AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 12, 2023

The Honorable Michael Burgess
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Lloyd Smucker
U.S. House of Representatives
302 Cannon House Office Building
Washington, D.C. 20515

The Honorable A. Drew Ferguson
U.S. House of Representatives
2239 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Blake Moore
U.S. House of Representatives
1131 Longworth House Office Building
Washington, D.C. 20515

The Honorable Early "Buddy" Carter
U.S. House of Representatives
2432 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Rudy Yakym
U.S. House of Representatives
349 Cannon House Office Building
Washington, D.C. 20515

Dear Representatives Burgess, Ferguson, Carter, Smucker, Moore, and Yakym:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write in response the House Budget Committee's Health Care Task Force request for information (RFI) on solutions to improve outcomes, reduce federal health care spending in the budget, and opportunities to build upon the Congressional Budget Office's (CBO) ability to project the impact of health care policies. As the nation's only medical specialty group dedicated solely to primary care, the AAFP sincerely appreciates the Task Force's focus on this important issue and the forum to provide feedback.

Family physicians are uniquely trained to care for patients across the lifespan, regardless of gender, age, or type of problem, be it biological, behavioral, or social. They serve as a trusted first contact for health concerns with training to address most routine health care needs. The foundation of family medicine is primary care, defined as 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. **Primary care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.**

Primary care is the only health care component where an increased supply is associated with better population health, more equitable outcomes, as well as lower mortality rates, leading the National Academies of Sciences, Engineering, and Medicine (NASEM) to call it a common good.[1] An increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%, or 49 fewer deaths per 100,000 per year.[2] Evidence clearly demonstrates that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations. Yet the United States has continuously underinvested

in primary care, which only accounts for a mere five to seven percent of total health care spending in the country.[3] The AAFP's Robert Graham Center, in collaboration with the Milbank Memorial Fund and the Physicians Foundation, released the nation's first primary care scorecard this year and found that primary care's share of the overall U.S. health care spend decreased from 6.2% in 2013 to 4.6% in 2020. This underinvestment in prevention and primary care is evidenced by U.S. health outcomes, with OECD data indicating that we have higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[4]

Our existing federal policy and regulatory framework fails to recognize and promote the true value of primary care. As it stands now, we financially reward individual health care transactions and financially penalize long-term relationships between a patient and primary care team. **Decades of systemic underinvestment in primary care and prevention, coupled with overwhelming administrative burden, has led to poorer population health and a greater emphasis on rescue medical care, which is directly contributing to our nation's exorbitant health care spending.** It is with this in mind that the AAFP offers the following feedback on opportunities for federal policymakers to meaningfully invest in primary care to reduce health care expenditures while improving patients' access to care and outcomes.

Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes:

High quality, comprehensive primary care, by design, is intended to reduce health care spending and improve patient outcomes. **Therefore, Congress should advance and support efforts to meaningfully promote and bolster access to comprehensive, continuous, patient-centered primary care, including for Medicare beneficiaries.**

Unfortunately, fee-for-service (FFS), the dominant model of physician payment, fails to support primary care by consistently underinvesting in primary care services. Primary care spending lags in the U.S. compared to most other high-income countries.[5] Across payers, including both public and private insurance, primary care spending in the United States amounts to approximately five to eight percent of health spending across all payers, 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 primary care reported better patient outcomes and lower health care costs.[6,7,8]

The piecemeal approach FFS takes to financing primary care undermines and undervalues the whole-person approach integral to primary care. 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 primary care, even though these services are all foundational parts of primary care.

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. As detailed in our recent comments on the Calendar Year 2024 Medicare Physician Fee Schedule (MPFS), we strongly believe that well-designed APMs provide primary care a path out of the under-valued and overly-burdensome FFS primary care payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population.

While fee-for-service is not the future the AAFP envisions for primary care, it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates

physicians to make more meaningful progress toward the future – one that rewards quality of care over volume of services. Specifically, **the Academy strongly urges Congress to consider legislative solutions, including reforms to MACRA, and support positive policy proposals that would address unsustainable FFS payment rates for physicians, promote patients' access to continuous, comprehensive primary care, improve health outcomes, and reduce federal health care spending.**

This is why the AAFP, alongside 36 other organizations representing clinicians, patient advocates, and other health care stakeholders, have expressed our strong support for a proposal by the Centers for Medicare and Medicaid Services (CMS) to implement an add-on billing code known as G2211 in the CY24 MPFS. G2211 would be billed with codes for office/outpatient evaluation and management (E/M) visits to better recognize the inherent resource costs clinicians incur when longitudinally managing a patient's overall health or treating a patient's single, serious or complex chronic condition. In simpler terms, G2211 reflects the time, intensity, and practice expenses needed to meaningfully establish relationships with patients and address most of their health care needs with consistency and continuity.

