AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

Bob Rauner, MD, MPH, FAAFP
President, Partnership for a Healthy Nebraska

To

United States Senate Committee on the Budget

On

How Primary Care Improves Health Care Efficiency

March 6, 2024

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

Chairman Whitehouse, Ranking Member Grassley, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Bob Rauner and I am a family physician from Nebraska. I am honored to be here today representing the 129,600 physicians and student members of the American Academy of Family Physicians (AAFP), including myself.

I spent the initial 15 years of my career caring for rural and underserved populations in Nebraska. The first five of those years were in private practice along with my wife Lisa, who is also a family physician, in my hometown of Sidney in the panhandle of Nebraska. We then moved on to a family medicine residency program teaching others to become rural physicians and caring for Lincoln's low income and refugee communities.

During that time, I became involved with a national research network that measured quality of care using our electronic health record (EHR)'s clinical data and studied which interventions were effective in improving the care of a clinic's patients. Our efforts were very successful, but the primary limitation to scaling up that success beyond our research network was that **our health care payment system neither funded nor incentivized providing high quality care to our patients.**

This led me to become involved in the Patient-Centered Medical Home movement in Nebraska to advocate for changes to our payment system in order to sustain and incentivize the provision of better care to our patients. Our first policy win came in 2009 when a Patient-Centered Medical Home pilot project was funded in two Nebraska communities. The goal of this project was to see if it would successfully improve care and save money in the Medicaid population. And as it turned out, the pilots successfully improved care and reduced emergency room visits.

In 2012, I helped launch Nebraska's first physician-led accountable care organization (ACO) with clinics from those two communities as well as seven others using the advanced payment option of the Medicare Shared Savings Program (MSSP). Within two years our ACO was one of the top ten highest scoring ACOs in quality of care in the country.[i] While advanced payment option of MSSP was critical to our initial success, we ran into challenges sustaining our care coordination efforts in year three due to the lack of an ongoing per member per month (PMPM) payment which was an essential component of the funding that supported our successful Patient-Centered Medical Home effort. Additionally, any potential cost savings from the ACO were impacted by our rural hospital's critical access funding. Due to critical access hospitals being paid on a cost basis, any reductions in hospitalizations did not directly show up as cost savings on our ACO budget.

In 2016, I helped start another primary care physician-led ACO called OneHealth Nebraska. Our launch was enabled by two critical developments. First, Nebraska was one of the Centers for Medicare & Medicaid Innovation's (CMMI) Comprehensive Primary Care (CPC+) intervention states which gave our clinics a risk-adjusted PMPM payment to fund their care coordination efforts. Second, the multi-payer component of CPC+ resulted in our Blue Cross Blue Shield of Nebraska ACO contracts also including a risk-adjusted PMPM payment which aligned our efforts across half of our payer mix. This sustained our efforts for the five years necessary to start receiving shared savings payments from the MSSP ACO contracts. Each year since we have done even better. In 2022, OneHealth Nebraska was one of only eleven out of 482 Medicare ACOs that achieved both a quality of care score *and* cost reductions above the 90th percentile.

High quality, comprehensive primary care, by design, is intended to reduce health care spending and improve patient outcomes. **In my testimony today, I'd like to illustrate how my experience is just one of the many successful examples of what happens when you recognize the true value of primary care by increasing the investment and changing the structure of payment to include a PMPM or population-based payment to provide a well-funded, stable, and predictable revenue stream.** Alternative payment models (APMs), when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable

revenue streams that provide sufficient funding and needed flexibility to build the teams and technology necessary to deliver high-quality patient-centered care.

Underinvestment in Primary Care Drives Increased Costs

Primary care is the only proven aspect of health care where more is better. The research is clear that increased use of primary care is associated with better population health, fewer health disparities, reduced mortality rates, and lower overall spending. In its latest report on primary care, the National Academies of Sciences, Engineering, and Medicine (NASEM) went so far as to call it a common good.[ii] Evidence clearly demonstrates that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces costly emergency visits and hospitalizations. Yet the United States has continuously underinvested in primary care with only five to seven percent of total health care spending going to primary care.[iii]

Last week, the AAFP's Robert Graham Center, in collaboration with the Milbank Memorial Fund and the Physicians Foundation, released the nation's second primary care scorecard, which reported that spending on primary care decreased from 6.2% in 2013 to 4.7% in 2021. Primary care spending decreased for all payers between 2019 and 2021 with Medicare being the most pronounced with a 15% drop.[iv] While some of this decrease could be due to a drop in office visits during the pandemic, it is a trend worth noting as the strength of our nation's primary care system was put to its greatest test during COVID.

