AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

December 7, 2021

Elizabeth Fowler, PhD, JD
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
200 Independence Avenue, SW
Room 310G-04
Washington, DC 20201

Dear Deputy Administrator Fowler:

On behalf of the American Academy of Family Physicians (AAFP), which represents 133,500 family physicians, residents, and medical students across the country, I write in response to the request issued by the Center for Medicare & Medicaid Innovation (CMMI) for stakeholder feedback on the Innovation Center's health equity strategy.

The AAFP shares CMMI's commitment to advancing health equity. Primary care is an important evidence-based intervention that must be leveraged to address health inequities. However, primary care practices are hampered by persistently low payments and limitations related to fee-for-service. New payment models that seek to increase investment are not readily availability to all primary care physicians, and in cases where they are, there are significant burdens created by the unique requirements of each payer. Advancing value-based care across payers will bolster the primary care system and ultimately facilitate equitable access to the kind of comprehensive, person-centered, longitudinal care patients need.

What approaches or interventions should the CMS Innovation Center prioritize when building models to eliminate health inequities?

Primary care should remain central to the Innovation Center's strategy to eliminate health inequities. The AAFP's policy on social determinants of health (SDOH) outlines how family physicians are uniquely qualified to identify health-related social needs (HRSNs) through their ongoing relationship with patients from infants to seniors and by connecting patients with third-party services and public programs in their community to address those needs.

However, existing fee-for-service (FFS) structures typically do not pay for or support robust activities, with services such as community health workers or care coordination that support family physicians' efforts to address HRSNs within a patient's community context. This disadvantages patients who require more support and the physicians who care for them. Family physicians cite expanded capabilities to address patients' HRSNs as a primary reason for transitioning to alternative payment models (APMs): they are looking for a payment model that will provide adequate, stable financial support and flexibility to deliver innovative whole-person care.

It is also important to note that even with the resources to properly assess and connect patients with identified needs using community health workers or care coordinators, family physicians cannot connect to resources that do not exist at the community level. As such, APMs need to be designed to adequately resource primary care physicians to comprehensively address patients' needs, inclusive of HRSNs, without inappropriately holding primary care physicians responsible for outcomes outside their control, such as the provision of resources that do not exist at the community level.

When designing primary care APMs, the AAFP believes payment should be prospective, include a comprehensive or global primary care payment, be robustly risk-adjusted to appropriately include patient-level clinical and social factors, and reflect physician or practice performance. This type of payment adequately supports and sustains comprehensive, longitudinal patient-physician relationships. It is widely agreed that fee-for-service payments have been both under-funded and insufficient in paying for important services. Given that primary care practices use new payment models to provide advanced services, it is reasonable for APMs to pay primary care physicians at a higher rate than provided in FFS. Additionally, person-centered prospective payments should be made within the context of a patient's regular source of primary care to avoid potential fragmentation, such as from third-party direct to consumer telehealth providers.

Not only is this payment infrastructure beneficial to practices intent on delivering holistic, person-centered care, it's essential to ensuring access to high quality, continuous primary care for patients. When primary care practices are supported by a predictable, prospective revenue stream that recognizes the full range of care needs, both clinical and social, patients have better outcomes, including fewer inequities in care, and primary care practices thrive.

Payment rates should be adjusted to ensure practices that care for high-risk patients are supported (and not penalized) for providing additional services that may be needed to facilitate addressing HRSNs, behavioral health concerns, or environmental factors. One approach, outlined in a recent Health Affairs blog post, used by the AAFP in the Advanced Primary Care Alternative Payment Model (APC-APM), and recently added to the primary care portion CMMI's Maryland Total Cost of Care Model, is to use geographic indices of social risk such as the Robert Graham Center's (RGC) social deprivation index (SDI). The RGC SDI is a composite measure of area level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socio-economic variation in health outcomes. While there are mechanisms to adjust payments, the larger outstanding question of what it costs to manage populations with increased social risks remains.

To date, many APMs have been focused on the Medicare population, with limited attention provided to Medicaid and safety net beneficiaries. Incorporating Medicaid and CHIP beneficiaries in APMs will facilitate equitable access to high-quality primary care and is an important step to advancing health equity. The AAFP is pleased that Administrator Brooks-LaSure and Deputy Administrator Tsai recently committed to increasing value-based care models and relationships in Medicaid. Aligning models across payers and embedding equity as a shared aim regardless of the patient population will foster physician participation and resource practices more efficiently to ensure all patients receive high quality, affordable, patient-centered care.

Additional opportunities to increase equitable access exist, including expansion of geographic testing of models and incentivizing patient participation. Current primary care models have been geographically limited in scope and repeatedly tested in the same regions. Since family medicine is uniquely qualified to care for patients of all ages in diverse settings nationwide, efforts should be made to expand where models are tested to increase equitable access and avoid further exacerbation of disparities.

