AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

January 8, 2025

The Honorable Morgan Griffith
Chairman, Health Subcommittee
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

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 for holding today's hearing titled "Legislative Proposals to Support Patient Access to Medicare Services." Given the significance of this issue to family physicians and the patients they serve, I want to offer the following recommendations and insights from the family physician perspective.

Spending within the Medicare program has reached an unsustainable tipping point. Total spend reached $1.03 trillion in 2023, representing more than a fifth of overall national health expenditures.[i] The Medicare Board of Trustees estimates it will reach $1.9 trillion in 2032.[ii] However, the health outcomes of Medicare beneficiaries are lagging significantly behind what we would expect for the amount we've spent. Nearly one out of every four of our nation's seniors who are not in an institutional care setting report being in fair or poor health.[iii] Of individuals 65 years and older, 93 percent have at least one chronic condition and nearly 79 percent have two or more chronic conditions.[iv] These data points make it clear that our current system isn't working to prioritize patients and their wellbeing.

According to the Medicare Payment Advisory Commission (MedPAC), the costliest five percent of beneficiaries accounted for 46 percent of annual Medicare fee-for-service (FFS) spending. Many of these individuals have multiple chronic conditions that, if prevented and/or treated with lower-cost, earlier interventions, could significantly reduce program spending. Currently, clinician services only represent about one-fourth of Medicare spending. Across payers, Medicare spends the least on primary care, dipping to only 3.4 percent in 2022.[v] Together with the Centers for Medicare and Medicaid Services (CMS), this Subcommittee and your colleagues in Congress have the opportunity to reconfigure Medicare spending to ensure that taxpayer dollars are actually being spent on the high-value care that matters to seniors – including prevention, chronic disease management, and primary care.

We applaud the Subcommittee for discussing three pieces of legislation that the AAFP has endorsed during today's hearing:

- H.R. 5269, *Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025* (Rep. Hudson)

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- H.R. 5347, *Health Care Efficiency Through Flexibility Act* (Rep. Buchanan)
- H.R. 6210, *Senior Savings Protection Act* (Rep. Matsui)

However, these bills are not the end of the road when it comes to solutions. To meaningfully increase access to primary care and other essential services for seniors, Congress should also consider additional payment and coverage reforms such as:

- **Making foundational changes to the Medicare Physician Fee Schedule (MPFS)**, such as increasing investment in primary care, reforming budget neutrality requirements, and implementing an annual inflationary update to physician payment;
- **Waiving Part B patient cost-sharing for primary care services** to help incentivize uptake of high-value, low-cost codes such as chronic care management (CCM), G2211, and advanced primary care management (APCM);
- **Supporting and expanding ongoing federal efforts to accelerate value-based payment (VBP) adoption,** a system which provides primary care practices with greater flexibility and resources to meet the needs of Medicare beneficiaries; and
- **Requiring Part B to cover all recommended vaccines for beneficiaries,** ensuring that they are easily able to receive any requested vaccine in the office of their trusted family physician.

Foundational Reforms to the Medicare Physician Fee Schedule

For years, the Academy has described at-length the many flaws within FFS payment models, and more specifically the MPFS, that have contributed to our national underinvestment in primary care. Briefly, some of the biggest factors are as follows:

- FFS payment is designed to pay for discrete services in ways that favor procedural service delivery.
- FFS coding and billing is incompatible with the continuous, comprehensive nature of relationship-based primary care.
- Budget neutrality requirements are unreasonably outdated and should not be narrowly focused only on physician services.
- The lack of an inflationary update means payment has not kept pace with the inflationary costs of running a practice.

It is for these many reasons that the AAFP continues to advocate for widespread adoption of value-based payment arrangements, including in Medicare, as described in greater detail later in this letter. However, it cannot be ignored that FFS underpins and informs virtually all existing alternative payment models (APMs). Thus, the success of primary care physicians and practices in these arrangements is contingent upon comprehensive reforms being made to the MPFS and the Medicare Access and CHIP Reauthorization Act (MACRA).

