plans generally use Medicare's payment system as a basis for how much they pay physicians and hospitals, meaning that this influences and directs spending and resources among commercial plans and patients. Therefore, adopting comprehensive site neutral payment policies in Medicare would have significant impacts in saving money across the health care sector, with one study estimating that it would lead to $471 billion in savings over the next 10 years.[x] In terms of direct patient costs, Medicare patients collectively would save about $67 billion on Part B premiums and $67 billion on cost-sharing. Premiums for private health insurance plans would be about $107 billion lower over that period, which would amount to a reduction in aggregate premiums of 0.75 percent. Privately insured patients would also save about $18 billion on cost-sharing due to lower payment rates.[xi]

  Therefore, the AAFP strongly urges the Committee to consider policies that meaningfully address site of service payment differentials and apply those cost savings toward improving Medicare physician payment.

- While we recognize the scope of this white paper is specific to traditional Medicare, overpayments to Medicare Advantage (MA) plans are an area where targeted reforms could be implemented to bolster payment for physician payment in Part B. The Medicare Payment Advisory Commission (MedPAC) released findings earlier this year that project the federal government will overpay MA plans by $88 billion in 2024.[xii] The AAFP is strongly supportive of comprehensive and accurate documentation of all patient's diagnoses and advises members that all coding should comply with the ICD-10-CM coding guidelines. If reports of overpayment are accurate, the AAFP is concerned that significant funding that could support broader, more equitable access to high-quality primary care is being diverted with no benefit to MA enrollees. Congress could consider advancing policies to address incentives that create unintended consequences and ensure that payments to MA organizations contracted to administer benefits are benefitting MA enrollees with the delivery of high value services, including comprehensive, continuous primary care that can help to reduce health care expenditures in the long run.

- Eliminating the required three-day hospital stay as a prerequisite to Medicare coverage of skilled nursing facility care may be another policy worth considering and one tested in some CMMI models.

The targeted policies suggested above hint at a broader consideration. Namely, as Congress considers potential offsets for costs associated with an alternative conversion factor framework, it should think of traditional Medicare holistically, rather than as inviolable silos such as Part A and Part B. Eliminating waste and anachronistic policies across the program may serve to yield the offsets necessary to achieve conversion factor reform under the physician fee schedule. Just as Medicare expects Medicare Advantage plans, some 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.

Addressing Concerns regarding Budget Neutrality Adjustments in the PFS:

The Committee is interested in exploring structural refinements to statutory PFS budget-neutrality requirements that would provide greater flexibility in determining pricing adjustments for services while maintaining financial responsibility and integrity.

1. *What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes?*

AAFP Response: We have supported proposals that would require the Secretary to compare utilization assumptions for relative value unit (RVU) adjustments that trigger a budget neutrality adjustment to actual utilization and apply a payment adjustment to reconcile the difference between the two. When over-utilization assumptions trigger budget neutrality adjustments, that money is allocated for in the fee schedule but never actually paid to physicians. Given the stringency of budget neutrality requirements, this is one mechanism that would provide greater flexibility without having a significant fiscal impact as the money already "exists" within the fee schedule.

2. *Should the Committee consider additional parameters to align the statute's budget neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?*

AAFP Response: The Academy urges the Committee to consider raising the budget neutrality threshold. At a minimum, it should be raised to $53 million, translating to what the original statutory threshold of $20 million in 1992 would be today when adjusted for inflation. However, to have a more meaningful impact, we strongly urge that the threshold be increased even further as we and others in the physician community have long contended that the existing threshold amount in comparison to the overall size of the physician fee schedule unnecessarily pits specialties against one another in a fight for scarce resources.

