AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 27, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: Request for Information (RFI): HHS Initiative To Strengthen Primary Health Care

Dear Secretary Becerra:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians (FPs) and medical students across the country, I write in response to the request for information (RFI) on the Department of Health and Human Services' (HHS) Initiative to Strengthen Primary Care, as noticed in the June 27, 2022, *Federal Register*. The AAFP is strongly supportive of HHS' Initiative and appreciates the Department's efforts to improve access to comprehensive, high-quality primary care (PC) for all. **To achieve this shared goal, the Department must use its authority to significantly increase our nation's investment in PC, improve patients' access to and connections with PC, grow and diversify the PC workforce, and address the administrative requirements that drive care delays and physician burnout.** Below we provide specific recommendations.

Increase investment in primary care by paying primary care teams to care for people.

PC is the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. PC care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs. Unfortunately, fee-for-service (FFS), the dominant model of physician payment, fails to support PC by consistently underinvesting in PC services. PC spending lags in the US compared to similar investment in most other high-income countries.[1] Across payers, including both public and private insurance, PC spending in the United States amounts to approximately five to eight percent of all health spending, with an even lower percentage in Medicare, compared to approximately fourteen percent of all health spending in most high-income nations. Nations with greater investment in PC reported better patient outcomes and lower health care costs.[2,3,4] **The negative impact of underinvestment is exacerbated by the fact that FFS payment models such as the Medicare physician payment system, have failed to keep up with the pace of inflation**, even while Medicare payments for hospitals, nursing facilities, hospital outpatient departments, and surgery centers continue to benefit from annual updates. These low payment rates contribute to PC workforce shortages and worsen beneficiaries' equitable, timely access to care.[5]

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

The AAFP strongly supported and appreciates HHS' recent efforts to improve payment to PC through the Medicare physician fee schedule (e.g., by revaluing office visits and repricing clinical labor). Unfortunately, many FPs employed by health systems report that their employers are not reflecting the increased relative value units or Medicare payment allowances in their employment contracts and many private payers are taking advantage of multi-year contracts with physician practices to delay or avoid increasing the value of codes PC physicians use most often until current contracts come up for renewal. Consequently, the increased investment in PC expected from HHS actions has not materialized in many cases. **We urge HHS to use its authority across various programs to ensure payment increases to PC are actually received by individual clinicians.**

The piecemeal approach FFS takes to financing PC undermines and undervalues the whole-person approach integral to PC. Across payers, physicians must document several unique screening codes, vaccine administration, other preventive services and counseling codes, an office visit, care management codes, integrated behavioral health codes, and several other services to justify payment for typical, comprehensive PC, even though these services are all foundational parts of PC. In addition to being administratively burdensome, this approach encourages carve-outs of behavioral health, telehealth, and other services that are more accessible and effective when they are integrated in and coordinated within the PC medical home.[6,7,8] FFS also undervalues the component parts of PC, like care management and integrated behavioral health, and therefore fails to account for the complexity of PC. The Medicare Payment Advisory Commission has long advised policymakers to address the underpricing of PC services in FFS and the National Academies of Science, Engineering, and Medicine (NASEM) consensus report confirmed that FFS does not adequately value or support the longitudinal, person-centered care that is the hallmark of PC.[9] For example, many patients benefit from regular care management and coordination services that are not billable under FFS. **Together, the failings of FFS are jeopardizing many community-based PC practices, driving consolidation, and eroding patients' timely, affordable access to PC in their own neighborhood. The AAFP urges HHS to examine opportunities to more comprehensively finance PC in FFS.**

Because FFS has continuously failed to support and invest in PC, the AAFP has long advocated to accelerate the transition to value-based care. Alternative payment models (APMs) provide PC practices with additional flexibility and financial stability, which practices leverage to hire additional staff (e.g., social workers, behavioral health professionals) and provide advanced PC services not paid for under FFS. These models have reduced utilization of emergency department and acute care services and improved patients' health outcomes.[10] Unfortunately, a dearth of PC models and the inadequacy of FFS payment rates are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for PC is one essential strategy for support physicians' transition into value-based care. The AAFP also 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 PC 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.**

Ensure timely, equitable access to person-centered PC for everyone.

The AAFP believes everyone should have comprehensive, affordable health coverage that provides equal access to evidence-based, inclusive, language-appropriate primary care. HHS should use its authority to increase connections to PC and ensure it is accessible for Medicare, Medicaid, CHIP, and marketplace enrollees. Maintaining a robust network of PC physicians and ensuring timely access to routine PC are foundational components of comprehensive health coverage. The AAFP has urged HHS to reinstate and strengthen federal network adequacy standards for PC. To this end, **the AAFP thanks HHS for finalizing time and distance standards to ensure network adequacy under Medicare Advantage and in marketplaces and supports the use of appointment wait time standards.**

The AAFP offered similar recommendations on improving access to care for Medicaid beneficiaries by reinstating and strengthening federal access standards for managed care, enforcing existing Medicaid reporting regulations, and enhancing federal monitoring and oversight of Medicaid beneficiaries' access to care. HHS should also monitor Medicaid enrollment changes for groups that are particularly vulnerable or at-risk of losing their Medicaid coverage to mitigate discriminatory and/or erroneous coverage denials resulting in care disruptions. **HHS must address low Medicaid payment rates and burdensome administrative processes, both of which create barriers to care for beneficiaries.** The AAFP is strongly supportive of expanding coverage and payment of telehealth services. Across programs, we urge HHS to support the provision of telehealth services that are provided by beneficiaries' usual source of care and integrated within the medical home. HHS should not allow health plans across programs to count telehealth services provided by direct-to-consumer telehealth companies to count toward meeting minimum federal access standards for PC.

