AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of
American Academy of Family Physicians
Submitted for the Record

U.S. Senate Committee on Finance

The President's Fiscal Year 2018 Budget

June 8, 2017

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On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, thank you for the opportunity to submit a statement for the record to the Committee on Finance regarding the Trump Administration's Fiscal Year 2018 Budget Request.

On the whole, the AAFP is deeply troubled by the Administration's FY 2018 budget, and its implications for patient health, safety, and access to care. The AAFP believes that if implemented, the spending reductions and policy changes requested in the budget would create a domino effect of damage that ultimately will harm the health of America on both an individual and community-wide basis. Below, the AAFP sets forth its principal concerns with the budget, as well as qualified support for selected policies:

1. **The Committee Should Reject the Administration's Position on Repeal and Replace of the *Affordable Care Act*.**

The AAFP supports health care coverage for all, consistent with the public-health mission of the specialty of family medicine. The AAFP promotes this in the form of "a primary care benefit design featuring the patient-centered medical home, and a payment system to support it," for everyone in the United States.[1] AAFP believes that all Americans should have access to primary-care services without patient cost sharing. This primary care benefit is especially important today in high-deductible health plans. The AAFP believes that universal health care also should include services outside the medical home (e.g. hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting access to primary care is also consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care in the United States. Research supports the AAFP's view that having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.[2]

The AAFP applauded the passage of the *Affordable Care Act* (ACA) in 2010 as an incomplete yet important step toward the goal of universal coverage. While the AAFP does not oppose repeal and replace of the *Affordable Care Act* per se, the AAFP has clearly articulated to Congressional leaders its grave concerns with any approach to replacing the ACA that would increase the number of uninsured, degrade the health-care safety net, or eliminate important patient protections in the health-insurance marketplace. After the Congressional Budget Office (CBO) issued its report dated March 13, 2017, projecting that H.R. 1628 (the *American Health Care Act* or AHCA) would "increase the number of uninsured people relative to the number under current law . . . to 24 million in 2026," the AAFP expressed to House leaders its formal opposition to that bill—based in large part on this projection about insurance coverage. The AAFP subsequently expressed "deep disappointment" when the House passed the current

[1] AAFP, Health Care For All (2014), *available at* http://www.aafp.org/about/policies/all/health-care-for-all.html.

[2] *See, e.g.*, The Robert Graham Center, The Importance of Having Health Insurance and a Usual Source of Care, Am. Fam. Physician (Sept. 15, 2004), *available at* http://www.aafp.org/afp/2004/0915/p1035.html.

version of the AHCA on May 3 (a later CBO report dated May 24, 2017 projected that under the modified version of the AHCA, the number of uninsured would increase to 23 million, 9 million of whom would have been insured through employer-based or private non-group coverage).

Although the Administration has never precisely articulated its vision for repealing and replacing the ACA, it states in this FY 2018 budget that it "continues to support a repeal and replace approach" to the *Affordable Care Act* (see Budget in Brief at 2) that broadly tracks the AHCA framework of tax credits, expanded health savings accounts, high-risk pools, and changes to Medicaid financing. The Administration proposal "eliminates Obamacare's onerous taxes and mandates, provides funding for states to stabilize markets and ensure a smooth transition away from Obamacare, and helps Americans purchase the coverage they want through the use of tax credits and expanded Health Savings Accounts," all of which matches the AHCA. (*Id*.) The Administration has also indicated (through a Statement of Administration Policy dated March 22, as well as a public event held in the White House Rose Garden on May 3) that it "strongly supports" the AHCA—both the version approved by the House Budget Committee and the version that the House passed on May 3.

Although the Administration has not made its own projection about coverage losses under its repeal-and-replace proposal, it is clear that the Administration's proposal is equivalent to the AHCA, and thus gives rise to the same concerns about loss of insurance coverage. The AAFP urges this Committee to reject the Trump Administration's vision for repeal and replace, and instead adopt reforms that extend affordable insurance to more Americans, strengthen the health-care safety net, and lower the overall cost of health care by investing in a stronger primary-care foundation.

