AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 28, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

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 in response to the request for information on accessing healthcare, provider experiences, and advancing health equity.

The AAFP appreciates the Centers for Medicare and Medicaid Services' (CMS) focus on reducing health inequities and ensuring all individuals have access to comprehensive, timely healthcare. Family physicians provide comprehensive primary care that is focused on the whole person, individualized to the diverse needs of each patient, and provided longitudinally across a patient's lifespan. As such, family physicians are uniquely suited to identify shortcomings within our current healthcare system that result in inequitable access to care. To this end, the AAFP appreciates the opportunity to provide the following comments.

Accessing Healthcare and Related Challenges

CMS is seeking public comment on challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across CMS programs.

The AAFP is committed to ensuring access to healthcare for all individuals, and primary care is an important, evidence-based intervention that must be leveraged to address health inequities. However, existing barriers prevent patients from accessing the care they need. These barriers include disruptions to health insurance coverage, rural-specific access challenges, and burdensome administrative work that takes physicians away from their patients. The AAFP strongly advocates to remove barriers to robust, affordable health coverage and to ensure that coverage enables them to access care in a timely, patient-centered manner.

Medicare covers close to 64 million individuals, Medicaid and the Children's Health Insurance Program (CHIP) cover approximately 83 million individuals, including some dual eligible individuals who qualify for both Medicare and Medicaid.[1] Another 14.5 million individuals are enrolled in marketplace plans.[2] As vital sources of healthcare coverage for a combined 145 million individuals CMS should make every effort to minimize disruptions to beneficiaries' coverage.[3] Health coverage disruptions often result in care disruptions, because individuals may delay care due to higher out-of-pocket costs or are forced to seek care from a new physician with whom they do not have an existing relationship or who may not understand the patient's full medical history.[4] The AAFP supports CMS's ongoing efforts to ensure Medicare and Medicaid beneficiaries do not experience coverage

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disruptions, including in the Medicare Eligibility and Enrollment proposed rule. The AAFP also urged CMS to limit potential coverage disruptions for current Medicaid beneficiaries following the end of the public health emergency (PHE).

Under Medicaid specifically, the AAFP made a number of recommendations to further ensure beneficiaries can access timely and comprehensive care. These include reinstating and strengthening federal Medicaid access standards with a national monitoring approach, implementing race, ethnicity, and language data reporting requirements, and providing flexibility, support, technical assistance, and oversight to state Medicaid agencies with the goal of minimizing coverage disruptions during eligibility redeterminations. The AAFP also highlighted the need to increase Medicaid payment rates and reduce burdensome administrative processes to ensure Medicaid beneficiaries have access to a robust network of physicians.

Furthermore, ensuring Medicare and Medicaid beneficiaries have access to comprehensive care requires Medicare Advantage, Medicaid, CHIP, and marketplace plans to retain a robust network of physicians. The AAFP applauded HHS' final rules implementing time and distance standards to ensure network adequacy under Medicare Advantage and in marketplaces, including using appointment wait time standards. However, Medicaid managed care plans still face additional barriers; these plans report caps on clinician's Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care. We urge CMS to continue using its available authority across these programs to continue strengthening federal standards and ensuring patients can access timely, affordable, and comprehensive primary care.

Family physicians also provide behavioral health services and are a major source for mental health and substance use care in the U.S. While psychiatric and other mental health professionals play an important role in the provision of high-quality mental health care services, primary care physicians are the first point of care for most patients and are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.[5] Integrating behavioral health care into primary care settings has shown improved health outcomes and cost savings for patients and payers.[6] However, lack of investments to integrate behavioral health into primary care setting—the most accessible setting for many patients—reduces access to critical services. Value-based payment arrangements that incorporate prospective payments or a capitation, allow physicians the flexibility to innovate their practice to meet their patients' behavioral health needs. Alternative Payment Models (APMs) designed to support behavioral health integration should also be risk-adjusted promote quality care. APMs must also promote care provided within or in close coordination with a patient's medical home to avoid care fragmentation, such as from third-party telehealth providers. When primary care practices are supported by a predictable, prospective revenue stream that is risk adjusted for the full range of care needs presented by their patients, primary care practices thrive, and patients have better outcomes.