Additionally, the statute's budget neutrality provisions should authorize and encourage CMS to consider the implications of physician fee schedule changes on other facets of the Medicare budget when calculating any budget neutrality adjustment in the context of the Medicare physician fee schedule. For instance, if changes within the physician fee schedule are expected to shift the volume of services from the hospital to physician office setting, the corresponding

increase in Medicare spending on physician services should be offset by savings in Medicare spending on hospital inpatient or outpatient services in determining any budget neutrality adjustment under the Medicare physician fee schedule. Consistent with some of our earlier comments, we believe Congress and CMS should think of traditional Medicare holistically, rather than as inviolable silos such as Part A and Part B or just within the Medicare physician fee schedule. Put more bluntly, if budget neutrality is to be applied, it should be applied to Medicare spending as a whole, not just the Medicare physician fee schedule.

Incentivizing Participation in APMs:

The Committee is interested in exploring ways to improve and sustain meaningful incentives for A-APM participation, particularly if Congress pursues CF reforms that diminish or eliminate the current-law differential conversation factor updates for A-APM and non-A-APM participants. Ideally, policies to extend or expand financial incentives to participate in A-APMs should account for lessons learned from successful models and programs, as well as for providers with lower A-APM uptake, and such potential incentives must reckon with budgetary conditions and realities.

The Committee is also interested in examining incentive payment reforms that would mitigate potentially misaligned linkages between bonus amounts and total PFS revenue, given that A-APMs operate most effectively when pursuing greater value for patients, rather than higher volume. […] the Committee also has an interest, more broadly, in better aligning any future bonus payments with providers within an A-APM who contribute to beneficiary attribution.

1. *In considering a new design for future A-APM bonus payments, are there existing demonstrations that structure A-APM incentive payments to reward providers that attribute beneficiaries to the A-APM?*

AAFP Response: 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.

2. *What methodology should form the basis for incentive bonuses, if not total PFS revenue for all providers participating within an A-APM? What bonus structure best encourages new providers participating in A-APMs?*

AAFP Response: Incentive payments, to date, have been too small, paid too far removed from the care delivered to be meaningful, and have no guardrails in place to ensure they flow to the physicians and clinicians delivering care to Medicare beneficiaries in employed settings. 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. There should also be mechanisms in place to ensure that within practices and other healthcare organizations, individual physicians and clinicians share in the financial rewards that accrue from their performance.

3. *Are there other A-APM programmatic designs that would make participation more attractive for providers?*

AAFP Response: Primary care practices need a stable suite of multi-payer models across the risk spectrum with predictable, prospective revenue streams adequate to meet patient and practice needs. In today's environment, primary care teams intent on delivering well-coordinated, advanced primary care continue to be hampered by the persistently low payments and limitations related to fee-for-service and burdened by the unique requirements of each payer. Streamlined, well-designed prospective payment models aligned with the AAFP's Guiding Principles for Primary Care Payment that adequately support and sustain comprehensive, longitudinal patient-physician relationships to address the whole patient, including health-related social needs (HRSN), are essential. Payments should also be risk-adjusted to accurately reflect patients' clinical diagnoses and HRSNs to ensure practices aren't penalized for caring for patients with increased needs. These payments should always be made within the context of a patient's usual source of primary care to avoid potential fragmentation. This payment infrastructure enhances patients' access to high-quality, continuous primary care and strengthens independent practices. When primary care practices are supported by predictable, prospective payment models, practices thrive, and patients have better outcomes.

As Congress considers redesigning the A-APM and its incentives, we urge them to look to the Health Care Payment Learning and Action Network (HCP-LAN) APM framework and use this as a guide to revise the distinction between APMs (HCP-LAN categories 1 and 2) and A-APMs (HCP-LAN categories 3 and 4). This would effectively move away from the current challenge of determining which APMs meet the nominal risk standard, which the AAFP believes nominal risk is different for different entities, and provides clearer guidance that is well-vetted and used broadly to described the APM landscape. We believe there is sufficient risk involved (both in the form of management and financial risk) in participating in models in Categories 3 and 4 to consider them A-APMs, rather than continuing to rely on an arbitrary nominal risk standard threshold.

4. *How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?*

AAFP Response: According to CMS data, in 2021, physician-led ACOs in the MSSP achieved net savings that were nearly double than hospital-led ACOs ($237 per capita in net savings versus $124 per capita net savings). 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 the Shared Savings Program. 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 evaluation and management (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.

