AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

January 14, 2025

The Honorable John Joyce
Chair, GOP Doctors Caucus
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kim Schrier
Chair, Democratic Doctors Caucus
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairs Joyce and Schrier:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write to thank you and your colleagues in the GOP and Democratic Doctors Caucuses for the opportunity to provide recommendations on necessary reforms to the Medicare Access and CHIP Reauthorization Act (MACRA).

MACRA sought to create incentives in Medicare to provide seniors with better quality care rather than just a greater volume of care. The AAFP has long-supported the transition to value-based payment (VBP) through alternative payment models (APMs) for family physicians ready to move away from fee-for-service (FFS) toward payment structures that promote and finance comprehensive, continuous, coordinated primary care.

MACRA permanently repealed the sustainable growth rate (SGR) and set up the two-track Quality Payment Program (QPP) that emphasizes value-based payment. However, while the elimination of the SGR 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 over the last decade as Medicare payment rates fail to keep pace with practice costs while caring for sicker, older, and more complex patients. The Academy applauds your continued commitment to working with the physician community to address MACRA's shortcomings and protect beneficiaries' timely access to care. We offer specific recommendations below in response to your two questions.

1. ***What legislative reforms are most needed to ensure future Center for Medicare and Medicaid Innovation (CMMI) models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?***

Congress should consider providing CMMI with additional flexibility in how it evaluates the success of primary care models. Currently, federal statute only allows CMMI to expand models that reduce health care spending and maintain quality *or* improve performance on quality metrics without increasing spending. Demonstrating savings in primary care often takes several years as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services like care management.

Early results and lessons learned from past CMMI models have continued to drive model improvements. The ACO Investment Model (AIM), a former primary care and population

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033

www.aafp.org

management model, offered advanced payments to ACOs to fund practice transformation. The model demonstrated savings and reduced inpatient admissions, readmissions, post-acute care utilization and emergency department visits while maintaining quality.[i] The success of AIM led to permanent changes to the Medicare Shared Savings Program (MSSP), incorporating advanced investment payments (AIP) to support physician participation in new ACOs. In 2024, MSSP saved Medicare $2.5 billion, making it the eighth year in a row that the program generated savings while producing high-quality performance results.[ii]

While the Next Generation ACO model did not generate net savings, gross reductions in Medicare spending were realized and larger declines in Medicare spending were associated with physician practice affiliation and organizations electing a population-based payment (PBP) mechanism over fee-for-service.

In December 2023, the final Comprehensive Primary Care (CPC+) evaluation report was published, which showed participating practices reduced emergency department visits, acute inpatient hospitalizations, and acute inpatient expenditures.[iii] Independent, physician-owned practices in CPC+ successfully reduced hospitalizations and expenditures on these hospitalizations in comparison to hospital- and system-owned practices. By the end of CPC+, practices had used the prospective payments to invest in care delivery transformation that would not have been possible if FFS was their only source of revenue. These practices reported that they:

- Provided patients with after-hours access to a physician or other clinical staff member who had real-time access to the practice's electronic health record;
- Used designated care managers (typically on-site staff who are nurses or medical assistants) to deliver longitudinal care management services;
- Increased the use of behavioral staff to offer behavioral health counseling at a higher rate than comparison practices;
- Co-located a pharmacist at the practice site to support comprehensive medication management; and
- Convened and collected feedback from patients during Patient and Family Advisory Council meetings.

Unfortunately, the current statutory framework for model evaluation and expansion criteria has prevented CMMI from making important model improvements or continuing to test models that do not show significant net savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. This nearly-impossible-by-design threshold for scaling innovations is significantly hindering the transition to VBP, both in Medicare and across other payers. Physicians and practices are understandably unwilling (or, in many cases, unable given geographic restrictions) to make time and resource investments to join something that doesn't have a clear future and may ultimately disappear.

We have been testing alternative payment models for decades at this point, with results consistently indicating that there are certain innovations that work. For these elements, physicians and patients don't need more tests. They need stability and permanent options.