2. The Committee Should Reject the Administration's Proposals to Cap Medicaid Financing.

The AAFP and its members are committed to ensuring that all individuals, regardless of their socio-economic status, have access to health care coverage. This commitment is focused on individuals and families who do not have access to employer-based health insurance and/or are economically unable to secure health care coverage through the individual market. Our commitment to low-income individuals and families is reflected in family physicians' participation in the Medicaid program. More than two-thirds (68%) of AAFP's members accept new Medicaid patients into their practices. Participation in Medicaid by family physicians is at its highest level since the AAFP began monitoring the issue in 2004.

The Administration's budget proposal "reforms Medicaid funding to States starting in FY2020 through either a per capita cap or a block grant." (Budget in Brief at 3.) The Administration projects that these changes will reduce federal Medicaid spending by $610 billion over 10 years. Amazingly, the budget also contemplates "additional savings to Medicaid as a result of the Administration's plan to repeal and replace Obamacare with solutions that focus Medicaid on the most vulnerable Americans—the elderly, people with disabilities, children, and pregnant women—those Medicaid was intended to serve." (Budget in Brief, at 61.) Office of Management and Budget (OMB) Director Mick Mulvaney confirmed[3] that the Medicaid

[3] See White House, Off-camera Briefing of the FY18 Budget by Office of Management and Budget Director Mick Mulvaney (May 22, 2017) ("We assume the Affordable Health Care Act that passed out of the House passes. That has some Medicaid changes into it. We wrap that

reductions in the budget proposal are to be added to those found in the AHCA ($834 billion per the CBO report dated May 24, 2017), yielding a potential total of more than $1.4 trillion in federal funds removed from Medicaid over 10 years. This strongly suggests that the CBO's estimate that 14 million Medicaid beneficiaries would lose their health coverage by 2026 is a floor, not a ceiling. President Trump's proposal would likely significantly reduce support to states, causing even more low-income Americans to lose Medicaid coverage—an unacceptable result to America's family physicians.

The AAFP has consistently stated opposition to the means by which the Administration achieves its budgetary goals in Medicaid (by shifting costs onto states, localities, providers, and patients). Rather, the AAFP supports maintaining the current financing structure of Medicaid: the federal medical assistance percentage (FMAP) system. Capping federal financial participation in Medicaid by definition shifts risk of medical loss to states, localities, and ultimately to patients themselves. Eventually, under the fixed federal contributions with the growth rate set forth in the AHCA, states will be unable to fill funding shortfalls, and will be forced to reduce payments to providers and managed-care organizations (MCOs). Many more providers will drop out of Medicaid, and many MCOs will shrink their provider networks, providing still fewer choices for Medicaid patients, and rendering states unable to fulfill the equal-access mandate of the Medicaid program. As federal contributions cover less and less of the total cost of care over time, some state Medicaid programs may ultimately create waiting lists for patients, and other forms of rationing for non-emergent services. And of course, for the 14 million or more who will lose coverage altogether, they will have no access to care at all save for charity and uncompensated care. The AAFP strenuously opposes such a fundamental undermining of the Medicaid entitlement and the damage that it would do to Americans' public health.

3. Congress Should Provide Long-Term Support for the Teaching Health Center Graduate Medical Education Program.

The budget proposal "maintains funding for the Teaching Health Center Graduate Medical Education Program and requests $60 million in new mandatory funding in both FY 2018 and FY 2019." (Budget in Brief, at 22.) The AAFP commends the Administration for its recognition of the importance of the THCGME program, which will expire on September 30, 2017, absent Congressional intervention.

The THCGME currently provides training for 742 medical and dental residents. Residents in the THCGME program train exclusively in primary-care medical specialties and dentistry—two-thirds of whom are training in family medicine and pediatrics.[4] Residents in the program train in

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into our budget proposals. We go another half a step further and ratchet down some of the growth rates that are assumed in the AHCA. So if you assume growth rates -- I can't remember what the exact measure is -- it's a CPI-plus measure. We take a measure that we think is closer to what the actual growth rates look like.").

[4] Health Resources and Services Administration, Teaching Health Center Graduate Medical Education Program, Academic Year 2014-2015, *available at* https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/teaching-health-center-graduate-highlights.pdf.

community health centers (including federally qualified health centers), and tend to be concentrated in rural and other underserved areas that need access to more providers, particularly primary-care physicians.

