AMERICAN ACADEMY of FAMILY PHYSICIANS

April 21, 2025

The Honorable Roger Marshall, MD
479A Russell Senate Office Building
Washington, DC 20510

The Honorable John Joyce, MD
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Vern Buchanan
2409 Rayburn House Office Building
Washington, DC 20515

The Honorable Lloyd Smucker
302 Cannon House Office Building
Washington, DC 20515

Dear Senator Marshall and Representatives Joyce, Buchanan, and Smucker:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,600 family physicians and medical students across the country, I write in recognition of your leadership to establish the Make America Healthy Again (MAHA) caucus in both the House and the Senate. We believe there are significant opportunities to partner with family physicians to achieve this group's stated goals of improving the health and well-being of our nation, including by finally centering primary care as the foundation it should be.

The MAHA Caucus has a mission statement that notes it "will focus on nutrition, and access to affordable, high-quality nutrient-dense foods and primary care" and that it aims to "address the root causes of chronic diseases and create a healthier, stronger nation." This is closely aligned with the mission statement of the AAFP and the specialty of family medicine.

Family physicians provide continuing and comprehensive medical care, health maintenance and preventive services to patients across the lifespan regardless of age, gender or type of problem. Through enduring partnerships, family physicians help patients prevent, understand, and manage illness, navigate the health system and set health goals. The defining features of primary care, including continuity, coordination, and comprehensiveness, mean family physicians are particularly well-suited to serve as the focal point of care for patients with chronic conditions.

Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits. Yet the United States has continuously underinvested in primary care. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4%.[i]

The impact of this long-term underinvestment is evidenced in our nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[ii] A common theme across countries with better health outcomes and lower health care costs is that they invest more in their primary care system with estimates placing primary care

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spending between 12 and 17% of total health care spending for these high-performing nations.[iii]

We appreciate that both the administration and this caucus have made commitments to champion policies that will right-size our primary care system, better manage the prevalence of chronic disease, and better target our health care dollars. It is with this clear synergy in mind that we would like to offer the following insights and recommendations on how to achieve the vision and goals of the caucus.

I. *Food is Medicine: Promote access to nutritious, affordable food, and encourage education on ingredient impacts, processed foods, and healthy eating habits to facilitate healthy outcomes.*

Family physicians play an important role in counseling patients on nutrition and healthy behaviors across the lifespan. We are also uniquely positioned to identify individuals in need of support and connect them to valuable community resources. A healthy diet is one that includes a wide variety of foods that provide the daily recommended level of nutrients. For people living with chronic health conditions, healthy foods can help promote disease management, treatment compliance, and reduce the reliance on prescription medications.

Unfortunately, fresh, whole, healthy foods are out-of-reach financially or otherwise inaccessible for many patients in communities across the country. Health-related social needs (HRSN), such as a lack of safe and stable housing, reliable transportation, safe places to exercise, financial security, in addition to access to nutritious foods, all make it difficult – if not altogether impossible – for many individuals and families to afford necessary medications and reliably make it to medical appointments, let alone eat healthy.

Research has consistently shown that unaddressed HRSN can influence the onset or worsening of many health conditions, including chronic diseases. For example, housing instability – difficulty paying rent, eviction, and living in overcrowded conditions – is associated with delayed medical care, medication nonadherence, and increased emergency department visits.[iv] Further, unsafe, inconvenient transportation impacts a person's ability to access medical care and is also associated with higher rates of unemployment, poverty, and chronic illness.[v]

While diet and exercise are critically important to health and wellness, these are not accessible choices for those who live in communities designed with them out of reach. Food and exercise can only be medicine if they are readily available, safe, and accessible. However, we believe Congress has ample opportunity to advance policies that would promote access to healthy, whole foods and address HRSN such as food insecurity. Some of these recommendations include:

- **Improving access to and coverage of nutrition services and supports for Medicare beneficiaries and veterans**: The AAFP encourages reintroduction of the *Medical*

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Nutrition Therapy Act, which would expand Medicare coverage of nutrition services for seniors with certain diet-impacted chronic conditions. We have also supported the *Medically Tailored Home-Delivered Meals Demonstration Pilot Act* and Representative Buchanan's *Veterans Nutrition and Wellness Act* (H.R. 1289), which would establish pilot programs to provide medically tailored meals and other services to eligible Medicare beneficiaries and veterans respectively. We also believe that expanding access to healthy congregate meals for seniors either via Medicare or through other funding streams would be beneficial both for their physical and social health.