Innovations that we know work and should be scaled:

***Increased investment in primary care*:** We know that prioritizing primary care not only improves patient outcomes, but it saves money. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, leading the National Academies of Sciences, Engineering, and Medicine to call it a "common good."[iv] For years, MSSP results have pointed out that ACOs composed primarily of primary care physicians (PCP) have achieved a higher quality of care while saving nearly twice as much money per Medicare beneficiary. In performance year 2024, PCP-dominant ACOs generated $403 in net per capita savings compared to $224 for ACOs with fewer PCPs. Prior analyses of ACO performance dating back to 2016 in the New England Journal of Medicine have shown similar performance comparisons of primary care-led ACOs versus other models.[v] However, outside of CMMI tests, Medicare has woefully underinvested in primary care. Across payers, Medicare spends the least on primary care, dipping to only 3.4 percent in 2022.[vi] **We urge Congress to build upon this clear evidence and success by implementing a statutory floor for primary care spending in Medicare.**

Provide prospective, predictable population-based payments for primary care: One effective way to both increase primary care spending while ensuring physicians can deliver continuous, comprehensive patient-centered care is through PBPs, such as a per-member-per-month (PMPM) payment. As previously discussed, CPC+ offered practices a non-visit-based care management fee payment which allowed practices to invest in staffing, care management workflows, and behavioral health integration. It also provided practices with a prospective primary care payment that reflected a percent of their expected FFS evaluation and management claims payment. More recent models, like Primary Care AHEAD, Primary Care First and Making Care Primary (PCF and MCP, both of which were terminated early in 2025), also provided primary care practices with a PBP that afforded them greater flexibility to tailor the delivery of patient care. The ongoing Primary Care AHEAD, which is part of the broader States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, provides participants with a prospective care management fee paid quarterly, ranging from $15 – 21, and adjusted based on both beneficiary risk and clinician quality performance.

Although the model was cut short, MCP met practices where they were with their level of VBP sophistication by offering both a risk-adjusted, tiered, prospective care management fee (inclusive of services such as chronic care management, behavioral health integration, and principal illness navigation) and a prospective primary care payment (inclusive of services like office visits, advance care planning, and depression screening).

Outside of CMMI, CMS has recently made advances to create care management codes that incorporate PBP elements into traditional FFS under the Physician Fee Schedule. The most recent example is the Advanced Primary Care Management (APCM) codes. These code bundles provide payment for the non-visit-based work that physicians must complete to effectively manage their patients, which gives practices the freedom to invest in whatever best supports patient outcomes – a flexibility that makes PMPM so attractive and effective. Additionally, APCM is unique under the fee schedule in that it is monthly, complexity-tiered, and focused on whole-person longitudinal care, making it a far more effective tool towards the transition to value-based care and alternative payment than MIPS. Congress should give CMS clear authority to build upon these incremental steps of implementing a prospective

care management fee by also exploring implementation of a prospective, capitated payment for office visits and other primary care services, with adequate investment.

***Waive patient cost-sharing for primary care services*:** Unfortunately, utilization of APCM and other care management codes has been hindered by statutory requirements for Part B patient cost-sharing. In the case of APCM, this is particularly challenging as patients often do not understand why they would be responsible for cost-sharing during months where they do not see their physician. Some CMMI models have addressed the cost-sharing issue for patients and helped facilitate increased access to and utilization of high-value services. For example, CPC+ did not require patients to pay coinsurance for care received outside of an office visit. PCF and Primary Care AHEAD also did/do not have any patient coinsurance associated with the model's population-based payments.

Congress could make a meaningful and immediate impact on affordability and quality by eliminating the statutory Part B requirement for cost-sharing for primary care services, or at a minimum, care management codes like APCM.

For future models, Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs, such as whether they:

- Successfully bring new physicians into VBP;
- Improve patient experience measures;
- Markedly improve care delivery transformation; and
- Enable more beneficiaries to access the behavioral health services they need.

When applicable, Congress should also allow CMMI to evaluate models both nationally and regionally. These additional criteria would allow CMMI to continue testing models that show early markers of success and iterate upon them to meet current patient, clinician, and market needs.

2. ***If MIPS were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes.***

To answer this question, it is important to explicitly state what the goal of any MIPS reform or successor quality program is. Congress tried to provide an on-ramp for more practices to participate in APMs with the passage of MACRA and implementation of MIPS, which was intended to provide clinicians with experience being measured on their performance. The AAFP supported the intent of fostering continuous performance improvements that lead to better outcomes for patients. Unfortunately, continuous cuts to Medicare FFS payments have inhibited most practices from making the necessary investments that would allow them to successfully move into APMs. Further, the current budget neutral design of MIPS, which also focuses on individual clinician performance using largely process rather than outcomes measures, does not appear to be driving care improvements as much as it is adding administrative complexities that detract from patient care while unfairly penalizing small and rural practices.

The AAFP does not believe the current design of MIPS can or will serve as a meaningful transition to APMs as it does not change payment. Alternative payment is a foundational element of value-based payment models. Given that FFS payment of discrete services is inherently incompatible with the comprehensive, continuous, relationship-based nature of primary care, MIPS or any other pay-for-performance program built upon FFS is limited in its utility to serve as a true mechanism to transition PCPs away from FFS. Instead, programs intended to "transition" primary care practices out of FFS are largely compliance programs that increase burden by forcing physicians to report on measures that are not relevant to patient care and outcomes and detract from time that could be spent with patients.