THCGME, which funded its first class of residents in 2011, is already achieving Congress's intent to get more doctors practicing in rural and underserved areas. The most effective way to get family and other primary-care physicians into rural and underserved areas is to train them in these underserved areas. American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[5] By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[6]

The AAFP stresses to Congress that the Administration's proposal to fund the program at $60 million per year is not enough to continue financing the program at its current size. The Health Resources and Services Administration (HRSA) has completed a study documenting that "the median overall cost of training a resident in a THC in FY 2017 is estimated to be $157,602."[7] Therefore, the annual cost to maintain the current size of the THCGME program is at least $117 million per year. The AAFP views this as the bare minimum that the program should receive in order to prevent reductions in existing levels of primary-care training. However, given that Congress devotes some $15 billion per year to training residents, Congress could fund the THCGME program at $150 million per year and still account for only one percent of the overall spending on GME. The AAFP urges Congress in the strongest possible terms to dramatically expand and make permanent this highly successful and bipartisan GME program.

4. The Committee Should Swiftly Approve a "Clean" Long-Term Extension of CHIP Funding.

The AAFP urges the Committee to swiftly approve a bipartisan long-term extension of CHIP, in order to promote stability and health security for 8.9 million low-income children[8] and their families. Time is of the essence in completing this work in order to ensure continuous access to primary and preventive services for this vulnerable population, protect progress in public health and allow States to adequately plan. Although the Administration's budget "proposes to extend funding for CHIP for two additional years through FY 2019" (Budget in Brief, at 66), the AAFP

[5] E. Blake Fagan, M.D., et al., Family Medicine Graduate Proximity to Their Site of Training, Family Medicine, Vol. 47, No. 2, at 126 (Feb. 2015).

[6] Candice Chen, M.D., MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, Academic Medicine, Vol. 88, No. 9, p. 1269 (Sept. 2013).

[7] Health Resources and Services Administration, Cost Estimates for Training Residents in a Teaching Health Center, *available at* https://bhw.hrsa.gov/sites/default/files/bhw/grants/thc-costing-fact-sheet.pdf.

[8] Centers for Medicare and Medicaid Services, 2016 Enrollment Report, available at https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf.

believes that Secretary Price articulated a better position during his January 24 confirmation hearing in this Committee when he suggested that an 8-year extension would be preferable.[9]

The AAFP has supported CHIP since its inception in 1997, and during each subsequent reauthorization and extension of funding (2007, 2009, and 2015), as a way to extend health coverage to uninsured children whose families do not meet eligibility requirements for Medicaid. Since the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the AAFP has reiterated support for CHIP funding beyond the current end-date of September 30, 2017—through letters to this Committee and to Congressional Leadership. Although the AAFP does not collect member survey data on CHIP participation, we know (due to the close connection between Medicaid and CHIP—including the fact that some states operate combined Medicaid / CHIP programs—and the fact that family physicians perform so many pediatric services) that family physicians are helping to carry out Congress's intent behind CHIP: treating low-income children, many of whom would be uninsured without the program.

Family physicians play an important role in addressing the health needs of American children. According to the AAFP's latest member census, published December 31, 2016, over 80 percent of AAFP members care for adolescents, and 73 percent care for infants and children.[10] Other AAFP member survey data reflect that about 20 percent of AAFP's members deliver babies as part of their practice, with roughly 6 percent delivering more than 30 babies in a recent calendar year.[11] Of AAFP active members with full hospital privileges, 70 percent provide newborn care in the hospital, and 64 percent provide pediatric care in the hospital.[12] This is consistent with family medicine's traditional role of practicing in the entire scope of the physician license, in order to meet the needs of the community in which the family physician practices. A family physician who serves a small rural community without a pediatrician, for example, will often perform most or all pediatric care for that community.

The AAFP urges the Committee to pass a "clean" extension of CHIP with a minimum of unnecessary policy changes. Accordingly, the Committee should extend the current enhanced federal medical assistance percentage (FMAP), as well as the current maintenance of effort (MOE) provisions, which are both in effect through September 30, 2019, in order to align with an extension of CHIP funding. For example, if Congress extends CHIP funding for 8 years, then it should extend the enhanced FMAP and MOE provisions for 6 years. The Administration proposal does quite the opposite—it "ends the 23 percentage point increase in the enhanced Federal match rate and the current law maintenance of effort requirement after FY 2017" (Budget in Brief, at 66), which would terminate these important policies this year—two years earlier than Congress had envisioned. The AAFP opposes scaling back what our current bipartisan commitments to the nation's most vulnerable children.

