AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 12, 2023

The Honorable Bill Cassidy
United States Senate
520 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Tim Scott
United States Senate
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Tom Carper
United States Senate
513 Hart Senate Office Building
Washington, D.C. 20510

The Honorable John Cornyn
United States Senate
517 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bob Menendez
United States Senate
528 Hart Senate Office Building
Washington D.C. 20510

Dear Senators Cassidy, Scott, Cornyn, Warner, Carper and Menendez:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write to offer feedback in response to your request for information on ways to improve care for patients jointly enrolled in Medicare and Medicaid. We appreciate your attention and interest in how to better support the experiences and outcomes for dually eligible individuals, for many of whom family physicians are the usual source of care.

Approximately 12.2 million people in the United States are jointly enrolled in Medicare and Medicaid. These individuals, known as “dual eligibles,” qualify for benefits due to their age or disability and low-income status. While some individuals in this population are relatively healthy, many have complex care needs including multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness.

Family physicians are an essential part of the safety net, providing comprehensive care to low-income and other underserved patients. They are trained to provide care across a patient’s lifespan, making them uniquely equipped to care for dually eligible individuals. Through established relationships, they help patients prevent, understand, and manage illness, navigate the health system, and set health goals. Their knowledge, skills, and training allow them to provide continuing and comprehensive medical care, health maintenance, and preventive services to each member of the family regardless of gender, age, or type of problem. Family physicians also play an important role in addressing health-related social needs and reducing health inequities by providing high-quality health care for the underserved.

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Despite being a relatively small population, dual eligibles have been responsible for disproportionate shares of Medicare and Medicaid spending. In 2019, the combined Medicare and Medicaid spending on dually eligible individuals was $440.2 billion or about one third of total spending.[i] Given that Medicare and Medicaid do not always work together, much of this spending comes from the lack of coordination, fragmented care, and misaligned incentives between the programs.

There is a clear need to update the bifurcated system that currently serves dual eligibles to ensure more seamless integration that streamlines enrollment, reduces administrative burden, improves access to care, and promotes better patient outcomes while lowering costs. To achieve this aim, the AAFP offers the following feedback in response to the questions provided.

How would you separately define integrated care, care coordination, and aligned enrollment in the context of care for dually eligible beneficiaries? How are these terms similar and how are they different?

Care coordination is a component of integrated care, ensuring at least basic collaboration across the health care system. For dually eligible individuals, especially those with complex care needs, care coordination is critically important. Care management refers to activities performed by health care professionals with a goal of facilitating appropriate patient care across the health care system to increase patient satisfaction and self-management skills resulting in improved outcomes. The goal of care management and coordination is to individualize health care to meet each patient's specific needs. Health care systems that are patient centric, outcome driven, and include payment structures that support services which patients need will be better aligned to meet this goal.

Care management and coordination help reduce care fragmentation by requiring communication through multiple modalities. Physicians and care teams discuss patient care with specialists and hospitals; incorporate specialist and hospital provider input into patients' care plans; and engage with patients about ongoing care management through the patient portal and by telephone. Care coordination spans the health care system with care teams reviewing hospital admissions, discharges, and emergency department visits; tracking tests and referrals to make sure results are returned; and providing appropriate community resources and patient education.

Integrated care for dual eligibles can help ensure comprehensive coordination across systems, reduce administrative burden, decrease health care costs, and ultimately improve patient outcomes. Therefore, **the AAFP supports federal efforts to improve care coordination and integration for dually eligible individuals and appropriately pay primary care physicians based on the value of care they provide.**

What are the shortcomings of the current system of care for dual eligibles? What specific policy recommendations do you have to improve coordination and integration between the Medicare and Medicaid programs?

As has been acknowledged, dually eligible individuals currently navigate a burdensome, unaligned web of care between Medicare and Medicaid programs. The current system frequently leads to duplication and care fragmentation for beneficiaries, which has been shown to negatively impact patient outcomes and increase health care costs. A 2020 Medicaid and CHIP Payment and Access Commission (MACPAC) report notes, for example, beneficiaries admitted to the hospital under their Medicare benefits may need home and community-based services (HCBS) to safely transition back into the community after discharge. However, because HCBS are covered under Medicaid, there may not be a mechanism in place to inform the beneficiary's HCBS provider of a hospital stay, making it harder for the HCBS provider to ensure a smooth transition.[ii]

