AMERICAN ACADEMY OF FAMILY PHYSICIANS

March 12, 2024

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
U.S. House of Representatives
300 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

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 the Committee for its focus on enhancing access to care in patients' homes and modernizing care in rural and underserved communities with today's hearing.

The AAFP has long advocated to improve access to high-quality care in rural communities. Seventeen percent of our members live and work in rural areas, the highest percentage of any medical specialty, and they are often the only physician embedded in the community. Family physicians are uniquely trained to provide a broad scope of health care services to patients across the lifespan. This enables them to tailor their practice location and individual scope of practice to the needs of their communities, including delivering care in a patient's residence.

Family physicians have always provided home care or "house calls." Home-based primary care allows family physicians to spend more time with their patients and deliver person-centered care in the setting most comfortable to them. Since home health care often requires continuing and comprehensive patient care in a family context, family physicians are particularly well-qualified and trained to provide home health care. Thus, the patient's family physician should be directly involved in the initial decision to provide home health care services plus the subsequent planning, provision and management of those services. Additionally, adequate compensation for family physicians providing and managing home health care services will help ensure on-going home health care access and availability.

Without access to home-based primary care, many patients have no option but to seek necessary care in an emergency department.[1] It is with these considerations in mind that we offer the following policy recommendations to improve access to home-based primary care in rural and underserved communities.

**Payment Reform**

Home-based primary care has the potential to ensure coordinated care, reduce reliance on more expensive settings such as emergency departments, and yield better patient outcomes through improved access to care, treatment adherence, and management of chronic conditions. However, home-based primary care also requires significant investments and revenue streams that allow said investments to be made. Patient-centered home-based primary care is enabled through technology,



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such as electronic medical records that can be accessed anywhere, lab tests that can be performed in the home, and portable equipment such as x-rays and ultrasounds.

Yet fee-for-service (FFS) payment, which remains the dominant system for physician payment, takes a piecemeal approach to financing primary care, including home-based primary care, undermines and undervalues the whole-person approach integral to primary care. It hinders the ability for rural family physicians to provide care in a way that is organic and responsive to their community. **Shifting away from FFS and investing in the transition to value-based care will allow rural primary care to be delivered in the ways that are most meaningful for the community's needs, including at home.**

The AAFP has long advocated for APMs that increase the investment in primary care using prospectively paid, population-based payments. **Participating in APMs that offer predictable, prospective revenue streams using population-based payments enables practices to invest in the infrastructure and care teams needed to deliver high quality, comprehensive primary care that meets the needs of their patients, such as in their home – without the administrative complexity of FFS**. Given these and other benefits, there is mounting multi-stakeholder, cross-industry support for a primary care payment system that rewards value and holds promise for improving health, addressing disparities, and slowing the overall growth of health care costs. **Federal policymakers should increase participation opportunities in primary care models that align with the AAFP's guiding principles for value-based payment (VBP) and meet practices where they are, allowing them to gain a foothold in VBP.**

While fee-for-service is not the future of primary care, though, it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates physicians to make more meaningful progress toward the future – one that rewards quality of care over volume of services. Primary care practices need an environment that allows them to thrive, but inadequate payment rates threaten their long-term viability. This is especially true in rural and medically underserved communities, where simply participating in Medicare and Medicaid is economically detrimental to independent practices. However, backing out would mean that these patients – who make up the greatest portion of a panel, especially of home-bound patients – are unlikely to access care elsewhere.

Rural communities are disproportionately impacted by insufficient FFS payments. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. Rural areas see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Patients requiring home-based care, in particular, tend to be more medically complex and thus "costlier" in terms of services required.

Therefore, **the Academy strongly continues to urge the Committee to prioritize legislative solutions that would address unsustainable FFS payment rates for physicians and promote community- and more specifically home-based primary care**, including in rural and underserved communities.