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[9] During his testimony, then-Representative Price stated about CHIP (in response to Senator Brown): "Well if we could extend it for eight [years] it would probably be better than five [years]."

[10] AAFP Member Census (Dec. 31, 2016), available at http://www.aafp.org/about/the-aafp/family-medicine-facts/table-13.html.

[11] AAFP, 2015 Practice Profile Survey (July 15, 2016).

[12] *Id.*

5. The AAFP Welcomes Efforts to Expand Direct Primary Care in Medicaid.

The Administration proposes to "expand Medicaid Direct Primary Care (DPC), which provides an enhanced focus on direct physician patient relationships through enrolling Medicaid patients in DPC practices. These practices enhance physicians' focus on patient care by simplifying health care payments for patients and physicians." (Budget in Brief, at 62.) The AAFP supports the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model, including the DPC practice setting.

Payments in all primary-care models should be appropriate to ensure an adequate supply of participating family and other primary-care physicians. Just as the fee-for-service payments in Medicaid should be at least at Medicare levels, periodic payments in Medicaid DPC should be comparable to payment levels from other third-party payers such as employers and Medicare Advantage plans, in order to allow family physicians to appropriately serve this patient population in this unique model.

6. The Committee Should Work to Ensure that CMS is Adequately Funded in Order to Implement the Many Programs Under the Committee's Jurisdiction.

The Administration proposes to reduce CMS program management by $379 million in FY 2018—a 13-percent reduction in the agency's FY 2017 budget. (Budget in Brief, at 71.) Given that CMS is responsible for the administration of Medicare, Medicaid, CHIP, and the *Affordable Care Act* federal marketplaces, as well as over one trillion dollars in corresponding annual payments, the AAFP advises the Committee to work with the Appropriators to resist such a large and unwarranted reduction to the CMS operating budget in FY 2018. The vast majority of AAFP members participate in one or more of Medicare, Medicaid, and CHIP, and the millions of newly insured under the ACA have looked to America's family physicians for primary care—many for the first time in their lives. Accordingly, ensuring the smooth functioning of CMS is critical to the ability of so many Americans—the elderly, the low-income, those insured in the marketplaces, and others—to receive high-quality primary care.

Moreover, the AAFP continues to invest significant resources preparing its members for the Medicare Quality Payment Program (QPP), established in the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) and launched on January 1, 2017. AAFP members are now reorienting their practices to prepare to report quality and other measures to CMS through the Merit-Based Incentive Payment System (MIPS) or one of the advanced alternative payment models (A-APMs) such as the Comprehensive Primary Care Plus (CPC+) model, rolled out earlier this year by the Centers for Medicare and Medicaid Innovation (CMMI). The AAFP has also submitted an original primary-care advanced payment model proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)—an expert panel established in MACRA to help review and approve new models for use under the QPP. These efforts to make the QPP a success will be compromised unless CMS receives adequate funding to implement them. The FY 2017 funding level of $2.82 billion already represents less than one-half of one percent of the $1 trillion in program payments flowing through the agency this year; the AAFP fails to apprehend the rationale for such a steep cut to program management in FY 2018 when it accounts for such a tiny fraction of the agency's overall budget.

The AAFP commends the administration for its statement that it wants to "work to reduce provider burden [under the QPP] while providing incentives for providing high quality care."

(Budget in Brief, at 53.) However, in the AAFP's experience, depriving CMS of resources to implement the QPP and other programs is not conducive to implementing bold initiatives like regulatory reform. Accordingly the AAFP urges Congress to reject a draconian cut to CMS program management.

7. Title X Funding

The Administration's FY 2018 Budget Request "provides $286 million—the same level as the FY 2017 Continuing Resolution—to support low-income individuals with comprehensive family planning and related preventive health services through the Title X Family Planning Program." (Budget in Brief, at 24.) The AAFP agrees that this important program should, at a minimum, receive $286 million for the upcoming fiscal year, in order to continue supporting existing Title X clinics, which offer preventive services such as: screening for sexually transmissible infections, cancer screenings, HIV testing, and contraceptive care.