CMS also seeks comments on improving access to reproductive and maternity care services. Family physicians play an important role in providing reproductive and maternity services. Family physicians provide delivery services and, in some rural areas, may provide 100 percent of the maternity care.[7] In fact, approximately 12 percent of family physicians who worked in rural communities in 2019 delivered babies as part of their scope of practice; more than twice as common as their urban counterparts.[8] CMS plays a crucial role in ensuring access to maternity care—Medicaid paid for 43 percent of U.S. births in 2018, including 50 percent of births in rural areas, 60 percent of births to Latina women, and 66 percent of births to Black women.[9] The AAFP has applauded CMS's commitment to ensuring states can extend postpartum Medicaid coverage from 60 days to 12 months, thereby ensuring continuity of coverage postpartum. The AAFP encourages CMS to continue

using its authority to approve postpartum coverage extensions and other measures for reproductive health coverage. Ensuring coverage during the critical perinatal period will help ensure access to necessary care for low-income individuals.

Individuals living in rural areas face the same coverage barriers, as well as additional access challenges. Rural hospitals have closed at an alarming rate over the last ten years, and many rural populations face long travel times for primary and emergency care. Additionally, while many patients benefited from new telehealth flexibilities, rural individuals were less likely to have broadband access and therefore less likely to connect via video for virtual visits.[10] The AAFP has long advocated to improve access to high-quality care in rural communities. 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. As a result, family physicians are an essential source of emergency services, maternity care, hospital outpatient services, and primary care in rural areas.

The AAFP provided detailed comments on CMS's proposal regarding rural emergency hospitals and also highlighted the critical need for behavioral health care in rural areas. Family physicians practicing in rural areas report that patients struggle to access behavioral health services within their communities and are often forced to rely on the emergency department for behavioral health services. Family physicians also face challenges referring patients to mental health professionals when they decide additional expertise would benefit their patients. Many family physicians are stepping in to fill the unmet need by seeking additional training, and/or integrating behavioral health into the primary care setting. This includes care for substance use disorder (SUD), which increased 325 percent in rural counties between 1999 and 2015.[11] The AAFP is strongly supportive of improving access to medication assisted treatment (MAT) for substance use disorders, including by removing regulatory and administrative barriers, such as the x-waiver, to providing buprenorphine and other treatments.

Understanding Provider Experiences

CMS is seeking feedback on the factors impacting provider well-being and the distribution of the healthcare workforce. CMS is specifically interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.

To improve physician well-being and the distribution of the current physician workforce, the AAFP recommends CMS focus on reducing administrative burden, addressing inadequate payment rates by continuously investing in community-based primary care, and supporting the primary care workforce. Family physicians report administrative burden as their number one concern about continuing their medical practice—administrative tasks are overburdening physicians, reducing the time they can spend treating patients, and leading to increased risk of burnout.[12, 13] One recent example of this is the administrative burden associated with new surprise billing regulations, for which the AAFP urged CMS to delay implementation. The AAFP agrees that providing a good faith estimate of expected charges for items and services to an uninsured or self-pay individual will improve patients' understanding of the costs of their care and may help avert some unexpected medical bills. However, since the requirement went into effect in January 2022, family physicians report that it is adding to their administrative burden, especially for new patients, those with complex medical needs, and those who are uncomfortable sharing their medical records with administrative and clinical staff.

The AAFP also regularly advocates for improved prior authorization, step therapy, and other plan requirements to reduce physician burden and sustain a robust physician network. These types of utilization management requirements are one of the biggest drivers of physicians' administrative burden. Family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe medications and order medical equipment without being subjected to prior authorizations. In the rare circumstances when a prior authorization is clinically relevant, the AAFP believes the prior authorization must be evidence-based, transparent, and administratively efficient to ensure timely access to promote ideal patient outcomes. While the administrative burden of prior authorizations cannot be meaningfully reduced without comprehensive reform to reduce the volume of requests, the AAFP supports efforts to implement electronic prior authorization as a meaningful first step to streamlining the process.