For many older adults, Medicare is the first line of health coverage and Medicaid often pays for beneficiary cost sharing. Dual eligibles often do not have another source of health insurance beyond Medicare, and without Medicaid support, they may be unable to access services not covered by Medicare, such as long-term services and supports. **The AAFP supports federal policies that streamline and standardize access to Medicaid benefits for dual eligibles across states, assist beneficiaries with enrolling in benefits for which they are eligible, and remove cost barriers.** To improve coordination and streamline enrollment across programs, the AAFP has encouraged the Centers for Medicare and Medicaid Services (CMS) to assist states with incorporating data from non-health programs into their eligibility determination processes. CMS should assist states with creating multi-benefit applications for these aligned programs, and CMS can facilitate sharing best practices across states. Data flow among state agencies and with federal benefits programs should be maximized so individuals are at least automatically referred or have their applications initiated to benefit from other available programs for which they may be eligible without excessive administrative burden on either agency staff or beneficiaries.

The AAFP has supported proposals to require states to follow Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements that they accept leads data from the Social Security Administration (SSA) and act upon such data as if it constituted a Medicare Savings Program (MSP) application. We believe requiring states to use leads data to facilitate eligibility and enrollment in Medicaid and MSPs will improve enrollment in both programs and reduce cost barriers to care for eligible individuals.

The AAFP has also supported policies proposed by CMS to streamline enrollment processes and refine requirements and definitions to increase enrollment and access to benefits for eligible individuals, such as defining “family of the size involved” at the federal level and giving states the option to include additional individuals. The AAFP supports a minimum federal standard for this for the sake of consistency and equality in access to benefits across states.

Additionally, the AAFP strongly urges Congress to consider ways to improve payment for family physicians who care for dual eligibles, which remains a major challenge. Currently, primary care physicians often receive lower payment when treating dually eligible individuals enrolled in traditional Medicare compared to Medicare-only beneficiaries. This is because of existing “lesser-of” payment policies under which state Medicaid programs can elect to not cover the full Medicare cost sharing amount of a certain service if the Medicaid payment allowance for that service is less than Medicare’s allowance. As of 2018, only seven states covered the full Medicare cost sharing amount.[iii] Once a patient has met his or her annual deductible, Medicare implements 20 percent cost sharing for physician visits, meaning physicians may be paid up to 20 percent less for dually eligible individuals in some states. Physicians are not able to collect Part B cost-sharing from most dually eligible beneficiaries. **Because of these “lesser-of” payment policies, clinicians are losing an estimated $3.6 billion in revenue.**[iv] These policies discourage primary care physicians from accepting dually eligible patients and have been associated with reduced access to primary care, which can result in poorer patient outcomes.[v]

Congress should consider policies to increase payment amounts at the point of service for physicians and others treating dually eligible beneficiaries. **We encourage Congress to act upon the Medicare Payment Advisory Commission’s (MedPAC) recommendation to enact a non-budget neutral add-on payment, not subject to beneficiary cost sharing, under the physician fee schedule for services provided to low-income Medicare beneficiaries, who are often dually eligible individuals**. These add-on payments should equal a clinician's allowed charges for these

beneficiaries multiplied by 15 percent for primary care clinicians, or five percent for non-primary care clinicians.

This issue of physician payment for serving dual eligibles is compounded by the fact that Medicare physician payment rates themselves are inadequate. **The AAFP strongly encourages Congress to identify opportunities to reform the Medicare Access and CHIP Reauthorization Act (MACRA) and has previously offered several policy recommendations in response to a Congressional RFI**.

While the elimination of the sustainable growth rate was lauded by the physician community at the time, MACRA has left the majority of Part B clinicians in a similar state of financial insecurity. Not only have physicians endured lower than expected increases to the Medicare physician fee schedule conversion factor (CF), they would have faced significant reductions in recent years if not for legislative interventions providing a temporary increase to the CF. Because Medicare budget neutrality rules require that any significant increases to Medicare payments for Part B services be offset by reductions elsewhere in the fee schedule, positive changes such as the recent revaluation of evaluation and management codes – a critical step toward appropriately valuing primary care – are partially negated by reductions to the CF. **Without legislative intervention, budget neutrality adjustments will continue to erode clinician payment.**

At the same time, physician practices face steep increases in practice costs and an ongoing public health emergency. Medicare physician payment rates have failed to keep up with the cost of inflation and have become increasingly insufficient. According to the American Medical Association's analysis of Medicare Trustees report data, Medicare physician payment has been reduced by 20 percent when adjusted for inflation over the past 20 years. Practically speaking, this means that physicians 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. **The AAFP urges Congress to implement an annual inflationary update for the Medicare Physician Fee Schedule to ensure physician payment rates account for rising costs.**