Sustained continuity of care has been shown to improve quality and reduce health care spending by improving uptake of preventive services, increasing adherence to care plans for patients with chronic conditions such as diabetes, and decreasing hospitalizations and emergency department use overall.[9] This add-on code is a much-needed investment in strengthening patient-clinician relationships by supporting clinicians' ability to foster longitudinal relationships, address unmet social needs, and coordinate patient care across the team. Evidence indicates increasing payments for these types of services reduce patient appointment wait times and supports the provision of services that improve patient health and can reduce costs.[10,11,12] **The Academy strongly urges Congress to support CMS' proposal to implement G2211.** Allowing this code to go into effect would be an incremental but meaningful step toward bolstering access to all the services that Medicare beneficiaries need and appropriately paying for the complex care that primary care physicians provide each and every day, with the likelihood to yield long-term health care savings.

Statutory budget-neutrality requirements and the lack of annual updates to physician payment to account for inflation will, without intervention from Congress, continue to hurt physician practices, slow the adoption of value-based payment models, accelerate consolidation, and jeopardize patients' access to care – all while increasing federal health care spending. In October 2022, the Academy submitted robust recommendations to Congress on reforming MACRA to address challenges affecting our members and their patients. The AAFP urges Congress to expeditiously consider additional reforms to MACRA and Medicare physician payment, such as relief from budget neutrality requirements, to modernize Medicare fee-for-service payments.

Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending:

Improving graduate medical education for primary care: The U.S. faces a critical family physician workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate care access for patients nationwide. Though the current system excels at educating skilled physicians and physician researchers, **the primary care physician shortage prevents the U.S. from taking advantage of the better outcomes and lower per capita costs associated with robust primary care systems in other countries.**

Effective health care systems have a physician workforce made up of roughly 50% primary care and 50% subspecialty. Today's U.S. physician workforce is 33% primary care. To achieve the overall goal

of 50% primary care, it is imperative that at least 25% of U.S. medical school graduates choose family medicine by 2030.

Evidence indicates that physicians typically practice within 100 miles of their residency program[13], meaning that the current distribution of trainees in large academic hospitals also leads to physician shortages in medically underserved and rural areas. These shortages result in access barriers and disparities in health outcomes for patients living in rural and underserved communities.

The Academy encourages Congress to consider ways to reimagine our country's GME system so that it better supports and invests in primary care, including an expansion of training in community-based settings. This will bolster our primary care workforce for the future and allow us to realize the true value of primary care for generations to come, including significant cost savings and improved patient outcomes as we shift toward a system that prioritizes health care, rather than sick care.

The AAFP supports consistent funding for GME for family medicine to ensure that new residency slots are allocated to address rural and urban imbalances, reduce physician shortages, and focus on medically underserved areas, including funding for programs such as the federal Teaching Health Center GME (THCMGE) program.

To date, the THCGME program has trained more than 1,730 primary care physicians and dentists, 63 percent of whom are family physicians. The program's reauthorization has been extended to November 17th with the recently passed short-term continuing resolution. The Academy continues to call on Congress to pass the Doctors of Community (DOC) Act (H.R. 2569) to provide permanent funding for and expansion of the program, which has a demonstrated track record of training and keeping primary care physicians in rural and medically underserved communities. We have also expressed strong support for the bipartisan Lower Costs, More Transparency Act (H.R. 5378), which includes a seven-year reauthorization of the program and historic funding levels. Without stable federal funding, most THCs would be unlikely to maintain residency recruitment and enrollment, threatening the initial program investments and even the viability of the program itself.

Moreover, Congress should take additional steps necessary to address disparate access to care in rural and other medically underserved areas. Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians. **Any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas**.

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. **Medicare is the largest single payer of GME, spending about $16 billion annually, but it does not assess how those funds are ultimately used or whether they actually address physician shortages**.[14] CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect, analyze data on how Medicare GME positions are aligned with national workforce needs, and publish an annual report.