The AAFP further believes step therapy protocols, in which insurers encourage less expensive prescription drugs to be prescribed prior to more costly alternatives, delay access to treatment and hinder adherence.[14] Therefore, step therapy should not be mandatory for patients already on a working course of treatment and generic medications should not require prior authorization. CMS can use its existing authority to streamline prior authorization, step therapy, and other treatment limits, and ensure a timely response when those requests are made. Further, CMS should delay implementation of the Good Faith Estimate provision of the surprise billing rule to allow physicians time to come into compliance and establish the correct mechanisms for providing a good faith estimate.

Low Medicare physician payment rates are another major challenge family physicians are currently facing. Due to budget neutrality requirements the proposed conversion factor for CY 2023 is about 4.5 percent lower than the current CY 2022 conversion factor, which alone will result in payment cuts for family physicians and all other Part B clinicians. On top of these cuts, CMS estimates that community-based family medicine practices will see a reduction in allowed charges in 2023 as CMS further shifts Medicare payments toward facility-based services. Thus, the proposed rule fails to sufficiently invest in community-based primary care.

At the same time as these cuts are proposed, physician practices are facing steep increases in practice costs and yet another public health emergency. **Medicare physician payment rates have failed to keep up with the cost of inflation and have become increasingly insufficient. These impacts have only been exacerbated by budget neutrality requirements and congressionally mandated sequestration cuts.** As a result, independent, community-based physician practices are closing or being sold to health systems and other corporations. Evidence clearly shows that these trends increase prices, do not improve quality, and can worsen access to care.[15] Practice owners, particularly primary care physicians, point to persistently low payment rates and increasing administrative requirements to explain this trend. They struggle to pay their staff, rent, and other expenses all while providing care on the frontlines of a global pandemic.

These challenges are only 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. 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 that physician acceptance worsens as the ratio of Medicaid payment rates to Medicare 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.** Managed care plans report caps on clinician's Medicaid patient

panels and low physician participation in Medicaid are top challenges in ensuring access to care. Patients covered by Medicaid experience longer office wait times, and both low-income patients and their physicians report that low payment rates lead to shorter, inadequate visit times. On the other hand, evidence indicates patient access improved when Congress raised Medicaid primary care payment rates to Medicare levels in 2013-2014.

To ensure all Medicaid beneficiaries can access high-quality primary care when they need it, **CMS should support states in raising Medicaid payment for primary care services to at least Medicare rates.** The AAFP has endorsed legislation to permanently reinstate the ACA primary care payment increase and urges CMS to work with Congress to promptly pass it. These low fee-for-service payment rates are undermining progress toward achieving CMS' strategic goals, like advancing health equity, improving behavioral health access, and accelerating the transition to value-based care.

The AAFP has long advocated to accelerate the transition to value-based care (VBC) using alternative payment models (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.** 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 fee-for-service (FFS) primary care payment system that exists today. 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 and 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.

Comprehensive and sustainable primary care payment enables practices to accept more low-income patients and is associated with better health outcomes.[16, 17, 18] FFS payments that fully support and invest in primary care services will secure primary care access in beneficiaries' own neighborhoods, drive meaningful quality improvement, and advance equity. The AAFP urges CMS to continually invest in community-based primary care.

This investment should include additional APM participation opportunities for practices of all kinds. Many primary care physicians choose to participate in APMs because prospective payments can provide better support for comprehensive, longitudinal primary care. In addition to low payment rates, current models are only offered in certain geographies, are not aligned across payers, and can lack adequate risk adjustment. **The AAFP recommends implementing a stable suite of multi-payer APMs that are appropriate for practices with varying levels of experience taking on financial risk and assist practices to transition to more advanced APMs over time.** Model features such as upfront access to capital, prospective payment, risk adjustment for clinical and social factors, and targeted technical assistance enhance patients' access to high-quality, continuous primary care and strengthen practice capabilities that improve quality and reduce health care spending. We further encourage coordination across Medicare, Medicaid, CHIP, marketplace plans, and commercial payers to harmonize requirements and quality measures. Aligning models across payers and

embedding equity as a shared aim regardless of the patient population will foster greater physician participation and resource practices more efficiently to ensure all patients receive high quality, affordable, patient-centered care. The AAFP urges HHS to increase APM participation opportunities, align models across payers, and ensure physicians caring for rural and underserved populations can successfully participate in APMs.