These challenges are further exacerbated in Medicaid, where payments are often even lower. Medicaid payment is on average 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent in some states.[vi] These low rates have historically been a barrier to physicians accepting more Medicaid patients. An internal analysis of the Medicaid and CHIP Payment and Access Commission (MACPAC) Report on Physician Acceptance of New Medicaid Patients from 2014-2017 revealed physician acceptance worsens as the ratio of Medicaid payment rates to Medicare allowances decreases. States with higher Medicaid-to-Medicare payment ratios typically had higher acceptance rates. Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients.[vii] Managed care plans report caps on clinicians' Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care.[viii] Patients covered by Medicaid experience longer office wait times, and both low-income patients and their physicians report low payment rates lead to shorter, inadequate visit times.[ix, x]

On the other hand, evidence indicates patient access improved when Congress raised Medicaid primary care payment rates to Medicare levels in 2013-2014. One study found that appointment availability increased during the "primary care fee bump" and decreased after it expired.[xi] Other studies found the fee bump did not significantly increase physicians' participation in the Medicaid program, likely due to the temporary nature of the payment increase.[xii] MACPAC surveyed physicians about the primary care fee bump and found that it modestly increased willingness to accept new Medicaid patients, though physicians reported early operational issues delaying the start of increased

payments were a major challenge. Raising Medicaid payment for primary care services can improve access to care for Medicaid beneficiaries and in turn mitigate health disparities.

To ensure all Medicaid beneficiaries, including dually eligible individuals, can access high-quality primary care when they need it, **Congress should support policies to help states raise Medicaid payment for primary care services to at least Medicare rates.** The AAFP has endorsed legislation to permanently reinstate the Patient Protection and Affordable Care Act (ACA) primary care payment increase and urges Congress to pass it promptly. These low, fee-for-service (FFS) payment rates are undermining progress toward advancing health equity, improving behavioral health access, and accelerating the transition to value-based care.

Furthermore, the current system of care for dual eligibles fails to support physicians moving into alternative payment models (APMs). While MACRA was designed to shift financial incentives away from FFS payment into alternative payment models, the aforementioned decreases in FFS payments under the Medicare physician fee schedule have inhibited most physician practices from making the necessary investments that would allow them to successfully move into alternative payment models.

MACRA may also negatively impact health equity by undervaluing the care delivered by those physicians caring for the most complex and challenging patient populations. Research has shown that physicians who participated in the Merit-based Incentive Payment System (MIPS) and serve a higher proportion of dually eligible patients have significantly lower MIPS scores compared to other physicians. As a result, physicians caring for larger proportions of patients with higher social risk receive greater negative payment adjustments. Penalizing practices caring for patients at higher social risk means practices have fewer resources to meet their patients' needs or make the investments that would allow them to transition to an APM. Furthermore, the budget neutral requirement for MIPS requires the negative adjustments to fund the positive adjustments and creates a "reverse Robinhood effect," where resources from those caring for less affluent patients is transferred to those caring for more affluent patients.[xiii] This gap will only become more pronounced as the program progresses and the MIPS performance threshold continues to increase. Ultimately, MIPS merely perpetuates the flaws of the value-based modifier program and exacerbates resource disparities rather than helping practices transition to payment models that more adequately support equitable, high-quality care.

The AAFP has long advocated to accelerate the transition to value-based care (VBC) using APMs that include comprehensive prospective payment to better support the provision of person-centered, longitudinal primary care. Since the passage of MACRA, it has become clear that stable, adequate fee-for-service payments are also a vital component to this transition, particularly for practices serving rural, low-income, and other underserved communities, including dually eligible individuals. Physician practices that struggle to keep their doors open cannot possibly transition into alternative payment models or hire care managers and behavioral health professionals on the under-valued and over-burdensome FFS primary care payment system that exists today within both Medicare and Medicaid. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows. Most practices continue to rely on FFS rates and/or payments for most of their payment and do not have the capital to begin transitioning into APMs. This is particularly true when the APM is built on an underfunded FFS chassis, as most are. As FFS rates increasingly fail to cover practice costs or support the advanced capabilities and services these practices provide, physicians find it increasingly challenging to generate shared savings or invest in new interventions for their patients, including robust integration of behavioral health care.