5. *Are there other A-APM programmatic designs that would make A-APMs more attractive to beneficiaries to increase attribution and thus support A-APMs?*

AAFP Response: The AAFP recognizes the importance of patient choice and the powerful impact of a strong relationship between patients and their primary care physicians. Payers are increasingly encouraging, incentivizing or requiring patients to identify their primary care physician as part of the insurance enrollment process. Many labels describe this approach to establish 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. One way to further the impact of patient choice is to incentivize voluntary selection of a usual source of care for Medicare beneficiaries and provide cost sharing waivers to patients with an identified usual source of primary care. This comes with the caveat that ensuring there is widespread access to these types of cost sharing waivers and A-APM design features for beneficiaries as to not exacerbate health disparities.

Reducing Physician Reporting Burden Related to MIPS:

Given the lack of improvement in patient outcomes and quality of care, the Finance Committee is considering repealing or scaling back the MIPS program to relieve physicians' administrative burden and alleviate churn from A-APMs back to MIPS.

1. *What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?*

AAFP Response: The AAFP does not believe MIPS can or will serve as a meaningful transition to alternative payment models as it does not change payment. Alternative payment is a foundational element of value-based payment models. Given that fee-for-service 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. Despite the challenges and shortcomings of MIPS, we believe there are policy changes that could reduce burden and potentially improve its relevancy specific to primary care physicians and patient outcomes.

There are multiple pain points associated with performance measurement that contribute to burden. First, lack of measure alignment coupled with a heavy focus on process measures significantly increases the burden associated with MIPS. 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, as well as the mechanisms of measurement, should be parsimonious and aligned across payers to reduce unnecessary administrative burden. Measures of primary care should focus on the unique features that are 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.

Further, the data collection and reporting processes are often complex and time-consuming.

Since payers have not agreed to implement common measures, despite agreement on "core sets" in multi-stakeholder forums, such as the Core Quality Measure Collaborative, physicians and their clinics often spend considerable time and resources building individual performance measures in their electronic health record (EHR) systems and/or manual reporting for each of their payer partners. This is not acceptable or sustainable.

Despite a concerted movement to optimize electronic reporting, the reporting burden remains great. Although the benefits of a centralized and standardized digital reporting system are many (e.g., streamlined submission processes, enhanced/real-time analysis, etc.), the upfront effort and costs required to make the necessary updates are substantial, and practices must be supported with enough time and assistance to complete the implementation successfully. Industry players, including EHR vendors and the federal Office of the National Coordinator for Health IT (ONC), need to ensure the new data infrastructure intended for performance measurement (e.g., Fast Healthcare Interoperability Resources [FHIR]-based data elements, digital quality measures [dQMs], etc.) is prepared for these system changes before pushing the change onto primary care practices. In many cases, these data system changes are beyond the capabilities of individual practices and must be addressed in a community-centric fashion using industry agnostic models, such as the health data utility.[xiii]

Further, as we have already stated previously and will again in later responses, reliable and flexible payment can help encourage this as it better supports innovative care delivery and is more tailored to a patient's needs and goals.

2. *Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?*

AAFP Response: Access to data is pivotal in supporting physicians' ability to care for their patients. However, the data must be meaningful, timely, and not contribute to increased burden. More data is not always better data. Claims data are inherently dated (lagging between 1-3 months on average) based on billing for services that have already happened, decreasing its usability for physicians when making informed decisions at the point of care or proactively identifying patients needing timely care management interventions. Furthermore, claims data can include inaccuracies attributable to human error and provide only a limited picture of a patient's care. These issues can sow distrust in the data among physicians who need integrated administrative (claims) and clinical data to be confident enough to act on the information.