Aligning payment across care settings: Site of service payment differentials also contribute to increased health care spending despite no demonstrated differences in the quality of patient care and outcomes. Currently, hospitals are directly rewarded financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings. Medicare allows

hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. Unfortunately, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[15]

The AAFP has long supported the advancement of thoughtful site neutral payment policies that would establish payment parity across care settings with careful consideration as to not unintentionally accelerate consolidation. We have called for an expansion of payment parity to all on-campus and off-campus hospital-based departments, as well as other facilities. We support reducing payment differences between sites of service since it enables patients to make more informed healthcare decisions by making costs more transparent and would reduce patient cost-sharing. As such, site neutral payment encourages patient choice based on quality rather than cost.

As noted previously, the AAFP has supported the Lower Costs, More Transparency Act (H.R. 5378), which ensures that payment for physician drug administration services will be the same in an off-campus hospital outpatient department (HOPD) as in a physician's office. We have urged Congress to swiftly pass this measure, while also continuing to advocate for additional action to build upon and advance more substantial site neutral payment policies.

Implementing prior authorization reform: Medicare Advantage (MA) and Medicaid managed care plans that use utilization management processes, such as prior authorization, frequently describe them as a cost-control mechanism. However, repeated evidence has shown that many MCOs use prior authorization inappropriately, causing care delays and worsening patient outcomes and satisfaction. A 2022 report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) confirmed that MA plans sometimes deny prior authorization and payment requests that meet Medicare coverage rules by using clinical criteria not in Medicare coverage rules and requesting unnecessary documentation, as well as making errors.

In addition to enrollees in MA plans, enrollees in other health plans needing care for their own chronic illness,[16] their children's chronic illness,[17] and rare diseases[18] have experienced barriers to care from prior authorization requirements. In 2022, California-based L.A. Care, which administers Medicaid and other types of coverage, failed to address a backlog of more than 9,000 prior authorization requests and more than 67,000 complaints or appeals.[19] Meanwhile, an Office of Inspector General report published in July found that Medicaid managed care organizations (MCOs) denied one out of every eight prior authorization requests in 2019, yet minimal data collection on and oversight of these practices is being done by state Medicaid agencies.[20]

In an American Medical Association (AMA) survey of physicians, 94 percent reported that prior authorization delays access to care, while 80 percent reported that it led to patients abandoning their treatment and 33 percent reported that it had led to a serious adverse event for their patient. Additionally, **86 percent of surveyed physicians reported that prior authorization sometimes, always, or often leads to higher overall utilization of health care resources, such as additional office visits, emergency department visits, or hospitalizations.**

The AAFP has strongly supported Congressional efforts to streamline and implement prior authorization reporting requirements as a means to address some of the unrelenting administrative burden physicians are subject to and ensure better patient access to care. This includes endorsing the bipartisan Improving Seniors' Timely Access to Care Act that passed the House last session and would require implementation of an electric prior authorization program in MA, as well requiring MA plans to provide real-time decisions.

We applaud CMS' recent steps to proactively implement many of the provisions of this legislation through rulemaking and have called for the swift implementation of the final rules. However, Congressional action is still greatly needed to codify these requirements. Congress could also consider requiring data collection and greater oversight by state Medicaid agencies on the use of prior authorization by Medicaid managed care plans.

Comments on CBO's modeling capabilities on health care policies, including limitations or improvements to such analyses and processes;

The AAFP greatly appreciates Task Force Chair Burgess' demonstrated leadership on efforts to reform CBO's modeling capabilities and ensure that the longer-term cost savings of legislation that would invest and enhance preventive care is more accurately reflected and considered as part of their analyses. We have endorsed the Preventive Health Savings Act (H.R. 766 / S. 114), which would instruct CBO to extend its analysis beyond the existing 10-year budget window to two additional 10-year periods to provide a fuller analysis of the potential impact of preventive health legislation. We believe this is an important step toward ensuring that the true value of primary care and prevention is reflected within our national budgetary environment.

Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long term health costs:

As Benjamin Franklin said, "an ounce of prevention is worth a pound of cure." And prevention is an integral part of primary care. Every day, family physicians provide routine and lifesaving preventive health measures and interventions, such as immunizations, screenings for cancer or heart disease, and tobacco cessation counseling. To promote equitable utilization of cost-effective preventive care, **the AAFP believes that all health plans should provide first-dollar coverage for low-cost, high-value, evidence-based services such as recommended vaccines, screenings, and preventive medications.**

Vaccines are one of the safest and most cost-effective public health technologies 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.[21] 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.[22]

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.[23] 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 on order to be vaccinated.