- Preserving and expanding upon ongoing state Medicaid innovations that improve access to healthy foods and address other HRSN: Many states have utilized existing Medicaid authorities to begin addressing HRSN and cover nutrition supports, including state plan authorities, section 1915 waivers, managed care in lieu of services and settings and section 1115 demonstrations. Covered benefits may include nutrition counseling and education; medically tailored meals; meals or pantry stocking for children under 21 or pregnant patients, including two months postpartum; fruit and vegetable prescriptions; and protein boxes. For example, under Massachusetts' section 1115 waiver, medically tailored meals may be provided to the whole household, not only the Medicaid beneficiary eligible for the service. This policy recognizes that a food-insecure parent will often give their nutrition supports to a hungry child, rather than feed themselves.

  Some states have used other levers, such as community reinvestment requirements for Medicaid managed care contracts. Examples of community reinvestments addressing nutrition needs include building and maintaining community gardens, farmers markets, community-supported agriculture, farm partnerships, or grocery stores in food deserts. Federal policymakers should explore opportunities for expansion of these types of community investment requirements at the national level or ways to support ongoing state initiatives.

- Increasing investments in the Supplemental Nutrition Assistance Program (SNAP) and improve coordination with other safety-net programs to better serve individuals in need: SNAP, which provides food benefits to low-income families to supplement their grocery budget, is a lifeline for those experiencing food insecurity. Healthy incentives programs (HIP), such as the federally funded Gus Schumacher Nutrition Incentive Program, also help increase healthy food consumption by providing enrollees with a coupon, discount, gift card, bonus food items or extra funds. Program evaluations have shown that HIP participants consumed more fruits and vegetables than non-participants.[vi] However, there remains a gap in the nutrition needs of many individuals who are not enrolled in or eligible for SNAP benefits.

  For example, over 40% of Medicaid enrollees with diabetes who were receiving SNAP benefits remained food insecure.[vii] There is undoubtedly room for improvement to ensure SNAP and related programs better serve those in need; to start, greater coordination and streamlined enrollment across safety-net programs such as SNAP

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and Medicaid, increased funding for benefits, improving public awareness about HIPs, and making it administratively easier for individuals to navigate and use said benefits.

- **Supporting other innovative programs that can positively address health-related social needs at the individual, family, and community level**: For instance, policies that support free or reimbursable public transit or improve the safety and accessibility of sidewalks and bike lanes help improve transportation access and can influence better health outcomes for both individuals and communities. Further, some primary care practices or other health care clinics provide free, whole, healthy food to patients, but often without stable funding streams. This caucus should explore other federal investments such as additional grants or more sustainable funding streams to expand these types of community-based resources, particularly in food desert communities.

II. *Chronic Disease Prevention: Shift health care resources toward preventive care, and research and implement non-pharmaceutical interventions to address chronic illnesses.*

The Centers for Disease Control and Prevention estimate that six in ten Americans have at least one chronic disease, and four in ten have two or more chronic conditions.[viii] Not only are chronic diseases such as heart disease, cancer, and diabetes the leading causes of death in the United States, but they are also the principal source of our $4.5 trillion in annual health care spending.[ix] Effectively meeting the current and future needs of our patients with chronic conditions requires our nation to better leverage primary care as the foundation of our health care system. However, our current health care system – including its continued reliance upon primarily fee-for-service payment structures – favors and incentivizes work that is done to a patient, rather than done with and for them. We need doctors who care for people, not doctors to deliver services.

Our policy recommendations on how to do overhaul and reform our health care system to better manage and prevent chronic disease include, but are certainly not limited to:

- **Increasing our nation's overall spending on primary care** and **requiring federal health programs to track and report on primary care spend**: Our nation cannot afford to keep spending less than five cents of every dollar on primary care. Improving health outcomes and preventing a further explosion of chronic illness requires us to reallocate our existing resources away from expensive sick care and toward prevention. As a starting point, we urge introduction of legislation that would require federal health programs to track and report data on their primary care spending so we have a clearer picture of the current landscape.

- Waiving patient cost-sharing **for high-value, low-cost preventive and primary care services, such as chronic care management (CCM) and the newly-implemented advanced primary care management (APCM) codes**: While efforts have been made in recent years to improve Medicare coverage of preventive and primary care services,

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many of the codes have associated patient cost-sharing responsibilities of 20%. This has been a contributing factor low uptake. One study found that Medicare billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients. The median use of the billing codes was 2.3% among eligible patients.[x] This caucus should thus advocate for the waiving of patient cost-sharing CCM, APCM, and other high-value, low-cost services.

- **Requiring Medicare Part B to cover all recommended vaccines so that seniors can receive them from their trusted primary care physician**: Currently, Medicare beneficiaries can only receive four vaccines from a physician (flu, pneumococcal, hepatitis B, and COVID). This severely hinders uptake of cost-effective vaccines that can prevent more expensive care and illnesses down the line. Statute must be amended to reflect updated advances in science and create parity between Part B and Part D, giving patients the ability to decide where they receive their vaccines.