Health centers, including federally qualified health centers (FQHCs) and rural health centers (RHCs), are crucial to ensuring accessible and affordable PC and reducing racial, ethnic, and income-based health disparities.[11,12] FQHCs and RHCs serve populations who would otherwise not have access to PC and provide care that is higher quality and more cost-effective than other sites of service.[13,14,15] **The AAFP supports HHS' efforts to strengthen federal supports for community health centers as well as the Center for Medicare and Medicaid Innovation's interest in creating APMs that better support FQHCs, RHCs, and other safety net providers.**

Many individuals are not connected with PC clinicians and experience barriers to obtaining inclusive, language-appropriate, comprehensive primary care.[16] **HHS should increase voluntary selection of PC clinicians across programs and plan types and use its authority to remove cost and other barriers to accessing recommended PC services.**

Target federal medical education resources to address physician shortages and diversify the workforce

Graduate medical education: The AAFP has long been concerned about the shortage of PC physicians in the U.S., particularly the supply of FPs, who provide comprehensive, longitudinal PC services for patients across the lifespan. It is projected that we will face a shortage of up to 48,000 PC physicians by 2034.[17,18] To address the shortage and maldistribution of physicians, the AAFP has advocated for the federal government to align physician training with workforce needs. The AAFP believes that Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need, including by considering those with a proven track record of training physicians who ultimately practice in physician shortage areas. We are pleased that HHS is prioritizing the distribution of new Medicare GME slots to programs located in health professional shortage areas and urge the Department to use a needs-based approach in future allocations. Another barrier to creating a more equitable and effective GME program at the federal level is the lack of transparency in how funds are used by teaching hospitals or whether they are effectively addressing physician shortages. Medicare as the largest single payer spends about $9.5 billion annually on GME. **We encourage HHS to collect, analyze, and publish data on how federal GME positions are aligned with national workforce needs.**

The Teaching Health Center GME Program is one example of successful federal efforts to increase the PC workforce and access to health care in underserved communities. **The AAFP urges HHS to support the establishment of new THCs and the expansion of existing THCs, both through federal funding and by removing burdensome regulatory requirements imposed on THCs.**

The lack of diversity within the physician workforce has significant implications for public health. Several studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[19,20] Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11% of physicians.[21,22] **HHS should expand funding for programs with a track record of diversifying the physician workforce, such as HRSA's Health Careers Opportunity Program and Centers of Excellence, and collaborate with other agencies to expand opportunities for women, LGBTQ, people of color, low-income individuals, and other populations that are underrepresented in the physician workforce.**

Physician-led PC teams: **HHS should support patients' access to physician-led PC teams to ensure all patients receive high-quality care.** Patients need access to every member of their health care team—PC physicians, nurse practitioners, physician assistants, and all the other professionals practicing to the full extent of their license. FPs are trained to provide complex differential diagnoses, develop a treatment plan, and order and interpret tests within the context of the patient's overall health condition. Wholesale substitution of non-physician health care providers for physicians is not the solution to addressing PC physician shortages, especially at a time when PC practices are being called upon to take on more complex care.

Improve health data sharing with primary care and reduce administrative burden

Improving accountable data sharing with PC: The AAFP has long supported efforts to facilitate health data exchange and standardization with the goal of equipping FPs with the data they

need to provide comprehensive, whole-person PC. The ongoing lack of interoperability across our health system and lack of standardization across EHR platforms inhibits effective information sharing and care coordination. Patients also struggle to access their own health data. **HHS must work to improve information sharing from hospitals, specialists, and other care team members with PC physicians.**

Prior authorization reform: Prior authorization (PA) continues to be a leading cause of physician burden and the AAFP is strongly supportive of efforts to reform and streamline the PA process. Not only do PA requirements negatively impact practice workflows and physician wellbeing, but evidence also shows PA forces patients to delay or discontinue needed care and worsens health disparities. **We support HHS' efforts to streamline PA by advancing electronic PA standards**. We have repeatedly called for HHS to broaden the electronic PA rule to include Medicare Advantage plans and finalize the rule as soon as possible. A recent report from the HHS Office of Inspector General confirmed that Medicare Advantage plans use PA to inappropriately deny coverage and payment for medically necessary services, creating barriers to PC for beneficiaries.[23] **Comprehensive PA reform is needed to reduce the volume of PA and ensure patients' timely access to care, including clear guidelines for PA requirements and timely responses from insurance plans.**

Harmonize regulations: FPs report challenges with complying with new information blocking requirements, including meeting the criteria for exceptions, while also continuing to comply with HIPAA. **The AAFP strongly urges HHS to work with its agencies to ensure that the regulations governing the sharing and protection of patients' health information are harmonized to meaningfully improve patients' access to their health data and advance interoperability while also safeguarding patient privacy and security.**

Enhance federal data and research funding to measure progress in strengthening primary care.