It also cannot be ignored that the budget neutral requirement placed upon the MIPS program is a significant challenge to yielding any meaningful quality improvements. Budget neutrality makes it very difficult, if not impossible, to construct a physician-led quality program that achieves the intended goals without having the same outcome as MIPS.

For these reasons, we would strongly encourage Congress to consider a new program in conjunction with efforts to address budget neutrality constraints, in lieu of merely reforming MIPS. However, absent a viable alternative, we believe there are policy changes Congress could implement to alleviate the administrative costs of reporting to the program, ensure it drives meaningful quality improvement, and assist physician practices in building the necessary competencies to transition into APMs. Specific recommendations to improve MIPS and the QPP include:

- **Granting CMS the authority to provide credit across multiple performance categories.** MIPS uses four siloed performance categories – all with different measures and reporting requirements. Despite multiple calls for consolidation and cross-category credit, CMS argues that they do not have the statutory authority to alter the program in that regard. One significant step toward reducing burden would be to give CMS the flexibility to provide cross-category credit. For example, a physician who reports a quality measure related to depression screening should automatically receive credit for the corresponding improvement activity.
- **Allowing practices to attest to using certified electronic health record technology (CEHRT) in place of reporting on Promoting Interoperability measures**. The AAFP has advocated for practices to be able to attest to their use of CEHRT rather than requiring multiple burdensome measures, but CMS does not have the authority to offer such an option. Years of policy changes to the legacy Meaningful Use program and now the Promoting Interoperability category have failed to move the needle on health information exchange. It is beyond time to move away from such burdensome requirements – doing so would be an important step toward reducing the burden of the MIPS program.
- **Providing CMS with the authority to modify the qualifying participant threshold through rulemaking to ensure it is attainable, and physician practices can receive the statutory benefits associated with advanced APM participation**. Currently, those statutory benefits include exemption from MIPS and an increased conversion factor. Existing thresholds set in federal statute are creating barriers for physician practices seeking to move into more advanced models. Providing CMS with the authority to modify the thresholds will help ensure the QPP is facilitating the transition to APMs instead of preventing it.

- **Providing technical assistance, shared learning collaboratives, and data infrastructure to support all primary care practices to transition to APMs**. Primary care's information needs are particularly complex which requires technical capabilities and a reliance on others to fill information gaps, including payers and other clinician organizations. Often, IT departments in small and rural practices may be non-existent or staffed by non-IT personnel, posing challenges when implementing new or updated hardware or software, connecting to regional health information exchanges (HIEs), and setting up registries. Additionally, building and understanding reports from an EHR is time-consuming, burdensome, and can be costly if there is a need for custom reports. Safety nets also face additional reporting burden on top of payer reports due to other reporting requirements based on their funding streams (grants, Uniform Data System, etc.).
- **Funding technical assistance programs to support overall adoption of APMs by all practices in all settings.** MACRA provided funding to support small practices with direct assistance through tools and resources to help them navigate the complex MIPS reporting requirements. In response, CMS created the QPP Small, Underserved, and Rural Support (QPP SURS) program which provided small practices in rural and health professional shortage areas with technical assistance at no cost to them. Unfortunately, funding for the QPP SURS expired in February 2022 and has not been renewed.

Thank you for the opportunity to provide these insights and recommendations. The AAFP appreciates your continued leadership on Medicare payment reform and we look forward to working with you to implement a system that better serves family physicians and the Medicare beneficiaries who rely upon them. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

---

[i] NORC at the University of Chicago. (n.d.). *Next Generation Accountable Care Organization Evaluation*. NORC. Retrieved from https://www.norc.org/research/projects/next-generation-accountable-care-organization-evaluation.html.
[ii] Centers for Medicare & Medicaid Services. (2024). *Fact Sheet: SSP PY24 Financial and Quality Results*. Retrieved from https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf.
[iii] Mathematica. (2021). *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Report*. Retrieved from https://www.mathematica.org/publications/independent-evaluation-of-comprehensive-primary-care-plus-cpc-final-report.
[iv] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/3393.

[v] McWilliams J, Hatfield L, Chernew M, Landon B, Schwartz A, "Early Performance of Accountable Care Organizations in Medicare, New England Journal of Medicine 2016;374:2357-66.
[vi] Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. *The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now*. The Milbank Memorial Fund and The Physicians Foundation. February 28, 2024.