The Academy has heard from some family physicians that their practices have had to stop accepting new Medicare beneficiaries altogether due to financial constraints, leaving them unable to address the needs of the entire community that they're trained to serve. While we appreciate recently implemented policy changes intended to further invest in primary care, **budget neutrality requirements undermine these steps in the right direction by requiring Medicare to offset increased investment with across-the-board payment cuts to all services.** This dynamic has

only exacerbated our underinvestment in primary care within FFS: primary care's voice is drowned out as organized medicine competes for arbitrarily limited resources without adequate focus on the services that would drive population health improvements and health equity while reducing costs.

Further, **the AAFP urges the Committee to pass legislation that would provide an annual update to the MPFS based on the Medicare Economic Index (MEI)**. This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries across settings. Stable, adequate FFS payments are also a vital component in the transition to value-based care, particularly for practices serving rural, low-income, and other underserved communities. Success in alternative payment models happens through practice transformation and quality improvement, which requires upfront resources and stable, prospective revenue streams to hire care managers and behavioral health professionals and make significant investment in practice capabilities including technology, people, and new workflows.

**Innovative Care Delivery and Payment Models**

*Independence at Home demonstration*: The Academy has supported the Independence at Home (IAH) demonstration at the Center for Medicare and Medicaid Innovation (CMMI), which provided chronically ill patients with a complete range of primary care services in the home setting. The demonstration ended on December 31, 2023 after receiving a three-year extension in the Consolidation Appropriations Act of 2021.

The demonstration tested whether home-based care reduced the need for hospitalization, improved patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. Practices that succeeded in meeting quality measures while generating Medicare savings had an opportunity to receive incentive payments after meeting a minimum savings requirement.

IAH was based on decades of data showing that home-base primary care is an effective way to deliver care for seriously ill patients and to produce savings. Research shows that the demonstration program produced high quality care for seniors with chronic diseases and met their complex needs. In the most recent evaluation report for 2021 – the second year of the COVID-19 pandemic – **IAH was shown to reduce inpatient spending by 9.6 percent and the probability of a patient dying by any cause by 16.3 percent.**[2] The expenditures for participants' applicable beneficiaries were approximately 21.3 percent or $32 million below their spending targets.[3] Given these findings, the AAFP encourages federal policymakers to continue to invest in and make available VBP opportunities that support primary care physicians' ability to deliver high quality care through the settings or modalities that most appropriately meet their patients' needs, including in their home.

*Direct primary care*: A growing number of family physicians are choosing to practice direct primary care (DPC), which gives family physicians a meaningful alternative to fee-for-service billing. DPC arrangements typically involve charging patients a monthly, quarterly or annual fee (i.e., a retainer) that covers all or most primary care services, including clinical, laboratory and consultative services as well as care coordination and comprehensive care management. Monthly membership fees typically range from $50 to $100 per adult. Many DPC practices offer home-based services for patients either as part of or in addition to their flat fee.

The AAFP supports direct primary care (DPC) and sees it as a model of care that provides a pathway to continuous, comprehensive and coordinated primary care for patients. For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Given that

health care costs have been skyrocketing for patients and many report being unable to afford necessary health care, it is not surprising that patient demand for DPC practices is growing. Additionally, employers and labor unions are driving growth in the model through benefits being offered to their employees and members. For example, two-thirds of family physicians surveyed in AAFP's 2022 DPC Study reported they participate in employer-based contracts.[4]

However, there are remaining barriers that prevent some patients from realizing the full potential of the DPC model. One of those barriers is the prohibition on the permissible use of health savings accounts (HSAs) funds to pay for participation in a DPC practice. Under existing interpretation of the Internal Revenue Code, patients with HSAs are prohibited from engaging in DPC arrangements with a family physician or other primary care clinician. The *Primary Care Enhancement Act* (H.R. 3029) would remove this current legal barrier and ensure that patients with HSAs can use those funds to pay for DPC arrangements. The Academy applauds the Committee for favorably reporting out this policy in September as part of a larger package, and **we continue to urge Congress to take further action to ensure that patients can more easily and affordably access primary care services suited to their unique needs, including in their home.**