Stakeholders continue to push for and implement interoperability standards, although the impact on physician access to information varies. Building on the efforts of the 2004 executive order and 2009 HITECH Act, national efforts continue to promote health information sharing through the 21st Century Cures Act passed in 2016. The Cures Act requires that patients have electronic access to all their electronic health information at no cost and implements penalties for intentional information blocking with limited exceptions. Furthermore, the national adoption of the Trusted Exchange Framework and Common Agreement (TEFCA) and Fast Health care Interoperability Resources (FHIR) seeks to improve health information transfer by establishing a universal floor for interoperability and standardizing how health information exchange is governed across the country. Still, the impact of these initiatives is yet to be determined, with many primary care physicians skeptical of these efforts due in part to the lackluster results of past reforms, which generally increased administrative burden and had an underwhelming impact on access to essential and usable data. While setting interoperability standards is necessary, policymakers should ensure this work is followed by evaluating whether these efforts

lead to intended improvements in information sharing that support more efficient delivery of care and better patient health outcomes.

The AAFP also believes additional considerations and support must be offered to practices that do not have the resources to build robust data infrastructures. Practices must invest in multiple tools, each operating with its own data environment and interoperability challenges. In addition to the EHR, physician practices will often pay separately for an enterprise data warehouse, analytics platform, care management solutions, and even separate tools for data visualizations. These disparate solutions to support population health management are in addition to other traditional solutions required to run a practice. The cost of implementing and maintaining these disparate solutions is a barrier for small, independent practices and a burden to the overall system. For these reasons, implementation and support for community-centric, industry agnostic approaches, such as the health data utility model, is essential and should be considered a prerequisite to support the movement to value.

Supporting Chronic Care in the Primary Care Setting:

In order to reduce administrative burden, appropriately compensate primary care, and create a viable pathway for independent primary care physicians to an APM, the Committee is exploring a hybrid payment model in FFS that would allow for a PMPM payment, provided in advance to the clinician. The Committee is also interested in pursuing reforms to A-APMs, which have the built-in administrative infrastructure to alleviate some of the burden associated with additional primary care codes, such as through targeted, reduced cost-sharing to improve care coordination and decrease patient financial burden.

1. *In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?*

AAFP Response: Fundamentally, the delivery of a primary care service and 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." When considering how this definition translates to the services to be included in a hybrid per-beneficiary per month (PBPM) payment, the AAFP suggests the following tenets:

- The following services should be included in the PBPM when they are delivered by primary care physicians and clinicians in a primary care setting:
    - Care management services;
    - Communications such as emails, phone calls, and patient portals with patients and their caregivers;
    - Behavioral health integration services; and
    - Office-based evaluation and management visits, regardless of modality, for new and established patients.

The AAFP recognizes the importance of consistent physician-patient relationships, as well as the power of VBP to help codify and reward these relationships by assigning accountability. 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.

As acknowledged in response to an earlier question, the Academy supports taking a tiered approach to population-based payments that recognizes each practice's unique needs and capabilities and meets them where they are in terms of the services they can provide, while providing them the necessary supports to eventually move into a more sophisticated arrangement if desired and feasible. We also acknowledge that population-based payments need to continually be updated based upon inflation and payment increases.

2. Should a hybrid model design include a hybrid-specific risk adjustor for primary care?

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

Risk adjustment—a process used to predict health care costs by assigning a risk profile to an individual's health status—has long been a critical component of health plan operations, particularly for plans paid on a capitated basis like Medicaid managed care organizations (MCOs) and Medicare Advantage Organizations (MAOs). Beginning in earnest in 1997 with the first federal requirements, risk adjustment was originally developed as a way to provide adequate financing to health plans who treat individuals with higher-than-average health needs, and to minimize incentives to selectively treat heathier members ("cherry picking").

Several decades later, while risk adjustment continues to be a core focus of health plans, it is increasingly relevant to other types of health care organizations who assume accountability for the total cost of care, including primary care practices participating in value-based payment. As physicians and practices transition away from FFS towards VBP—particularly those involving downside risk and/or population-based payments—they can benefit from the same protections risk adjustment provides to health plans. The ability to predict the relative needs and costs of care for patients and populations is important for achieving success in VBP, and risk adjustment is an essential tool/process to help inform that understanding. Under VBP arrangements, where practice payments are tied to the cost and quality of outcomes for defined populations or services, risk adjustment is an important tool for ensuring payments and the benchmarks used to determine financial performance reflect the acuity of the patient population.