Legislative action is needed to ensure that physicians can easily provide all ACIP-recommended vaccines to Medicare beneficiaries. **The Academy urges Congress to pass legislation to require Medicare Part B coverage of all vaccines, allowing beneficiaries to more readily access vaccines from their usual source of care and improving our nation's uptake of one of the most cost-effective public health measures.**

Recommendations to reduce improper payments in federal health care programs.

Overvaluation of global surgical codes: Under the MPFS, surgical services are billed and paid for using global codes that are valued to include most parts of a surgical episode of care. Depending on the service, some include preoperative appointments, the surgery itself, and various types of postoperative care. MACRA required CMS to collect data on how best to value global packages and to reassess every four years the continued need for this data collection.

As MACRA required, CMS began data collection in 2017, making 2023 the seventh year of data collection. As CMS' contractor, RAND, has reported, the data clearly show that the reported number of visits does not match what's expected based on the assumptions underlying the valuation of the 10 and 90-day global procedures. For example, only four percent of postoperative visits assumed in 10-day global surgical codes are provided.[24] Thus, CMS continues to be concerned that its current valuations of the global packages reflect certain E/M visits that are not typically furnished in the global period. **In other words, there is strong evidence suggesting that the current RVUs for global packages are inaccurate in terms of the number and level of postprocedural visits involved and who is providing them when they do occur.**

The zero-sum, budget-neutral nature of the fee schedule ensures any overvaluation of one part, such as the 10 and 90-day global packages, undervalues the remainder of the fee schedule, including primary care. The continued potential overvaluing of the 10 and 90- day global packages contributes to the MPFS' underinvestment in primary care. The AAFP believes the global period for all surgical services should be zero days. All surgical services with a longer global period, such as 10 or 90 days, should have their global period reduced to zero days and be revalued accordingly. Use of a zero-day global period facilitates more accurate valuation of surgical services.

In their most recent report, RAND outlined an alternative methodology for valuing the global surgical packages and estimated that it would result in more than $2.5 billion being returned to the Medicare conversion factor.[25] **The AAFP has and will continue to encourage CMS and Congress to address the apparent overvaluation of these surgical packages given the negative impact of these overpayments on primary care and other non-surgical services under the MPFS.**

Overpayments to Medicare Advantage (MA) plans: CMS makes monthly payments to private payers who serve as MA organizations administering Medicare benefits to beneficiaries who enroll in their MA plan. The payment amounts are partially determined according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

The AAFP recognizes that risk adjustments are important for ensuring payments to MA organizations accurately reflect patient complexity and support equitable access to coverage and care for patients. However, a growing body of evidence suggests that some MA organizations may be overly focused

on recording health conditions that increase risk scores and therefore, increase their monthly payments without a corresponding level of care documented for enrollees.[26,27] For example, plans have reported diagnosis codes that are not fully supported by patients' medical records, an indication that patients aren't receiving related or indicated care.[28]

Analysis suggests that these incentives have resulted in an estimated $27 billion in overpayments to MA plans.[29] The AAFP is strongly supportive of comprehensive and accurate documentation of all patient's diagnoses and advises members that all coding should comply with the ICD-10-CM coding guidelines. If reports of overpayment are accurate, the AAFP is concerned that significant funding that could support broader, more equitable access to high-quality primary care is being diverted with no benefit to MA enrollees. **Congress could consider advancing policies to address incentives that create unintended consequences and ensure that payments to MA organizations contracted to administer benefits are benefitting MA enrollees with the delivery of high value services, including comprehensive, continuous primary care that can help to reduce health care expenditures in the long run.**

Additional guardrails should be considered to prevent MA organizations from failing to invest in and support the provision of high-quality primary care. Primary care practices continue to struggle with inadequate physician payment rates, staffing shortages, and overwhelming administrative burden. Additional payment cuts, costly system updates, and other downstream effects of these changes could further destabilize the primary care practices Medicare beneficiaries depend on.

Thank you for the opportunity to provide these recommendations and we look forward to working with you to advance policies that invest in primary care, improve patient outcomes, and ultimately reduce federal health care spending. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N Ransone, Jr MD FAAFP

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Board Chair, American Academy of Family Physicians

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