



March 28, 2022

Elizabeth Fowler, PhD, JD
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
200 Independence Avenue, SW
Room 310G-04
Washington, DC 20201

Dear Deputy Administrator Fowler:

On behalf of the American Academy of Family Physicians (AAFP), which represents 127,600 family physicians, residents, and medical students across the country, I write in response to the request issued by the Center for Medicare & Medicaid Innovation (CMMI) for stakeholder feedback on how CMS can support safety net provider participation in value-based care and CMS Innovation Center models.

The AAFP shares CMMI's commitment to advancing health equity. Primary care is an important evidence-based intervention that must be leveraged to address health inequities. However, primary care practices, particularly those serving as safety nets, are hampered by persistently low payments and limitations related to a volume-based payment system. New payment models that seek to increase investment are not readily available to all primary care physicians, and in cases where they are, there are significant burdens created by the unique requirements of each payer. Advancing value-based care across payers will bolster the primary care system and ultimately facilitate equitable access to the kind of comprehensive, person-centered, longitudinal care patients need.

Given the range of providers who care for underserved populations, how should the CMS Innovation Center define “safety net providers” for purposes of model design and recruitment?

Family physicians are an essential part of the safety net, providing primary care to low-income and other underserved patients, including in federally qualified health centers (FQHCs) and rural health centers (RHCs) across the country. As of 2019, 15% of AAFP members practiced in an FQHC setting and 17% of members practice in rural areas. To define “safety net providers” for model design and recruitment, CMMI should look to Section 330 of the Public Health Service Act, which created and authorized the Health Center program. This statute can be used to guide the types of practices and physicians that care for patients who are the most marginalized and vulnerable, including: community-based safety organizations and health centers, community health centers, rural health centers, clinics, Title X, Title V Maternal and Child Health Block Grant, certified tribal clinics, Health Center Program look-alikes, and volunteer-based free and charitable clinics. In addition, CMMI should consider practices providing care to patients insured through Medicaid and the Children's Health Insurance Program (CHIP) as part of the safety net. While the payment mechanisms for these practices differ from Health Centers, they face many of the same barriers and may be one of the only places where patients with Medicaid and CHIP can receive timely, comprehensive primary care.

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What financial incentives, structures, and support are necessary to recruit safety net providers to participate in CMS Innovation Center models?

Safety net practices lack value-based, accountable care model options. Previous alternative payment models (APMs) have focused on larger systems and excluded safety net practice sites from participation. **Safety net providers need a stable suite of multi-payer models across the risk spectrum with predictable, prospective revenue streams that increase the investment in primary care to adequately to meet patient and practice needs, inclusive of both clinical and behavioral health. The suite of models should be designed with the unique patient population and payment mechanisms in mind for these practices, including upfront investment to build infrastructure necessary for long-term sustainability.**

Some CMMI models are designed in such a way that physicians are penalized if spending for their patients increases for reasons beyond the physician's control or if a physician cares for patients with complex needs. Most Innovation Center models base financial penalties and rewards on whether the total cost of care (TCOC) for a patient population is lower or higher than a historical average, not on the subset of costs the physician can control. Benchmarks in these models are typically calculated using historical spend, so any intervention that fills previously unmet care needs will inherently fail to reduce spending. Additionally, the referral network to sub-specialists willing to accept patients who are uninsured or have Medicaid is small, which may ultimately increase spending if low-cost, high-quality specialists are unavailable. Model design for safety net providers should include provisions to reward physicians for providing access to high-quality primary care and avoid unintended consequences that may hinder efforts to reduce health-related disparities.

In addition, payments in CMMI models are typically risk adjusted using CMS' Hierarchical Condition Category (HCC), which only adjusts for differences for certain conditions from a prior year, but not for acute conditions, newly diagnosed chronic conditions, or health-related social needs (HRSNs). As a result, physicians serving low-income and other vulnerable patient populations with more clinical and HRSNs may have a higher TCOC than is expected based on their HCC score. Lower Medicaid payment rates also leave little room for savings to be actualized. As such, many physicians that care for a high proportion of low-income patients should have the option to participate in models that place more emphasis on improving patient outcomes and less emphasis on reducing TCOC and have more robust risk adjustment methodologies. CMMI models should be designed to ensure physicians are not penalized based on differences in the characteristics of their patients, as current model design may not appropriately or accurately measure differences in the physicians' efficiency or quality.

Current models would require safety net practices to take on additional risk that is not accounted for in model design due to the mandate that they serve all patients regardless of their ability to pay. **To account for this risk, payment rates should be adjusted to ensure practices caring for high-risk patients are supported (and not penalized) for providing additional services that may be needed to facilitate addressing HRSNs, behavioral and mental health concerns, or environmental factors.** One approach, outlined in a recent Health Affairs [blog](#) post and added to the Primary Care Program of CMMI's Maryland Total Cost of Care Model in 2022, is to use geographic indices of social risk such as the Robert Graham Center's (RGC) [social deprivation index](#) (SDI). The RGC SDI is a composite measure of area

level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socio-economic variation in health outcomes. We encourage methodologies like the SDI as they use pre-existing data to not further exacerbate burden on safety net providers.

What types of technical assistance, data, and workforce do safety net providers need to sustain safety net provider participation in CMS Innovation models? What are effective mechanisms for addressing these infrastructure needs?

The existing volume-based payment system for health centers typically does not pay for or support robust activities, such as community health workers or care coordination services that support family physicians' efforts to provide whole-person care within a patient's community. Much of this work in safety net settings, if funded, comes through grants which does not provide practices with predictable, stable revenue streams. Staffing poses additional challenges in these settings as safety nets consistently face staffing shortages and have high turnover due to low wages. This disadvantages patients who require more support and the physicians who care for them. Family physicians cite expanded capabilities to address patients' HRSNs as a primary reason for transitioning to alternative payment models (APMs): they are looking for a payment model that will provide adequate, stable financial support and flexibility to deliver innovative whole-person care to meet patients clinical, behavioral, and social needs. CMMI should consider upfront investments and model on-ramps to better fund safety net practices providing access to critical primary care in their communities.

Safety nets would benefit from additional technical assistance, particularly for technology, data, reporting, and information sharing needs. Often, safety net IT departments may be non-existent or staffed by non-IT personnel, posing challenges when implementing new or updated hardware or software, connecting to regional health information exchanges (HIEs), and setting up registries. Additionally, building and understanding reports from an EHR is time-consuming, burdensome, and can be costly if there is a need for custom reports. Safety nets also face additional reporting burden on top of payer reports due to other reporting requirements based on their funding streams (grants, Uniform Data System, etc.). Considerations for the unique challenges safety net practices face are essential to ensure they are able to successfully transition to VBP. CMMI should invest in technical assistance, shared learning collaboratives, and data infrastructure to support safety net providers in transitioning to APMs and do so in partnership with other payers, both Medicaid and commercial, as much as possible.

We appreciate the opportunity to provide these comments. We look forward to working closely with CMMI to advance the transition to value-based care and improve patients' access to comprehensive primary care. If you or the CMMI staff have any questions or the AAFP may be of further assistance, please contact Kate Freeman, Manager of Market Transformation, at katef@aafp.org or (913) 906-6168.

Sincerely,



J. D. Stewart, MD

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