We sincerely appreciate that CMS has leveraged their existing authorities in recent years to implement positive policy changes for primary care. This includes implementing new codes to pay for work that was not previously captured by existing codes (i.e.: G2211 add-on code for office and home-based visits), taking steps toward providing prospective per-member-per-month (PMPM) payments for care management services with the advanced primary care

management (APCM) codes, and using other empirical data sources to more accurately estimate the time it takes physicians to provide certain services.

However, the potential impact of many of these policies has been significantly blunted by the current zero-sum nature of the MPFS. For example:

- Extremely restrictive budget neutrality requirements – which haven't been updated since the inception of the MPFS – mean that, in most cases, new codes can't be added without triggering an across-the-board payment cut to all services.
- The budget-neutral nature of the MPFS also means that the Merit-based Incentive Payment System (MIPS), which was intended to move more physicians successfully into value-based payment, has failed in its goal. Penalties applied to "low-performing" clinicians pay for the awards provided to high-performers, creating a cycle whereby small, independent, and rural practices are consistently punished instead of offered a necessary helping hand.
- If CMS increases the valuations of any codes, it means that the valuations of other codes have to be reduced or the conversion factor is cut.
- And finally, all of this is happening within the same pot of money that has existed since 1992 – despite a growing beneficiary population, increasing costs of running a practice, and significant strides in medicine over the last several decades leading to more services and technologies being added to the MPFS. This policy framework has forced physician specialties to compete against each other for smaller and smaller pieces of the pie each year.

Comprehensively reforming the MPFS and MACRA must be a priority for Congress if there is a sincere desire to improve patient access to the care that matters. To this end, **the AAFP continues to urge Congress to provide an annual inflationary update to physician payment**, which the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R. 6160) would do. Further, we have previously provided recommendations for more modest reforms to MIPS and the Quality Payment Program that this Subcommittee should consider. We also support proposals to **provide CMS with the authority to correct over- or under-utilization assumptions when implementing new codes**, ensuring that funds within the fee schedule are not irreversibly lost due to inaccurate assumptions.

On the topic of budget neutrality, the AAFP urges Congress to consider thinking of traditional Medicare holistically, rather than as inviolable silos such as Part A and Part B. Eliminating waste and anachronistic policies across the program may serve to yield the offsets necessary to provide inflationary adjustments to the conversion factor or alleviate budget neutrality constraints. Just as Medicare expects Medicare Advantage plans, some CMMI models, and even physicians (i.e.: MIPS) to think of total cost of care, **Congress should consider the total costs of Medicare across the multiple Medicare silos and look for offsets across those silos, not just within Part B or the physician fee schedule**. As has been noted above, spending on physician services is not what's bankrupting the Medicare program. Rather, appropriately valuing and paying for the work primary care physicians provide to beneficiaries stands to save money for the Medicare program in the long-run while ultimately improving health outcomes.

Waive Patient Cost-Sharing for Primary Care Services

Statutorily, Medicare is required to charge patients a cost-sharing amount of 20 percent for many Part B services. While most preventive care is covered without cost-sharing, many primary care services delivered by family physicians remain subject to these requirements, resulting in financial barriers for patients and often low uptake.

As discussed above, FFS coding and billing has historically failed to capture much of the work provided by primary care physicians. However, CMS has taken steps to correct these errors in recent years. In 2015, Medicare began paying physicians for delivering non-face-to-face chronic care management (CCM) through separate codes. Additional coding advancements made have included implementation of the G2211 add-on code for office and home-based visits and the APCM code bundle. Overall, physicians have reported that being able to bill for these services has been a positive experience for them and their practices. However, cost-sharing requirements are limiting uptake by patients who would truly benefit from this type of additional support.

A 2022 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 preventive and care coordination billing codes was 2.3 percent among eligible patients.[vi] Family physicians regularly report patients opt out of receiving these services simply because the $15 or so a month they faced in cost-sharing was not financially feasible. In almost every case these are the very patients that would most benefit from CCM. Patients are not used to paying for these services and, understandably, are likely to be resistant to doing so. If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.