The resilience and commitment of the primary care workforce shone brightly through many of our darkest days as a nation. Primary care practices went to great lengths to ensure their patients were cared for and even expanded services as a result of COVID with 72% reporting that they increased support for their patient's mental health needs and 25% reporting increased rates of screening for domestic violence and child abuse. One primary care physician reported setting up heaters outdoors so that he could meet his patients in person.[v] However, those efforts have also taken a toll on the primary care workforce. As the pandemic was winding down in 2023, just 19% of primary care practices reported that they were fully staffed and 78% of primary care clinicians believe the current workforce is inadequate to meet the population need, 61% believe the US primary care system is crumbling and 64% believe a new approach to payment is needed to address the current challenges.[vi]

The impact of this long-term underinvestment is evidenced in our nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[vii] A common theme across countries with better health outcomes and lower health care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17% of total health care spending for these high-performing nations.[viii]

Not only are primary care services undervalued, but it is also extremely complex to get paid. In fee-for-service (FFS), the predominant payment method, physicians are required to submit unique codes for each discrete service they provide – documenting both what they did and why they did it. This is incompatible with the wide range of services delivered in a primary care setting which range from basic preventive services such as screenings, vaccine administration and routine physicals to more complex services involving chronic care management, integrated behavioral health, and coordination of care.

To address these problems, the AAFP has long advocated for APMs that increase the investment in primary care using prospectively paid, population-based payments. These arrangements

provide primary care practices with a sustainable source of revenue that does not weigh them down with mountains of paperwork and unnecessary "mother may I" requests.

Participating in APMs that offer predictable, prospective revenue streams using population-based payments enables practices to invest in the infrastructure and care teams needed to deliver high quality, comprehensive primary care – without the administrative complexity of FFS. Given these and other benefits, there is mounting multi-stakeholder, cross-industry support for a primary care payment system that rewards value and holds promise for improving health, addressing disparities, and slowing the overall growth of health care costs. Federal policymakers should increase participation opportunities in primary care models that align with the AAFP's guiding principles for value-based payment (VBP) and meet practices where they are, allowing them to gain a foothold in VBP.

Primary Care APMs Can Yield Cost Savings and Improve Patient Outcomes

Early results and lessons learned from APMs have continued to drive model improvements. The ACO Investment Model (AIM), a former primary care and population management model administered by CMMI, offered advance payments to ACOs to fund practice transformation. The model demonstrated savings and reduced inpatient admissions, readmissions, post-acute care utilization and emergency department visits while maintaining quality. While the Next Generation ACO model did not generate net savings, gross reductions in Medicare spending were realized and larger declines in Medicare spending were associated with physician practice affiliation and organizations electing a population-based payment mechanism over FFS.

The success of AIM led to permanent changes to MSSP, incorporating advanced investment payments (AIP) to support physician participation in new ACOs. In 2022, MSSP saved Medicare $1.8 billion, making it the sixth year in a row that the program generated savings while producing high-quality performance results.[ix]

In December 2023, the final CPC+ evaluation report was published, which showed participating practices – many of which are also part of ACOs including OneHealth Nebraska – reduced outpatient ED visits, acute inpatient hospitalizations, and acute inpatient expenditures.[x] Independent, physician-owned practices in CPC+ successfully reduced hospitalizations and expenditures on these hospitalizations in comparison to hospital- and system-own practices. By the end of CPC+, practices had used the prospective payments to invest in care delivery transformation that would not have been possible if FFS was their only source of revenue. These practices reported that they:

- Provided patients with after-hours access to a physician or other clinical staff member who has real-time access to the practice's EHR;
- Used designated care managers, typically on-site staff who are nurses or medical assistants, to deliver longitudinal care management services;
- Increased the use of behavioral staff to offer behavioral health counseling at a higher rate than comparison practices;
- Co-located a pharmacist at the practice site to support comprehensive medication management; and
- Convened and collected feedback from patients during Patient and Family Advisory Council (PFAC) meetings.

We made many of these investments which are reaping dividends in our overall ACO performance at OneHealth Nebraska.

