



January 31, 2024

The Honorable Brett Guthrie
Chairman
House Energy and Commerce Committee,
Health Subcommittee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
House Energy and Commerce Committee,
Health Subcommittee
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

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 to thank the Subcommittee for its focus on addressing the high costs of health care in this country with today's hearing titled "Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers." As the nation's only medical specialty group dedicated solely to primary care, the AAFP sincerely appreciates the Subcommittee'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.ⁱ 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.ⁱⁱ 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.ⁱⁱⁱ

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 last 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 Organization for Economic Co-operation and Development (OECD) data indicating that we have

STRONG MEDICINE FOR AMERICA

President
Steven Furr, MD
Jackson, AL

President-elect
Jen Brull, MD
Fort Collins, CO

Board Chair
Tochi Iroku-Malize, MD
Islip, NY

Directors
Gail Guerrero-Tucker, MD, *Thatcher, AZ*
Sarah Nosal, MD, *New York, NY*
Karen Smith, MD, *Raeferd, NC*
Kisha Davis, MD, MPH, *North Potomac, MD*
Jay Lee, MD, MPH, *Costa Mesa, CA*
Teresa Lovins, MD, *Columbus, IN*

Sarah Sams, MD, *Dublin, OH*
Brent Smith, MD, *Cleveland, MS*
Jefferey Zavala, MD, *Billings, MT*
Matthew Adkins, DO (New Physician Member), *Columbus, OH*
Janet Nwaukoni, DO (Resident Member), *Grayslake, IL*
Taree Chadwick (Student Member), *Reno, NV*

Speaker
Russell Kohl, MD
Stilwell, KS

Vice Speaker
Daron Gersch, MD
Avon, MN

Executive Vice President
R. Shawn Martin
Leawood, KS

higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.^{iv}

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, have 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.

Appropriately Paying for Primary Care

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.^v 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 14 percent of all health spending in most high-income nations. Nations with greater investment in primary care report better patient outcomes and lower health care costs.^{vi vii viii}

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 [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 FFS 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 the Medicare Access and CHIP Reauthorization Act (MACRA), and support positive policy changes 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, applauded the Centers for Medicare and Medicaid Services (CMS) for finalizing their proposal to implement the add-on code known as G2211. As of January 1, 2024, G2211 is being billed alongside codes for office/outpatient evaluation and management (E/M) visits to better recognize 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.^{ix} This add-on code is a 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.^{x xi xii} The Academy greatly appreciates Congress allowing G2211 to be implemented. This is 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.

However, **an across-the-board cut of 3.37% to Medicare payment for all services provided by physicians also went into effect on January 1, 2024.** This cut is undermining positive policy changes intended to promote investment in primary care and hamstringing CMS' ability to appropriately pay for all the services a patient needs. The AAFP, alongside the entire physician community, [urges](#) the Subcommittee and the rest of Congress to provide physicians with immediate relief from the full cut. **If Congress fails to act in a timely manner, patients across the country will further struggle to access care.** They are likely to face increased health care costs as they may be unable to see a clinician before their condition(s) are exacerbated or they will be forced to seek care in a more expensive setting, like the emergency department.

The Subcommittee and Congress must also act to address statutory budget-neutrality requirements and the lack of an annual inflationary update to physician payment, which together 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 June 2023, the Academy submitted [robust recommendations](#) to the Subcommittee on ways to reform MACRA to address challenges affecting our members and their patients. We [applaud](#) the Committee for recently advancing the *Physician Fee Schedule Update and Improvements Act* (H.R. 6545) which would, among other things, provide relief from the zero-sum budget neutrality requirements by increasing the budget neutrality threshold and requiring timely updates to the direct costs used to calculate practice expense Relative Value Units (RVUs). The AAFP urges the Subcommittee to expeditiously consider additional, meaningful reforms to MACRA and Medicare physician payment.

Reimagining Graduate Medical Education

The U.S. faces a critical family physician workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate access to care 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.**

Evidence indicates that physicians typically practice within 100 miles of their residency program^{xiii}, 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 Teaching Health Center GME (THCMGE) program.

The THCGME program has a proven track record of achieving its legislative mandate to train the next generation of primary care physicians. Since its inception in 2010, the program has trained more than 2,027 primary care physicians and dentists in community-based settings, 61% of whom are family physicians. THCGME graduates are more likely to continue practicing primary care and serving in medically underserved communities than those in traditional Medicare GME-supported programs.