**Telehealth**

Telehealth was undoubtedly a lifeline for many patients seeking care from their homes during the COVID-19 pandemic, and it has significantly shifted the accessibility of and interest in care received from their homes for more patients since. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities and vulnerable populations. **The AAFP strongly believes that permanent telehealth coverage and payment policies should:**

- **Ensure coverage and access to audio/video and audio-only telehealth services for all Medicare beneficiaries, regardless of their physical or geographic location;**
- **Include guardrails to ensure care continuity and quality by encouraging the use of telehealth with a patient's usual primary care physician or another trusted care relationship; and**
- **Enable patients, in consultation with their trusted primary care physician, to determine the most appropriate modality of care for each encounter.**

Telehealth should also enable higher-quality, more personalized care by making it more convenient and accessible for patients. 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, impede a continuous and comprehensive patient-physician relationship, increase care fragmentation, and lead to the patient receiving suboptimal care.

Telehealth is essential for many rural residents, who may encounter significant barriers such as distance, financial, insurance coverage, or lack of transportation to easily access in-person care. However, **existing barriers continue to hinder the ability for individuals in rural communities to access quality telehealth services, as well**. The lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits.[5,6,7]

In many instances, **family physicians have reported that some of their patients, particularly seniors, are most comfortable with or can only access audio-only telehealth visits.** One recent

study of FQHCs found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[8] Therefore, permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs.

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

**The AAFP strongly urges Congress to pass the *Protecting Rural Health Access Act* (S. 1636 / H.R. 3440)**, **which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services.** The available data clearly indicates that coverage of and fair payment for audio-only services is essential to facilitating equitable access to care after public health emergency-related telehealth flexibilities expire.

This legislation would also permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home, which the AAFP has advocated to Congress in favor of previously. The COVID-19 pandemic demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

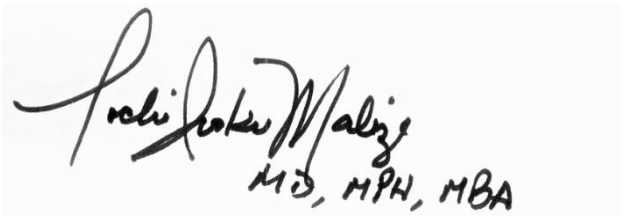
Finally, the *Protecting Rural Telehealth Access Act* would permanently allow RHCs and FQHCs to serve as distant site for telehealth services. As noted above, FQHCs and RHCs are essential sources of primary care for patients in underserved communities, including low-income individuals and those living in rural areas. During the pandemic, FQHCs and RHCs made significant investments to integrate telehealth into their practices and ensure equitable access to telehealth services for their patient populations. Passing this bill would ensure these facilities can continue to provide telehealth services, improve equitable access to health care for historically underserved patients, and preserve care continuity with their primary care physicians.

**The AAFP has also continuously advocated for and supported legislative proposals to permanently remove CMS' in-person requirement for telemental and behavioral health visits**. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[9,10] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients, which are even more pronounced in rural areas. Arbitrarily requiring an in-person visit prior to coverage of telemental health services will unnecessarily restrict access to behavioral health care. Removing the in-person requirement would improve equitable access to care for low-income patients and those in rural communities. We note that our position on in-person visit requirements is unique to telemental health services.

As the current payment landscape still largely relies on fee-for-service, it is vital to promote telehealth policies that provide adequate payment to protect access and the patient-physician relationship. However, **the best long-term solution is a payment system that moves away from the transactional and focuses on payment that better supports whole-person primary care.** Reliable, prospective payment that that is agnostic of care modality or encounter fosters innovations that allow practices to meet the diverse needs of their patient populations.

Thank you for your continued attention on the need to enhance and modernize access to care in rural and underserved communities, including home-based primary care. The AAFP looks forward to working with you on the policy recommendations outlined above to do just that. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

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American Academy of Family Physicians, Board Chair

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