Accelerating the transition to value-based care has the potential to improve access to care for patients while also enabling practices to provide advanced primary care services, which dually eligible beneficiaries may especially benefit from. APMs provide primary care practices with a stable and predictable revenue stream, which grants them the needed flexibility to transform care delivery and meet patients' health related social needs. Increasing the availability of models with stable, robust prospective payments would help address long standing challenges with low Medicare and Medicaid payment rates, provided that the prospective payments adequately support the high-value care practices deliver. For example, practices participating in APMs often choose to hire social workers, mental health professionals, pharmacists, or other additional staff that are equipped to provide behavioral health care, connect patients to community services, and expand care coordination and medication management services. As noted previously, the dually eligible population tends to experience more complex conditions which require large teams to appropriately manage and coordinate care. Helping primary care practices that serve dual eligibles move into APMs will enable them to make sincere investments that ultimately benefit patients.

How does geography play a role in dual coverage? Are there certain coverage and care management strategies that are more effective in urban areas as compared to rural areas?

Dually eligible individuals are a diverse population that includes many beneficiaries with multiple chronic conditions, physical disabilities, and cognitive impairments. Being low income, having more complex health needs, and living in a rural area puts these dually eligible individuals at risk of lower access to health care services and worse health outcomes. Approximately 21 percent of dually eligible individuals, or 2.6 million people, live in rural areas.[xiv, xv] In a study of dually enrolled individuals, rural beneficiaries had higher all-cause mortality rates than their urban counterparts.[xvi] Efforts to improve coverage for dually eligible individuals must consider the unique needs of rural beneficiaries and include improving both the geographic availability of primary care physicians in rural areas as well as coordination of coverage, benefits, and care delivery.

Medicare payments to physicians are generally less in rural areas than in suburban and urban areas, as reflected in the geographic adjustment factors associated with the Medicare Physician Fee Schedule (MPFS). This current structure of low payment can prevent physicians from being able to feasibly accept as many patients as urban and suburban physicians, further disadvantaging dually eligible individuals living in rural areas and consequently reducing their access to primary care services. For this reason, **the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas).**

When implemented appropriately and intentionally, telehealth and other digital health tools can be one effective way to connect patients to health care services and can advance health equity by enabling patients with time, transportation, distance, and language barriers to connect with their primary care physicians. Telehealth is beneficial for all dually eligible individuals, as it has enabled members of these patients' care teams to participate in consultations and better coordinate care.[xvii] Care coordination is particularly critical for dually eligible individuals who reside in skilled nursing facilities, long-term care facilities, or those who are in the hospital, as well as patients seeking additional social supports, to ensure all practitioners of the patient's care team are in communication with the patient's usual source of primary care.[xviii]

However, not all patients can easily access telehealth services due to unreliable broadband. This is especially pronounced among rural Americans, who are 10 times more likely to lack broadband access than their urban counterparts, leading to fewer telehealth visits.[xix] The lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth access for rural

Americans, including dually eligible beneficiaries.[xx] **Congress must work to invest in the expansion of modern, high speed broadband internet, expand programs that provide patients with the technology necessary to participate in virtual visits with their usual source of primary care, and incorporate telehealth in integrated care delivery models for dually eligible individuals.** However, improving access to broadband and technology is just one strategy to improve equitable access to telehealth for dually eligible beneficiaries.

Addressing health care shortages in rural areas along with investing in coverage and payment policies that enable the appropriate expansions of care delivery and telehealth use for these populations is key to reducing the disparities between urban and rural dually eligible beneficiaries. The AAFP has long called for eliminating geographic restrictions, expanding the originating site, allowing federally qualified health centers and rural health clinics to furnish telehealth services, delaying in-person requirements for tele-mental health services, and providing coverage and access to audio-only telehealth services. We appreciate Congress extending these Medicare telehealth flexibilities through December 31, 2024. The AAFP continues to advocate for appropriate permanent payment and coverage policies for telehealth services to provide family physicians with the flexibility needed to provide optimal care to all their patients, including dually eligible individuals.

Thank you again for the opportunity to provide feedback on ways to improve care for patients jointly enrolled in Medicare and Medicaid. The AAFP looks forward to continuing to work with you and other members of the Senate Finance Committee to better support dually eligible individuals and the family physicians who serve them. Should you have any questions, please contact Natalie Williams, Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

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Board Chair, American Academy of Family Physicians

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