Finally, as the largest funder of graduate medical education (GME), Medicare plays a significant role in addressing physician maldistribution and disparate access to care across the nation. Currently, most physicians are trained at large academic medical centers in urban areas. Evidence indicates physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees also leads to physician shortages in medically underserved and rural areas.[19] These shortages result in access barriers and disparities in health outcomes for Medicare beneficiaries and other patients living in rural communities. The AAFP has advocated for Congress and CMS to implement an equity-focused approach to the distribution of new Medicare GME residency slots. We applauded CMS for prioritizing training programs in health professional shortage areas (HPSAs) in the distribution of 1000 new slots authorized by Congress. We also recommended that CMS implement a distribution methodology that prioritizes residency programs with a proven history of training physicians who practice in shortage areas. The AAFP urges CMS to continue using equity-focused approaches for distribution of new slots now and in the future.

Advancing Health Equity

CMS wants to further advance health equity across their programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. This includes understanding individual and community-level burdens impairing access to comprehensive quality care.

The AAFP appreciates CMS and President Biden's commitment to achieving health equity. We strive to apply a health equity lens to our advocacy and many of the aforementioned recommendations may help advance this shared goal. The AAFP opposes patient discrimination in any form, including but not limited to, on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin. The AAFP has provided the following recommendations on additional oversight and monitoring of enrollment denials under Medicaid and Medicare, appropriate accommodations for patients, tools to address discrimination under clinical algorithms, and other health equity concerns.

To begin, the AAFP strongly supports CMS' commitment to improving health care data with the goal of better identifying and addressing health disparities. The AAFP firmly believes comprehensive indicators of race and ethnicity, beyond the five broad racial groups and two ethnicities (Hispanic/Not Hispanic), as well as indicators for sexual orientation and gender identity, are essential to capture information on groups which may be disproportionately affected by their socioeconomic status, health, and other disparities. Robust data collection must also be accompanied by actionable steps to address disparities illustrated by the data. Without specific indicators and subsequent action, historically underserved populations may not receive adequate consideration in budgeting processes and resource allocations, resulting in further disadvantage.

With this in mind, the AAFP urges CMS to provide oversight and monitoring of enrollment denials under Medicaid, Medicare, state based-exchanges, and other payers to ensure coverage is equitable for all, especially historically marginalized populations like gender diverse individuals or individuals belonging to minoritized race or ethnicity groups.

Further, the AAFP supports culturally sensitive care and endorsed HHS's National Standards for Culturally and Linguistically Appropriate Services in Health and Heath Care. The AAFP also supports meaningful access to care for individuals with limited English proficiency (LEP) and/or those with disabilities. The AAFP continues to advocate that health insurers cover the most integrated setting appropriate to the needs of individuals with disabilities or LEP individuals. The AAFP also supports that network adequacy should take into account accessible medical equipment for individuals with disabilities, as well as language and translation accessibility for LEP individuals and individuals with disabilities. CMS should use its authority to require that plans take reasonable steps to make accessible care available within established time, distance, and wait time standards.

Finally, recent studies indicate clinical guidance and existing algorithms for clinical decision making may be based on biased studies and exacerbate inequities.[20] One study found an algorithm used in hospitals systematically discriminated against Black patients.[21] Experts also predict that rapid implementation of AI-solutions amid the COVID-19 pandemic may widen the already disparate impact of the virus.[22] To improve trust in and equitability of AI/ML solutions, discriminatory outcomes must be addressed before successfully integrated AI/ML into clinical care. It is essential that AI-based technology augment decisions made by the user, not replace their clinical judgment or shared decision-making. The AAFP continues to recommend CMS, the Office of Civil Rights (OCR), and the Office of the National Coordinator for Health IT (ONC), work with physician practices and algorithm developers to mitigate potential discriminatory outcomes.