In many ways, APCM, CCM, and other similar codes are preventive services in that they can reduce emergency department and other outpatient visits. This is a question that CMS has begun to investigate, as indicated by their RFI about whether APCM should be considered a preventive service in the proposed CY26 MPFS. Removing cost-sharing for CCM and other primary care services increases access to these services without increasing overall health care spending.[vii] The available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health. Thus, **the AAFP urges the Subcommittee to consider advancing legislation to remove cost-sharing barriers for APCM and CCM as a starting point**.

Opportunities to Support and Expand Adoption of Value-Based Payment

Primary care physicians – particularly those in rural and underserved communities – still face significant barriers to entering and sustaining participation in VBP arrangements. Practices must comply with an ever-increasing number of federal and state regulations, negotiate contracts with multiple payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs – all while doing their primary job of taking care of patients. This creates an immediate and high barrier to entry, particularly for independent practices that don't have the upfront capital or resources.

To address this, the AAFP has called on federal policymakers to increase options for primary care practices to participate in APMs that provide upfront or advance payments and other

supports to enable the investments required to be successful. For example, practices participating in the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) not only received population-based, PMPM payments, but CMMI provided them with a robust data dashboard and other technical assistance that enabled new practices to join the model and successfully reduce emergency visits and hospitalizations. CMMI also partnered with state Medicaid agencies and commercial payers to drive alignment across payers in CPC+ regions, which in turn provided practices with greater financial support across their contracts and accelerated care delivery innovations.

We appreciate that CMMI has recently announced some promising models which seem to answer this call, including:

- Accountable Care Organization (ACO) Primary Care Flex – Beginning last year, this model provides low-revenue ACOs participating in the Medicare Shared Savings Program (MSSP) with a one-time upfront shared savings payment and a prospective PMPM payment.
- Long-term Enhanced ACO Design (LEAD) Model – This 10-year model, announced just last month, iterates upon past ACO models but with an eye toward bringing more rural, small, and independent practices and those that serve high-needs patients into the fold. Early details indicate LEAD will provide flexible, capitated population-based payments to support team-based care and downstream value-based care arrangements, in addition to incentivizing Medicaid-ACO partnerships and beneficiary incentives to seek care from ACO-participating clinicians.

The Academy looks forward to seeing how these models play out over the next several years and we encourage the Subcommittee to continue to partner with CMS to support their success. The emphasis of models like LEAD on bringing in new independent practices without prior ACO experience or that primarily care for underserved populations (i.e. Federally Qualified Health Centers and Rural Health Clinics) is likely to yield significant lessons learned, and may not immediately manifest in pure dollars and cents savings. For these reasons, **the AAFP continues to strongly encourage Congress to provide 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. The current statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant 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. 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 value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, 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.

Further, additional opportunities for the Subcommittee to improve the landscape of APMs include extending MACRA's advanced APM (AAPM) incentive payments, which expired at the end of performance year 2024. The AAPM incentive payments have served as an important tool for attracting physicians to participate in AAPMs, which require significant upfront (and often ongoing) investments in new staff, technology, and other practice improvements. Primary care practices have also used the bonus payments to offset the cost of investing in care delivery transformation that drives success in these models by improving patient outcomes and lowering spending.

Should the Subcommittee reauthorize these incentive payments, the Academy encourages implementation of guardrails to ensure the funds flow to the physicians and clinicians delivering care to Medicare beneficiaries in employed settings. Previous AAPM incentive payments were distributed at the organization level and did not have stipulations for how those incentives were shared or flow to physicians and clinicians delivering care. This is one reason why independent practices have better outcomes in value-based arrangements, as the resources and incentives flow directly to the practices and care teams delivering the care and are uniquely positioned to be more agile, flexible, and timely in their implementation of care interventions. To better encourage new participation in AAPMs, bonuses should be structured based on the value of what physicians and clinicians deliver, their impact on health outcomes and patient satisfaction, and both improved and sustained performance.