The program's reauthorization has been extended to March 8, 2024 with the recently passed short-term continuing resolution. While 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, we have also [expressed](#) strong support for the bipartisan *Lower Costs, More Transparency Act* (H.R. 5378) and applaud the House for passing this important legislation. The bill 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 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.^{xiv} 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 the Department of Health and Human Services (HHS) and other relevant agencies authority to collect and analyze data on how (or if) Medicare GME positions are aligned with national workforce needs and publish an annual report.

Addressing Misaligned Incentives that Increase Health Care Costs

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.^{xv}

Medicare's increased payments for services performed in HOPDs does not just impact the Medicare program and beneficiaries, however. Private health plans generally use Medicare's payment system as a basis for how much they pay physicians and hospitals, meaning that this influences and directs spending and resources among commercial plans and patients. Therefore, **adopting comprehensive site neutral payment policies in Medicare would have significant impacts in saving money across the health care sector**, with one study estimating that it would lead to \$471 billion in savings over the next 10 years.^{xvi}

In terms of direct patient costs, Medicare patients collectively would save about \$67 billion on Part B premiums and \$67 billion on cost-sharing. Premiums for private health insurance plans would be about \$107 billion lower over that period, which would amount to a reduction in aggregate premiums of 0.75%. Privately insured patients would also save about \$18 billion on cost-sharing due to lower payment rates.^{xvii}

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 strongly [supported](#) the *Lower Costs, More Transparency Act* (H.R. 5378), which bipartisan leaders of the Energy and Commerce Committee have championed. We appreciate that it ensures 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.

The Academy also appreciates that the *Lower Costs, More Transparency Act* seeks to codify and increase compliance with existing hospital and insurer price transparency requirements, as well as to advance billing transparency by requiring off-campus HOPDs to use distinct National Provider

Identifiers (NPI). Improving transparency ultimately provides policymakers, researchers, and other stakeholders with a better understanding of the factors that are accelerating consolidation and increasing health care costs, and will better prepare them to respond and implement meaningful solutions.

Implementing Prior Authorization Reform

Medicare Advantage (MA) and Medicaid managed care organizations (MCOs) 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 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,^{xviii} their children's chronic illness,^{xix} and rare diseases^{xx} 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.^{xxi} Meanwhile, an OIG report published in July 2023 found that Medicaid 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.^{xxii}

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 Congress 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 recently finalized rulemaking. However, Congressional action is still greatly needed to codify these requirements. **Congress should also consider requiring data collection and greater oversight by state Medicaid agencies on the use of prior authorization by Medicaid managed care plans.**

Promoting Utilization of Cost-Effective Interventions

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.^{xxiii} 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.^{xxiv}

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. Medicare currently splits vaccine coverage between Part B (outpatient care) and Part D (prescription drug coverage). New vaccines, such as respiratory syncytial virus (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.^{xxv} 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 Advisory Committee on Immunization Practices (ACIP)-recommended vaccines to Medicare beneficiaries. **The Academy urges Congress to pass legislation to require Medicare Part B coverage of all recommended 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.**

Reducing 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.^{xxvi} 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.^{xxvii} **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.^{xxviii xxix} 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.^{xxx}

This month, **the Medicare Payment Advisory Commission released new findings that project the federal government will overpay MA plans by \$88 billion in 2024.**^{xxxi} 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 offer these recommendations. The AAFP looks forward to continuing to work with you to advance policies that ensure all Americans have access to quality affordable health care. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,



MD, MPH, MBA

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
Board Chair, American Academy of Family Physicians