3. How can such a policy account for quality?

AAFP Response: The AAFP believes quality and 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, as well as the mechanisms of measurement, should be parsimonious and aligned across payers to reduce unnecessary administrative burden. To that end, the AAFP continues to champion the Person-Centered Primary Care Measure introduced in 2019 by The Larry A. Green Center, which uses a comprehensive and parsimonious set of 11 patient-reported items to assess the broad scope of primary care. Part of the Measures That Matter to Primary Care initiative, the PCPCM measures the high-value aspects of primary care based on a patient's relationship with the physician/clinician or practice. The PCPCM has been endorsed by CMS and NQF and became available for use as a Quality Payment Program Merit-based Incentive Payment System clinical quality measure and is being

used in CMMI's Making Care Primary and ACO Primary Care Flex models.

4. *Are there benefit design flexibilities that would ease financial burden for ACO-attributed beneficiaries who require chronic care management?*

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, and we urge Congress to waive cost sharing for chronic care management and transitional care management services for all Medicare beneficiaries who have identified a usual source of primary care and who receive those services from their usual source of primary care, regardless of the payment model through which the patient is attributed.

5. *If Congress were to pursue such a hybrid model design, should policymakers also differentiate the CF, budget-neutrality adjustments, and other mechanisms to promote team-based care and appropriately account for distinctions in payment models across specialties and subspecialties?*

AAFP Response: To really move the needle, a hybrid PMPM for primary care payment should not be subject to budget neutrality. As previously stated, if budget neutrality was viewed through a different lens and shifted to focusing on overall management of Medicare spending, there would be multiple levers to pull that would not be solely limited to the Medicare PFS. Additionally, a hybrid PMPM for primary care is an opportunity for Medicare to increase its investment in primary care and reap the rewards of such. The United States invested just 4.7% of its health care dollars in primary care in 2021 compared to an average of 12-17% in other Organization for Economic Co-operation Development (OECD) nations in 2016.[xiv,xv] Medicare spending lags behind all other payers for primary care spending, clocking in at just 3.9% in 2021. High-performing health systems commonly "invest in primary care systems to ensure that high-value services are equitably available in all communities to all people," resulting in better health outcomes for a nation's citizens.[xvi] Application of budget neutrality to a hybrid PMPM for primary care could potentially be counterproductive in this regard.

Supporting Chronic Care Benefits in FFS:

Given the prevalence of chronically ill beneficiaries in both MA and Medicare FFS, the Committee is interested in exploring which benefits would be the most meaningful in addressing health outcomes for beneficiaries in Medicare FFS.

1. *Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?*

AAFP Response: Primary care services provided by a patient's usual source of primary care are proven to reduce downstream health care costs and improve patient outcomes, including those of the chronically ill. This includes preventive and other services that promote a continuous relationship between a patient and his or her usual source of primary care. With regards to preventive services, the Medicare statute has traditionally limited Medicare coverage to services for the diagnosis and treatment of an illness or injury, thus excluding many preventive services not explicitly written into the law (e.g., preventive medicine evaluation and management services defined by Current Procedural Terminology codes 99381-99387 and 99391-99397). The Medicare statute fails to recognize what everyone else seems to - that "an ounce of prevention is worth a pound of cure." Broader coverage of preventive services under

Medicare would be helpful.

The statute has also made provision of recommended vaccines problematic by dividing coverage between Part B and Part D. New vaccines, such as RSV and shingles, are only covered under Part D, which was designed for pharmacies to submit claims and makes it particularly challenging for primary care physicians to deliver recommended vaccines in their office. Further, approximately 8.5 million Medicare enrollees have Part B but not Part D coverage, leaving them without affordable access to Part D vaccines.[xvii] Legislative action is needed to ensure that physicians can easily provide all ACIP-recommended vaccines to Medicare beneficiaries. We urge the Committee to consider requiring Medicare Part B coverage of all vaccines, allowing beneficiaries to more readily access vaccines from their usual source of care and improving our nation's uptake of one of the most cost-effective public health measures.