Finally, outside of payments, the AAFP believes there are additional changes Congress can enact to incentivize more primary care physician-led ACOs or greater primary care physician participation in MSSP. According to CMS data, in 2021, physician-led ACOs in the MSSP achieved net savings that were nearly double that of hospital-led ACOs ($237 per capita in net savings versus $124 per capita net savings).[viii] ACOs comprised of 75 percent primary care clinicians or more saw $281 per capita in net savings compared to $149 per capita in net savings for ACOs with fewer primary care clinicians. The data clearly shows primary care is essential to the success of MSSP. As such, Congress should consider the following options to encourage ACOs led by independent physician groups and/or with a larger proportion of primary care clinicians:

- Create a minimum threshold of primary care spending within an ACO to be eligible for shared savings.
- Set a minimum utilization rate of E/M encounters with primary care clinicians to be eligible for shared savings.
- Require ACO rosters to maintain a minimum ratio of primary care to other clinicians.
- Require primary care physician representation in the ACO governance structure.

Require Part B Coverage of All Recommended Vaccines

Vaccines are one of the safest and most cost-effective public health innovations we have. Current adult vaccination coverage yields an estimated 65 million averted disease cases and $185 billion in averted case costs over a 30-year period.[ix] The COVID-19 pandemic was a real-time demonstration of the invaluable role that vaccines play in saving lives when they are affordable and accessible. Yet each year, the United States spends $27 billion on four

vaccine-preventable illnesses in adults over the age of 50: flu, pertussis, pneumococcal (pneumonia), and shingles.[x]

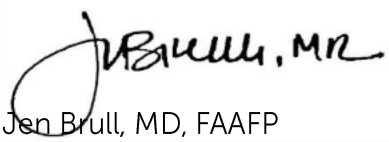
This is in part due to remaining barriers that prevent many individuals from being able to readily access and receive all recommended vaccines in their physician's office. For example, Medicare currently splits vaccine coverage between Part B (outpatient care) and Part D (prescription drug coverage). New vaccines, such as RSV, are only covered under Medicare Part D, which was designed for pharmacies to submit claims and makes it particularly challenging for primary care physicians to deliver recommended vaccines in their office.

Approximately 8.5 million Medicare enrollees have Part B but not Part D coverage, leaving them without affordable access to Part D vaccines.[xi] For those with Part D coverage, physicians can give patients a bill to submit to their Part D plan for reimbursement, but this forces patients to pay a potentially high out-of-pocket cost upfront, which creates barriers to access. There is an online clearinghouse that allows physicians to check Part D coverage and electronically submit an out-of-network Part D claim, but physicians must pay for this service by sharing a portion of their payment. Because of these barriers to administering the vaccine in-office, physicians can recommend or prescribe a Part D-only vaccine to a patient, who must then identify and secure a separate appointment at an in-network pharmacy in order to be vaccinated. Family physicians frequently share stories of Medicare patients that come in requesting a vaccine – or agree to receive one after months of discussions – only to have to turn them away and hope they are able to access it somewhere else. This coverage gap ignores consistent findings that patients want to receive vaccinations from their usual source of care, with whom they have established trust and respect over time.

However, Congress has the authority to remedy this issue and ensure that family physicians can easily provide all recommended vaccines to Medicare beneficiaries. Specifically, **the Academy urges the Subcommittee to consider legislation to require Medicare Part B coverage of RSV, shingles, and other evidence-based, medically recommended vaccines as they come onto the market**. Such a statutory update would explicitly meet the objective of this hearing by allowing beneficiaries to more readily access vaccines from their usual source of care and ultimately improve our nation's uptake of one of the most cost-effective public health measures.

Thank you for holding this hearing on one of the most salient issues impacting family physicians and their patients. The AAFP appreciates your consideration of our recommendations and looks forward to continuing to partner with you to reform the Medicare program to better serve our nation's seniors. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,



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