- **Modernizing our flawed fee-for-service (FFS) payment structures, which will ultimately better support physicians' successful transition into value-based payment**: FFS payment has consistently undervalued the largely cognitive work delivered by primary care physicians. Further, the retrospective, volume-based nature and requirement to submit unique codes for every discrete service is compatible with the continuous, comprehensive, and longitudinal nature of primary care. We strongly believe well-designed alternative payment models (APMs) provide primary care a path out of the under-valued and overly burdensome FFS payment system that exists today.

  Unfortunately, a dearth of widely available primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is an essential first step. This is why the AAFP urges Congress to implement long-term reforms to Medicare physician payment, including providing an annual inflationary update based upon the Medicare Economic Index and addressing arbitrary budget neutrality requirements.

- **Enacting Representative Buchanan's *Chronic Disease Flexible Coverage Act* (H.R. 919) to preserve pre-deductible coverage of chronic disease management services and items for those enrolled in high-deductible health plans (HDHPs)**: In 2019, the Internal Revenue Service issued a notice expanding its interpretation of preventive care that HDHP sponsors can cover before patients hit their deductible to include certain items and services that are prescribed to individuals with certain chronic conditions. This bill, which codifies this guidance, passed the House in February. We appreciate Representative Buchanan's leadership on this bill and strongly urge its enactment to permanently provide patients with HDHPs affordable access to critical chronic care services and treatments.

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III. *Primary Care Access: Expand community health centers and telehealth initiatives, and promote direct primary care models to reduce costs and improve access. As well as expanding HSAs and association health plans.*

America faces a critical primary care workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate care access for patients nationwide. For many of the reasons mentioned above, our physician workforce skews heavily toward non-primary care specialists, and we have fewer primary care physicians relative to the population than in other countries.

The number of primary care clinicians in the United States dropped from 105.7 per 100,000 in 2021 to 103.8 per 100,000 in 2022. More than 30% of US adults lacked a usual source of care in 2022 — the highest level in a decade, despite historically high rates of insurance coverage during this period. The percentage of children without a usual source of care dropped from 13.6% in 2021 to 12.4% in 2022.[xi]

Low primary care payment rates in a system that rewards volume over value means physicians are pressured to see as many patients as possible. Meanwhile, overwhelming administrative burden takes time away from delivering patient care and often requires physicians to spend hours outside of the office doing documentation. These factors are leading current primary care physicians to leave the field and, when combined with the burden of student loan debt, dissuading medical students from pursuing primary care specialties like family medicine.

At a time when Americans have more chronic conditions than ever, we should be making strides to embed primary care physicians in every community. Instead, we've created a policy framework that is actively driving prospective physicians away from primary care and perpetuating nationwide workforce shortages. However, Congress can intervene and ensure every individual has access to a primary care physician by:

- **Supporting the viability of independent, physician-owned primary care practices, particularly in rural and underserved communities, by continuing and expanding the availability of tax incentives:** Independent physician practices continue to face challenges to their very existence in an increasingly consolidated health care environment. We encourage the caucus to champion the continuation of existing small business tax credits that many family practices use. However, more can be done to support them.

  Congress should consider providing income or property tax credits for primary care physicians who serve or work in rural communities. Specifically, primary care physicians who care for Medicare and/or Medicaid patients in a rural community should be eligible for a $50,000 tax credit on their federal income taxes in each year that they meet the qualifying requirements. Additionally, if the physician provides prenatal, obstetrical and postpartum services, they should be eligible for an additional

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$25,000 tax credit in each year that they meet the qualifying requirements. Providing these tax credits would provide additional capital to further encourage primary care physicians to practice and stay in rural communities.

- **Preserving and strengthening programs that address financial barriers to physicians choosing family medicine and other primary care specialties**: Students from low-income backgrounds are more likely to be drawn to practicing primary care. However, without the availability of Public Service Loan Forgiveness (PSLF) and other loan repayment programs, we know that many students would not be able to afford or would be further dissuaded from pursuing family medicine. The AAFP has an active survey out with members, which has so far found that more than 80% of respondents utilize PLSF. We encourage the caucus to prioritize preservation of PSLF, the National Health Service Corps, and other existing loan repayment programs while also expanding the number of opportunities available to recruit and retain primary care physicians.