Lastly, there is the matter of health-related social needs (HRSN). HRSNs constrain opportunities for people to access resources that promote better health. Broader Medicare coverage of and payment for services to address HRSNs within the context of a patient's usual source of primary care are likely to reduce downstream health care costs and improve outcomes for the chronically ill. Medicare's implementation of community health integration and principal illness navigation services under the Medicare physician fee schedule in 2024 is a step in the right direction. The AAFP urges health insurers and payers to provide appropriate payment to support health care practices to identify, monitor, assess, and address individual HRSNs and community-based social drivers of health (SDoH). AAFP policy on value-based payment clearly states that primary care physicians cannot be held accountable for providing resources to address social determinants of health that do not exist in the community. Because health inequities arise outside of the health care sector, the AAFP urges funders, including the federal government, to provide sufficient funding to address the SDoH and reduce health inequities that result from broad inequities at the community level. In addition to other interventions, this includes robust financial support for the nation's public health infrastructure to support their efforts to facilitate cross-sector community collaboration, strategic planning for health, Health in All Policies, and the core public health functions.

2. *What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?*

AAFP Response: Beyond which services provide the most value in this regard is the matter of how those services are paid. 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 Primary Care First (PCF) models, participating practices emphasized that reliable prospective payments were invaluable for budgeting, hiring staff, and providing services otherwise not paid for. For example, 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.[xviii] 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."[xix]

Further, we reiterate our support raised in response to earlier questions for waiving patient cost-sharing for chronic care management and transitional care management services, as well as for any hybrid primary care payment in the MPFS. Patient cost-sharing requirements are limiting uptake by patients who would truly benefit from these additional supports. A 2022 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. The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.[xx]

Many family physicians report that patients decline CCM services because the $15 or so a month they faced in cost-sharing was not financially feasible. This rings true for many of the other new codes Medicare has implemented, including G2211, SDOH risk assessments, and community health integration services. Patients are not used to paying for these services and, understandably, are likely to be resistant to doing so. If we want to incentivize usage of these high-value services, we must waive patient cost-sharing. This is particularly critical when considering that the patients least likely to afford the out-of-pocket costs are those most in need of these services.

In many ways, CCM is a preventive service in that it prevents complications from chronic illness and reduces emergency department and other outpatient visits. Removing cost-sharing for CCM and other primary care services increases access to these services without increasing overall health care spending.[xxi] The available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health. While cost-sharing is waived across payers for most preventive services, many patients don't access all the preventive care recommended for them because they don't know what is or isn't covered or they are concerned they might be charged for raising other health issues in the same visit. Expanding the definition of "preventive services" and ensuring that beneficiaries understand when cost-sharing does and does not apply is an important role that CMS plays in maximizing the investments they make in important preventive services.

Ensuring the Integrity of the PFS:

The Committee is interested in exploring recommendations from experts and stakeholders regarding the program integrity and accuracy of all of the inputs to the PFS, including RVUs.

1. *What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS's RVU and rate-setting processes?*

AAFP Response: We have 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 would make it challenging for *any* body, 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 the addition of new money perpetuates the unnecessary food fight among physician specialties.

The AAFP is an active participant in the RUC process and has been since its inception in 1991. The RUC and CMS have revalued E/M codes multiple times (1997, 2007, 2021) since the first Medicare physician fee schedule in 1992. We acknowledge that, each time, the work RVU has increased.

That said, it is important to continue evaluating whether the methods and data used by the RUC and CMS remain appropriate to accurately value all services under the fee schedule. The underlying methodology was developed by Harvard University and CMS (formerly, the Health

Care Financing Administration) in the late 1980s. Much has changed in the world and in medicine since then. It's worth noting that what CMS and the RUC use now is not exactly what Dr. Hsiao and his colleagues recommended to CMS. It may be worth exploring/identifying how the current system deviates from RBRVS as initially envisioned and whether returning to RBRVS's roots has any value.