-
- ⁱ 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>
- ⁱⁱ Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv*. 2007;37(1):111-26. doi: 10.2190/3431-G6T7-37M8-P224. PMID: 17436988.
- ⁱⁱⁱ Jabbarpour Y, Greiner A, Jetty A, et al. Investing in Primary Care: A State-Level Analysis. Patient-Centered Primary Care Collaborative and the Robert Graham Center; July 2019. <https://www.grahamcenter.org/content/dam/rgc/documents/publications-reports/reports/Investing-PrimaryCare-State-LevelPCMH-Report.pdf>. Accessed February 9, 2023.
- ^{iv} Turner A, Miller G, and E Lowry. "High U.S. Health Care Spending: Where Is It All Going?," The Commonwealth Fund. Published October 4, 2023. Available online at: <https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going>
- ^v 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>
- ^{vi} Primary Care Collaborative. (2020). "Spending for Primary Care Fact Sheet."
- ^{vii} Reid R, Damberg C, Friedberg MW. (2019). "Primary Care Spending in the Fee-for-Service Medicare Population." *JAMA Intern Med*. Web.
- ^{viii} Shi L. (2012). "The Impact of Primary Care: A Focused Review." *Scientifica (Cairo)*. Web.
- ^{ix} Cabana MD, Jee SH. Does continuity of care improve patient outcomes? *J Fam Pract*. 2004 Dec;53(12):97480. PMID: 15581440.
- ^x Increased Medicaid Reimbursement Rates Expand Access to Care. National Bureau of Economic Research. 2019.
- ^{xi} Candon M, Zuckerman S, Wissoker D, et al. Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients. *JAMA Intern Med*. 2018;178(1):145–146. Doi:10.1001/jamainternmed.2017.6302
- ^{xii} Williams MD, Asiedu GB, Finnie D, et al. Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives. *BMC Health Serv Res*. 2019;19(1):92. Published 2019 Feb 1. Doi:10.1186/s12913-019-3916-5
- ^{xiii} Fagan BE, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training - Graham Center Policy One-Pagers - American Family Physician.
- ^{xiv} Congressional Research Service. Federal support for graduate medical education: an overview. <https://fas.org/sgp/crs/misc/R44376.pdf>. Published December 27, 2018. Accessed February 9, 2023.
- ^{xv} Post, B et al. Hospital-physician integration and Medicare's site-based outpatient payments Available at: <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13613>
- ^{xvi} Ellis P. Estimated savings from adopting site-neutral payment policies for Medicare. February 2023. Available online at: https://www.bcbs.com/sites/default/files/file-attachments/affordability/Phil_Ellis_Site_Neutral_Payment_Cost_Savings_Report_BCBSA_Feb_2023.pdf
- ^{xvii} Ibid.
- ^{xviii} Armstrong D, Rucker P, Miller M. 2023. UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings. *Propublica*. <https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis>
- ^{xix} Dickens DS, Pollock BH. Medication prior authorization in pediatric hematology and oncology. *Pediatr Blood Cancer*. 2017 Jun;64(6). doi: 10.1002/pbc.26339. Epub 2016 Nov 5. PMID: 28436209. <https://pubmed.ncbi.nlm.nih.gov/28436209/>
- ^{xx} Johnson CY. 2023. I wrote about high-priced drugs for years. Then my toddler needed one. *Washington Post*. <https://www.washingtonpost.com/wellness/2023/01/30/high-priced-drugs-step-insurance-policies/>

-
- ^{xxi} Liss S. 2022. L.A. Care fined \$55M after members faced barriers to timely care. Healthcare Dive. <https://www.healthcaredive.com/news/la-care-55m-fine-members-barrierstimelycare/619925/#:~:text=L.A.%20Care%2C%20the%20nation%27s%20largest,Managed%20Health%20Care%20announced%20Friday.>
- ^{xxii} Grimm CA, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care." Office of Inspector General, U.S. Department of Health and Human Services. Published July 2023. Available online at: <https://oig.hhs.gov/oei/reports/OEI-0919-00350.asp>.
- ^{xxiii} Carrico J et al. "Cost-benefit analysis of vaccination against four preventable diseases in older adults: Impact of an aging population," Vaccine Volume 39, Issue 36, 23 August 2021, Pages 5187-5197. <https://doi.org/10.1016/j.vaccine.2021.07.029>.
- ^{xxiv} McLaughlin JM, McGinnis JJ, Tan L, Mercatante A, Fortuna J. Estimated Human and Economic Burden of Four Major Adult Vaccine-Preventable Diseases in the United States, 2013. J Prim Prev. 2015 Aug;36(4):25973. doi: 10.1007/s10935-015-0394-3. PMID: 26032932; PMCID: PMC4486398.
- ^{xxv} Centers for Medicare and Medicaid Services, "Medicare Monthly Enrollment." Updated June 2023. Accessed October 10, 2023. Available online at: <https://data.cms.gov/summary-statistics-on-beneficiaryenrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data?query=>
- ^{xxvi} Centers for Medicare and Medicaid Services, "Medicare Monthly Enrollment." Updated June 2023. Accessed October 10, 2023. Available online at: <https://data.cms.gov/summary-statistics-on-beneficiaryenrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data?query=>
- ^{xxvii} RAND Corporation. Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods Updated Results Using Calendar Year 2019 Data. 2021. Available at: <https://www.cms.gov/files/document/rand-revaluation-report-2021.pdf>
- ^{xxviii} Murrin S, "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments." Office of Inspector General, U.S. Department of Health and Human Services. Published September 2021. Available online at: <https://oig.hhs.gov/oei/reports/OEI-03-17-00474.asp>.
- ^{xxix} Grimm C, "Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns." Office of Inspector General, U.S. Department of Health and Human Services. Published September 2020. Available online at: <https://www.oig.hhs.gov/oei/reports/OEI-03-1700471.asp>.
- ^{xxx} Murrin S, "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments."
- ^{xxxi} Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report," January 12, 2024. Available online at: <https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>