- **Suspending the accrual of further interest on federal student loans for primary care residents**: This proposal, which recognizes that most residents cannot afford to start paying back their loans while completing their training, could provide a financial buffer needed for new physicians to feel comfortable entering less lucrative primary care specialties and to work in rural and underserved areas. The AAFP supports the bipartisan *Resident Education Deferred Interest (REDI) Act* (H.R. 2028 / S. 942), a bill that would allow for this deferral of interest on federal loans for physicians and dentists while completing their residencies.

- **Ensuring that international medical graduates who train in the United States can stay here and practice primary care in communities with the greatest need**: The AAFP supports the *Conrad State 30 & Physician Access Act* (H.R. 1585 / S.709), which would allow IMGs to remain in America upon completing their residency, rather than having to return to their home country for two years, under the condition that they practice in areas experiencing physician shortages.

- **Providing permanent, stable funding for community health centers (CHCs)**: Family physicians are embedded in CHCs around the country, which serve more than 30 million patients and are often the only accessible source of primary care in many communities. CHCs are also excellent stewards of money, with research showing that CHC patients have lower overall medical expenditures than non-CHC patients.[xii] They also consistently meet or exceed benchmarks for controlling chronic diseases such as hypertension and diabetes.[xiii] Unfortunately, CHCs are reliant upon a patchwork of inconsistent funding to keep their doors open. They operate on increasingly thin margins and any cuts or instability threaten their ability to deliver the care their community needs. Thus, we urge the caucus to push for permanent, stable, and reliable funding for CHCs as part of any agenda intended to improve access to primary care.

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- **Reimagining our country's graduate medical education (GME) system so that it better supports and invests in primary care, including an expansion of training in community-based settings**: Our current GME system excels at educating non-primary care specialists and physician researchers, but fails to produce the primary care workforce America needs. The disparity in growth in medical residents per capita between primary care and all other specialties continues to widen, with the rate of primary care residents remaining stagnant while the rate for all other specialties increased from 2020 to 2022. In fact, research has shown an inverse relationship between Medicare GME funding at the state level and the percentage of new PCPs entering the physician workforce; the more GME funding into the state, the fewer new PCPs in that state.[xiv]

  Only 15.9% of primary care residents spend most of their training in a community-based setting, despite that being where the bulk of primary care is delivered. Congress must restructure our GME system to better support and train PCPs. This includes continuing to support and expand the Teaching Health Center GME (THCGME) program, which – like CHCs – relies upon temporary funding to train primary care residents in outpatient settings in rural and underserved communities. Further, traditional GME programs must be modified to focus on training physicians in rural areas. The AAFP supports the *Rural Physician Workforce Production Act* (H.R. 1153), which would help support and grow rural teaching hospital GME programs.

- **Expanding access to direct primary care (DPC) arrangements for patients**: The AAFP supports DPC and sees it as an innovative model of care that provides a pathway to continuous, comprehensive and coordinated primary care for patients. It can also yield significant cost savings, with one study finding the potential for a single practice to generate $25k more in net income.[xv] We applaud the caucus for proactively identifying DPC as a model worth investing in, and we encourage support for two existing bipartisan bills that would promote greater participation in DPC: the *Primary Care Enhancement Act* (H.R. 1026) and the *Primary Care Improvement Act* (H.R. 1162).

- **Reigning in administrative burdens that interfere with the practice of medicine and negatively impacts patients' access to necessary care**: We sincerely appreciate that Dr. Marshall and others within this caucus have been vocal proponents for addressing the unrelenting avalanche of administrative burden that physicians face today. Prior authorization, step therapy, quality measurement reporting and other regulatory burdens impede the ability for doctors to actually practice medicine. Primary care clinicians also spend more time on electronic health records than clinicians in any other specialty.

  We encourage this caucus to lead legislative efforts that will, if not eliminate, significantly reduce the use of utilization management processes by insurers, minimize documentation and other paperwork burden, and standardize/streamline the use of quality measurement across programs and payers. Proposals that we have and continue to support are the *Safe Step Act*, the *Improving Seniors' Timely Access*

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to Care Act, and the *Reducing Medically Unnecessary Delays in Care Act* (H.R. 2433). Another opportunity to reduce burden for primary care physicians in particular is by requiring the use of a standardized Family and Medical Leave Act form, as currently every state utilizes their own form. This is particularly burdensome for physicians that regularly treat patients near state borders.

- **Ensuring the continued coverage of and payment for primary care services delivered via telehealth**: Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities. The AAFP strongly believes that permanent telehealth coverage and payment policies should:
    - Ensure coverage of and payment for 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.

Thank you for your commitment to improving the health outcomes of Americans, now and in the years to come. We look forward to partnering with you on our shared mission to advance comprehensive policy reforms that increase investment in primary care, address our nation's chronic disease burden, and ensure all of our patients can attain positive health and well-being. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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