We believe there is value in utilizing different data sources and modernizing data collection to allow other experts to make supplemental recommendations to CMS, particularly with regard to the valuation of primary care services. The RUC is currently challenged to capture the work of primary care in its current process of valuing E/M services. There are two ways in which this happens. First, the RUC survey process focuses on the "typical" patient and distributes surveys based on vignettes for E/M services that are much less specific, making it more difficult to quantify the physician work involved in more cognitive interactions than for more specific procedural service vignettes. It also struggles to account for evolving clinical practice as new treatments and technologies become available, leading to the delivery of more complex E/M visits.

For example, the "typical" patient vignette for the most recent survey of code 99214 read, "Office visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment." Compare this with the vignette for 45379 (Colonoscopy, flexible; with removal of foreign body(s)): "A 50-year-old patient with abdominal pain and constipation swallowed a diagnostic capsule, which became lodged at the ileo-cecal valve. Colonoscopy with removal of the foreign body is performed."

Second, this problem is compounded when these broad E/M vignettes are surveyed across more than 50 specialty societies, many of which do relatively few and much more straight-forward E/M visits than primary care. This approach under-values the input of the primary care specialties that provide the most complex E/M services and do so most commonly. We also have concerns that the survey process is labor intensive for the clinicians taking it and therefore relatively few complete surveys, potentially worsening the reliability of the results. Additional data sources could therefore be warranted and result in more robust recommendations.

We note that 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.

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 this 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 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.

3. *What third-party entities could produce the most credible and reliable analysis of CMS's RVU determination and rate-setting processes, and what key areas should such analysis examine?*

AAFP Response: The Academy does not have a specific recommendation in this regard. However, there are numerous data sources available that would provide a more comprehensive overview of patient care activities by physicians and other members of the care team. There are likely several entities, both inside and outside academia, who could do a credible and reliable analysis of CMS's RVU determination and rate-setting processes, and it may be worth the effort for CMS to issue an RFP to identify such potential entities. The GAO may want to also do its own analysis in this regard. In any case, such analysis should examine areas such as (including but not limited to) data used, available/extant alternative data sources and/or effort necessary to collect better data, processes applied to the data, etc.

Ensuring Beneficiaries' Continued Access to Telehealth

The Committee shares concerns voiced by patients, frontline clinicians, and countless others that inaction by Congress on extending Medicare telehealth flexibilities would likely result in diminished health care outcomes for scores of seniors. With those considerations in mind, the Committee plans to engage in a bipartisan, bicameral basis to chart a responsible path forward that preserves access to crucial telehealth services under Medicare FFS.

AAFP Response: The AAFP supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes, and decrease costs when utilized as a component of, and coordinated with, longitudinal care.

Any permanent expansion of telehealth benefits must be structured to not only increase access to care but also promote high-quality, comprehensive, continuous care, as outlined in the joint principles for telehealth policy put forward by the AAFP, the American Academy of Pediatrics and the American College of Physicians. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

The AAFP strongly believes telehealth is most appropriate when provided by a patient's usual source of care. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the central value offered by a usual source of primary care, a continuous and comprehensive patient-physician relationship, increase fragmentation of care, and lead to the patient receiving suboptimal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care.

The Academy supports the implementation of telehealth coverage guardrails to protect the quality and continuity of care delivered virtually, such as requiring an established patient relationship for some telehealth services. Ensuring beneficiaries receive telehealth services from a clinician that knows them and can access their health record will help ensure patients receive appropriate care, including in-person services when needed.

A report from the Department of Health and Human Services Office of the Inspector General found that 84 percent of Medicare fee-for-service telehealth visits are already being provided by clinicians who have an established relationship with the beneficiary.[xxii] Other studies indicate patients prefer telehealth services provided by their usual source of care.[xxiii] Implementing additional guardrails would help ensure high-quality services are being delivered to beneficiaries without unduly restricting access to care, while also safeguarding program integrity.

Thank you to the Committee for its continued bipartisan leadership to examine Medicare coverage of and payment for chronic care. The AAFP looks forward to continuing to work with you to advance policies that will meaningfully reform Medicare physician payment and better support family physicians and the patients they serve. 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

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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