Impact of COVID-19 PHE Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

The AAFP appreciates the comprehensive actions taken by CMS, HHS, and other agencies to respond to the COVID-19 pandemic over the last two years. The emergency waivers, flexibilities, coverage policies, and other actions provided family physicians and other frontline clinicians with urgently needed resources to care for patients and keep their practices open during these challenging times. Given that many of these policy changes have been in place for two years and, in some cases, have significantly altered the health care coverage and delivery landscape, transitioning away from the federal PHE could cause considerable disruptions to physicians and their patients. To prevent disruption across the health care system, it is vital that HHS implements a transparent, intentional, and equity-focused approach to ending the PHE and unwinding its associated policy changes.

Further, the AAFP deeply appreciates CMS taking swift action to expand coverage and payment for telehealth services across programs during the COVID-19 PHE. The flexibilities implemented by CMS helped ensure timely access to care for patients while also helping to keep primary care practices open. **Patients and clinicians agree that telehealth is a valuable modality of care that should be available and accessible after the end of the PHE**. When provided as part of a patient's medical home, telehealth can enhance the patient physician relationship, remove barriers to care, and improve health outcomes. However, telehealth services provided by direct-to-consumer telehealth companies, which typically do not have access to patients' medical records and are not usually integrated with a patients' medical home, can result in care fragmentation. **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 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**
- **Enable patients, in consultation with their trusted primary care physician, to determine the most appropriate modality of care for each encounter.**

Network adequacy standards should also ensure patients across programs can access telehealth from their usual source of care, and states and plans should not be permitted to count telehealth providers toward meeting network adequacy standards unless they also offer in-person care within the specific standard.

CMS has, for several months, continuously taken action to prepare states for Medicaid redeterminations with the goal of minimizing coverage losses and disruption for current beneficiaries once Medicaid continuous enrollment requirements expire. The AAFP is strongly supportive of these efforts, including recent guidance providing states with more time to complete eligibility redeterminations and outlining waivers and other strategies states can use to prevent disenrollment and facilitate continuous coverage once redeterminations begin. The AAFP is also pleased that CMS recently published a proposed rule which, if finalized, will significantly reduce enrollment churn in Medicaid and CHIP, as well as alleviate patient burdens related to application and enrollment. We encourage CMS to continue taking steps to ensure equitable enrollment continuity and to avert disruptions to necessary primary and preventive care once the PHE ends.

While the AAFP appreciates the intent of CMS's roadmap for the end of the PHE; the AAFP has concerns and recommendations detailed in our end-of-PHE letter that were not sufficiently addressed in this roadmap or through other agency actions. Specifically,

during the PHE, coverage of vaccines, testing, and therapeutics without cost-sharing helped to ensure equitable access to the needed medical interventions to keep communities safe. Although there were significant gaps in vaccine, treatment, and testing rollout, requiring coverage of these services without cost-sharing ensured more timely and equitable access than would otherwise be expected given the well-documented effects of cost leading to delayed care. However, once the PHE ends, Medicare, Medicaid, and marketplace beneficiaries may be unable to access these lifesaving services due to coverage gaps and cost-sharing requirements. **The AAFP urges CMS to take action to ensure timely, equitable access to COVID-19 vaccines, testing, and treatment across payers and programs.** Across payers, CMS should take steps to ensure coverage and minimize cost sharing associated with COVID vaccines and therapeutics, including using CMS authority to place anti-virals in drug tiers with the most comprehensive coverage and minimal cost sharing. CMS must also provide physicians, beneficiaries, and other stakeholders with at least 60 days of notice before transitioning the purchase of COVID-19 vaccine supplies, testing, or therapeutics on to physician practices or beneficiaries. Finally, we urge CMS to ensure that payment rates for vaccine products and vaccine administration are adequate once the PHE ends or the federal government transfers the vaccines to the commercial market.

Thank you again for the opportunity to provide these comments and we look forward to working with your agency on these recommendations. For additional questions, please contact Meredith Yinger, Manager of Regulatory Affairs, at myinger@aafp.org.

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American Academy of Family Physicians, Board Chair

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