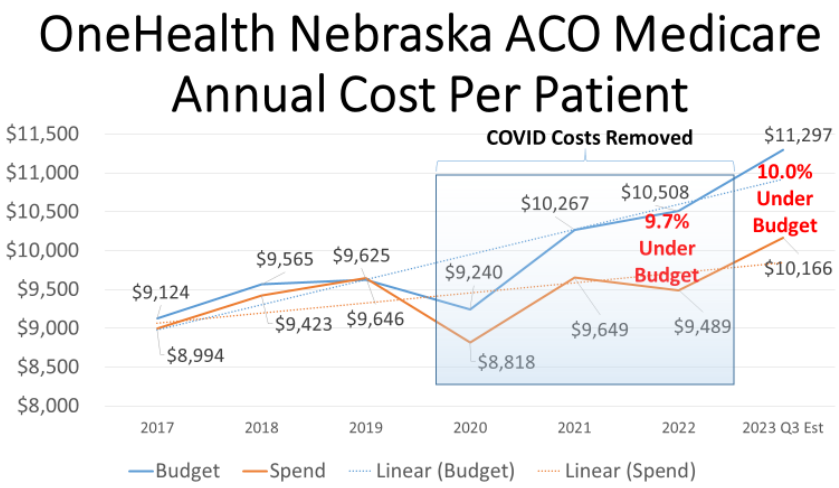

Figure 1

Figure 1 displays OneHealth Nebraska's budget performance for 2017 through 2023. Although our cost overall was lower than expected for the first three years, we did not meet the Medicare shared savings threshold and therefore did not receive any money from Medicare for our ACO efforts. We did meet the threshold for receiving shared savings in 2020, but that means we did not receive a shared savings payment from Medicare until October of 2021, a full five years after we started forming our ACO. If we had not had the PMPM payments from our Medicare population through the CPC+ program and our largest commercial contract, I am not sure we could have sustained our efforts and achieved this success.

While it is possible to achieve shared savings in the first year or two of an ACO contract, sometimes those are false savings from risk coding strategies or even from denying and delaying necessary care. Denying and delaying care may save costs upfront in the short-term, but it's very likely to increase costs down the line due to complications resulting from that denied or delayed care and reduced overall quality of care. However, **OneHealth Nebraska achieved shared savings the right way: we focused on better chronic disease management, post discharge visits, and increasing our rate of Annual Wellness Visits.** While these efforts did not result in short-term cost savings, they are now resulting in longer-term savings that appear to be paying off like compound interest.

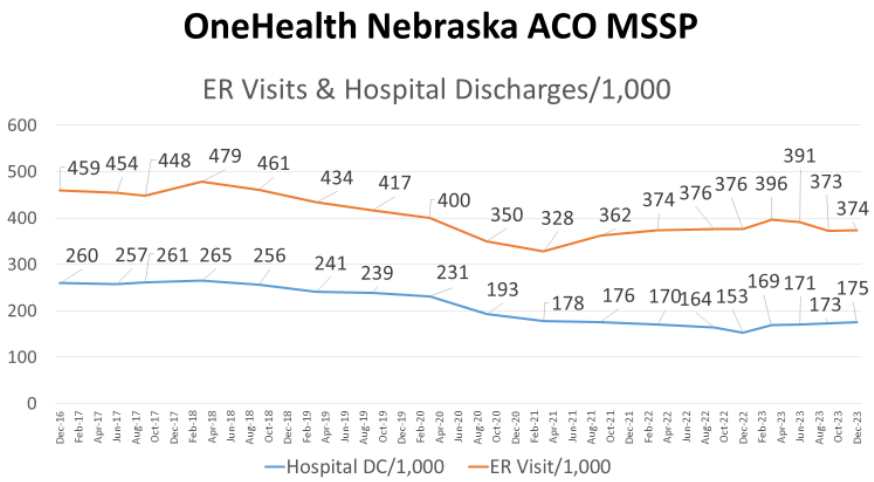

Figure 2

Figure 2 shows the reduction in our emergency room and hospitalization rates. They dropped substantially in the third year and are the largest source of our cost reductions. **When you control chronic conditions like high blood pressure and diabetes, the cost savings take several years to materialize.** But when sustained over multiple years, improved care of chronic conditions pays back like compound interest.

For the last three years, press releases from the Centers for Medicare and Medicaid Services (CMS) summarizing the results of MSSP have pointed out that **ACOs composed primarily of primary care physicians have achieved higher quality of care while saving twice as much money per Medicare beneficiary**. Prior analyses of ACO performance dating back to 2016 in the New England Journal of Medicine have shown similar performance comparisons of primary care led ACOs versus other models.[xi] But unfortunately, the growth of new primary care led ACOs has plateaued.