Despite PC being the only segment of health care where an increased supply is associated with better population health and more equitable outcomes, federal support for PC research has not increased over the years, with PC research comprising less than 0.4 percent of NIH's budget.[24] **We urge HHS to request increased federal funding for PC research.**

Many states are working to measure primary care spending. However, the lack of national definitions and benchmarks, methodological differences across states and challenges with obtaining data across payer types create measurement challenges and make comparisons difficult. Relatedly, the NASEM report recommended the development of a national scorecard to provide accountability for the nation's progress in high-quality primary care implementation. The AAFP's Robert Graham Center (in collaboration with other partners) is creating a scorecard to meet this need. **We urge HHS to invest in federal data improvements to enable more accurate measurement of primary care spend and changes in the PC workforce. Finally, the AAFP recommends HHS use this scorecard to enhance national measurement of PC, identify and address PC disparities, and evaluate the impact of federal policies on PC.**

A coordinated, whole-of-government approach is needed to strengthen primary care in the United States. The AAFP is hopeful HHS' Initiative will catalyze the urgently needed improvements we have recommended throughout this letter. Please contact Stephanie Quinn,

Senior Vice President of Advocacy, Practice Advancement, and Policy at squinn@aafp.org with any questions.

Sincerely,

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

[1] Primary Care Collaborative, Robert Graham Center. Investing in Primary Care: A State-Level Analysis. 2019. Available at: https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/BKG-PrimaryCareSpend.pdf
[2] Primary Care Collaborative. (2020). "Spending for Primary Care Fact Sheet."
[3] Reid R, Damberg C, Friedberg MW. (2019). "Primary Care Spending in the Fee-for-Service Medicare Population." JAMA Intern Med. Web.
[4] Shi L. (2012). "The Impact of Primary Care: A Focused Review." Scientifica (Cairo). Web.
[5] Medicare Payment Advisory Commission. Physician and other health professional services. March 2022 Report to Congress. Available at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch4_SEC.pdf
[6] Balasubramanian BA, Cohen DJ, Jetelina KK, et al.; Outcomes of integrated behavioral health with primary care. J Am Board Fam Med. 2017;30(2):130-139.
[7] Ross KM, Klein B, Ferro K, McQueeney DA, Gernon R, Miller BF. The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: a prospective, case-control program evaluation. *J Clin Psychol Med Settings.* 2019;26(1):59-67
[8] Welch BM, Harvey J, O'Connell NS, McElligott JT. Patient preferences for direct-to-consumer telemedicine services: a nationwide survey. BMC Health Serv Res. 2017 Nov 28;17(1):784. doi: 10.1186/s12913-017-2744-8. PMID: 29183372; PMCID: PMC5704580.
[9] Medicare Payment Advisory Commission. Physician and other health professional services. March 2022 Report to Congress. Available at: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch4_SEC.pdf
[10] Mathematica. Independent Evaluation of Comprehensive Primary Care Plus (CPC+). Fourth Annual Report. May 2022. Available at: https://innovation.cms.gov/data-and-reports/2022/cpc-plus-fourth-annual-eval-report
[11] NACHC (National Association of Community Health Centers). 2020a. Community health center chartbook. Bethesda, MD: National Association of Community Health Centers.
[12] Politzer, R. M., J. Yoon, L. Shi, R. G. Hughes, J. Regan, and M. H. Gaston. 2001. Inequality in America: The contribution of health centers in reducing and eliminating disparities in access to care. Medical Care Research and Review 58(2):234–248.
[13] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality PC: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983
[14] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality PC: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983
[15] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality PC: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[16] Benjamin D. Sommers et al., "Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults," Health Affairs 36, no. 6 (June 1, 2017): 1119–28, https://doi.org/10.1377/hlthaff.2017.0293.
[17] IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: AAMC; 2021.
[18] Congressional Research Service. Federal support for graduate medical education: an overview. https://fas.org/sgp/crs/misc/R44376.pdf Published December 27, 2018. Accessed July 15, 2022.
[19] Cooper LA, Powe NR. Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. The Commonwealth Fund. Accessed October 19, 2021.
[20] Poma PA. Race/ethnicity concordance between patients and physicians. J Natl Med Assoc. 2017;109(1):6-8.
[21] U.S. Census Bureau. Quick Facts: United States. Retrieved July 15, 2022, from https://www.census.gov/quickfacts/US
[22] Diversity in Medicine: Facts and Figures 2019. AAMC. Retrieved July 15, 2022, from https://www.aamc.org/datareports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018
[23] U.S. Department of Health and Human Services. Office of the Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 2022. Available at: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[24] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality PC: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.