Evidence clearly indicates that removing cost-related barriers to care facilitates equitable access to needed services. Models should be designed to remove patient barriers to access, such as waiving co-pays or co-insurance for primary care. Waived co-pays should be covered by the payer rather than being waived by the practice to avoid financially penalizing practices.

We also note that a robust public health system that is integrated with primary care is needed to meaningfully advance health equity and address SDOH. While physicians and other clinicians, inclusive of all specialties, can assist in identifying and facilitate addressing HRSNs, they cannot and should not be held responsible for resolving community-level SDOH factors.

CMS is currently exploring options for expanding collection of self-reported demographic and social needs data. What could the CMS Innovation Center do to support collection of self-reported data? What are successful approaches for such collection?

Primary care physicians are trusted partners in patients' health care experience. They are well suited to act as an important partner in the data collection process, however they should not be considered the sole source for collection of patients social needs and demographic data. To better foster collaboration in data collection, required data should be standardized to ensure the uniform collection of many types of health care data, including HRSNs and demographic characteristics, such as race, ethnicity, and preferred language (REL). Many states have taken steps to standardize collection of REL data, using legislative and regulatory processes to ensure appropriate collection and use of data to protect patient privacy. Additional efforts are needed to standardize the collection of other types of data that may be important for identifying health disparities and ensuring robust risk adjustment. Standardizing the data elements used for race, ethnicity, primary language, gender identity, sexual orientation, income status, and other characteristics will help ensure primary care teams can identify and facilitate addressing HRSNs. The AAFP encourages CMS to explore options for collecting this data at various touch points, not just when they seek care at a physician's office. For example, this data may also be collected at enrollment and shared with the patient's preferred source of primary care.

What are the most significant obstacles for safety net providers who want to participate in a CMS Innovation Center or another value-based, accountable care model, and how do you recommend the CMS Innovation Center help these providers overcome these obstacles?

Some CMMI models penalize physicians if spending for their patients increases for reasons beyond the physician's control or if a physician cares for patients with complex needs. Most Innovation Center models base financial penalties and rewards on whether the total cost of care (TCOC) for a patient population is lower or higher than a historical average, not on the subset of costs the physician can control. Benchmarks in these models are typically calculated using historical spend, so any intervention that fills previously unmet care needs will inherently fail to

save money. Model design for safety net providers should include provisions to reward physicians for providing access to high-quality primary care and avoid unintended consequences that may hinder efforts to reduce health-related disparities.

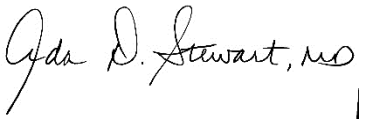
In addition, payments in CMMI models are typically risk adjusted using CMS' Hierarchical Condition Category (HCC), which only adjusts for differences for certain conditions from a prior year, but not for acute conditions, newly diagnosed chronic conditions, or HRSNs. As a result, physicians serving low-income and other vulnerable patient populations with more clinical and HSRNs may have a higher TCOC than is expected based on their HCC score. Lower Medicaid payment rates also leave little room for savings to be actualized. As such, many physicians that care for a high proportion of low-income patients should have the option to participate in models that place more emphasis on improving patient outcomes and less emphasis on reducing TCOC and have more robust risk adjustment methodologies. CMMI models should be designed to ensure physicians are not penalized based on differences in the characteristics of their patients, as current model design does may not appropriately measure differences in the physicians' efficiency or quality.

To further ensure safety net practices are able to successfully transition to VBP, models must include on-ramps that include technical and financial assistance to provide support and build necessary infrastructure. CMMI should invest in technical assistance, shared learning collaboratives, and data infrastructure to support safety net providers in transitioning to APMs and do so in partnership with other payers, both Medicaid and commercial, as much as possible.

Finally, ongoing issues with model evaluation create barriers to widespread adoption of successful primary care models. Often improving access to primary care leads to increased costs at the onset, especially for the Medicaid population. Existing evaluation methodologies do not fully capture the benefits or savings associated with improving access to person-centered primary care. Often these benefits are realized or accrued over a number of years, particularly for interventions addressing HRSNs, long after the evaluation period for an APM has concluded. Model evaluations also do not capture savings across other government programs and agencies (e.g., Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Women, Infants, and Children), which may be particularly vital for capturing overall savings when low-income individuals have improved access to high-quality primary care. CMMI should work to address these issues to ensure successful primary care models can be scaled and adopted.

We appreciate the opportunity to provide these comments. We look forward to working closely with CMMI to advance the transition to value-based care and improve patients' access to comprehensive primary care. If you or the CMMI staff have any questions or the AAFP may be of further assistance, please contact Kate Freeman, Manager of Payment and Care Transformation, at katef@aafp.org or (913) 906-6168.

Sincerely,



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