As I noted in my story about starting an ACO before OneHealth Nebraska, primary care physicians face significant barriers to entering and sustaining participation in value-based payment. Practices must comply with an ever-increasing number of federal and state regulations, negotiate contracts with multiple commercial payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs – all while doing our primary job which is 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 problem, **federal policymakers should increase options for primary care practices to benefit from APMs that provide upfront or advance payments and other supports to enable the investments required to be successful**. For example, practices participating in 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.

CMMI's forthcoming Making Care Primary (MCP) model, which is set to launch in July, also builds upon lessons learned from CPC+ and Primary Care First (PCF) and provides participants who are new to value-based care with upfront payments to develop infrastructure and build advanced care delivery capabilities. CMMI is also working with state Medicaid agencies and other payers in the selected states to align MCP and state programs, helping facilitate the multi-payer alignment that has contributed to successful aspects of earlier models.

In short, we need a payment mechanism that funds the necessary startup costs, as well as ongoing care coordination and management work to support new primary care-led ACOs until they can improve care to the point that they achieve substantial cost reductions and become sustainable. In my opinion, the best model would be to include a combination of the risk-adjusted PMPM payments included in CPC+ and the advance payment model of the early MSSP contacts.

For OneHealth Nebraska, the combination of current fee for service reimbursement, population-based payments from CPC+ and now PCF plus the shared savings payments we are earning is providing funding that amounts to a primary care spend rate of around 12-13%. This corresponds with the 10-15% primary care spend rate that many health policy experts say is necessary to budget in order to achieve accessible, high quality primary care that improves population health, reduces overall health care costs, and reduces health disparities. I believe MSSP should add a primary care spend target as a measure of success for its ACO participants in order to ensure sustainable funding for future primary care led ACOs.

Congress should also consider providing 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. As shown in the case of OneHealth Nebraska, **demonstrating savings in primary care often takes three to five 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 model 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, as well as iterate upon them to meet current patient, clinician, and market needs.

While value-based payment can and should be used to buoy primary care practices, health systems, hospitals, payers, and other large companies will continue to enter these models. Federal policymakers should take steps to ensure that value-based payment is being used as a tool to significantly increase our nation's investment in primary care, not as a leverage point to increase profits in other business areas. In other words, payments and financial rewards from APMs should be reinvested back into the primary care practice, not redirected to other service lines or books of business.

The AAFP increasingly hears from family physicians that their employers – whether they are health systems, health insurers, or another type of employer – are using primary care as a management tool and are failing to reinvest financial gains into their primary care practices and clinicians. This prevents primary care practices from reaping the full benefits of APM participation, including practice improvements that can advance quality and bolster patient health outcomes. **The AAFP urges Congress to examine additional guardrails to ensure that hospital systems, vertically integrated payers who also deliver care, and other physician employers participating in primary care APMs or ACOS are required to direct primary care payments, including incentives earned from high-quality primary care, back into the delivery of primary care services within their organizations whether that is through investments in technology, people or other resources**.

In closing, thank you again for the opportunity to provide this testimony and share my story. On behalf of the AAFP and as a family physician, I look forward to working with the Committee to advance policies that invest in high-quality primary care, improve patients' outcomes and experiences, and ultimately reduce health care costs.

Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and

wellness, please visit the AAFP's consumer website, www.familydoctor.org.

[i] Rappleye E. Becker's Hospital Review, "20 Medicare ACOS With the Highest Quality Scores in 2014" August 31, 2015. Available online - https://www.beckershospitalreview.com/accountable-care-organizations/20-medicare-acos-with-the-highest-quality-scores-in-2014.html

[ii] 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

[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.

[iv] Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now. The Milbank Memorial Fund and The Physicians Foundation. February 28, 2024.

[v] COVID-19 Survey — The Larry A. Green Center (green-center.org)

[vi] Larry A. Green Center, "Quick Covid-19 Primary Care Survey Series 37: Fielded March 13-19, 2023." Available online at: C19+Series+37+National+Executive+Summary+vF.pdf (squarespace.com)

[vii] 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/highus-health-care-spending-where-isit-all-going

[viii] Baillieu R, Kidd M, Phillips R, et al. The Primary Care Spend Model: a systems approach to measuring investment in primary care BMJ Global Health 2019;4:e001601.

[ix] Centers for Medicare and Medicaid Services, "Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care." August 24, 2023. Available online at: https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high

[x] Centers for Medicare and Medicaid Services, "Independent Evaluation of Comprehensive Primary Care Plus (CPC+): Final Report." December 2023. Available online at: https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report

[xi] McWilliams J, Hatfield L, Chernew M, Landon B, Schwartz A, "Early Performance of Accountable Care Organizations in Medicare, New England Journal of Medicine 2016;374:2357-66.