June 14, 2024

The Honorable Ron Wyden
Chair, Committee on Finance
United States Senate
Washington, DC 20515

The Honorable Mike Crapo
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20515

Dear Chairman Wyden and Ranking Member Crapo:

I write today to convey the response of the Primary Care Collaborative (PCC) to the Finance Committee's May 17, 2024 White Paper "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options." **Recognizing the overwhelming evidence demonstrating that primary care reduces costs and increases positive health outcomes, the PCC and its partners in the Better Health – NOW campaign urge Senators to place primary care at the center of legislation addressing chronic care and Medicare Part B payment**.

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 70 organizational Members ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high-value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships and "upstream" drivers for a better patient experience and better health outcomes. (See the Shared Principles of Primary Care). In March 2022, PCC launched the Better Health – NOW (BHN) campaign to realize bold policy change rooted in one simple principle: We need strong primary care in every community to achieve better health for all. A diverse set of organizations drive the BHN campaign.

Primary Care Can Unlock Powerful Health Improvements and Cost Savings

The evidence base is crystal clear: primary care payment reform can unlock powerful improvements in patient health and real cost savings. High-quality, comprehensive primary care is an essential component that must be part of any national strategy to address chronic physical and mental health conditions and the constant, unaffordable costs they generate. Recognizing these facts, recent reports from both NASEM and CBO provide bedrock evidence of not only the necessity of investing in primary care, but the success – both to people and taxpayers - that comes from doing so.

In their 2021 consensus report, *Implementing High-Quality Primary Care*, the National Academies of Sciences, Engineering and Medicine's (NASEM), **found that "primary**

care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."[1]

In fact, within the Medicare Shared Savings Program (MSSP), **primary care-centric ACOs (those ACOs consisting of 75% or more primary care physicians) reduced preventable downstream costs compared to other ACOs and produced twice the shared savings as other, high-revenue ACOs**.[2] [3]

Today's Medicare Payment Policy Undermines Primary Care Access

Despite these bright spots, our overall health care system's priorities remain out of balance. **America dedicated less than five (4.7) cents of each dollar to primary care in 2021**[4] , a decline from 5.4% in 2014.[5] Across America, the majority of primary care practices report no participation in either shared savings or population-based payment[6] and in 2023, an estimated one in four (28.7%) Americans said they lack a usual source of care.[7]

Medicare Part B is no exception. In fact, status quo Medicare Part B payment policies are the heart of the problem; CMS data indicates the share of Medicare Part B expended on primary care ranges from 2.96 to 5.79% across the fifty states.[8]

The Primary Care Collaborative and Robert Graham Center's 2023 Evidence Report, *Relationships Matter: How Usual is Usual Source of (Primary) Care*, found a growing proportion of patients lack a usual source of care across all sources of coverage, including Medicare. In addition to disturbing disparities observed across states, rural/urban location and racial or ethnic groups, nearly 10% of dually eligible beneficiaries lacked a usual source of care.[9]

---

[1] The National Academies of Sciences, Engineering and Medicine. (2021, May). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Nationalacademies.org. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

[2] *Improve Care in Medicare by Growing Primary Care in ACOS*. Primary Care Collaborative. (2024b, March). https://thepcc.org/resource/improve-care-medicare-growing-primary-care-acos

[3] https://thepcc.org/resource/improve-care-medicare-growing-primary-care-acos

[4] *The health of US Primary Care: 2024 Scorecard Report - No One Can See You Now*. Milbank Memorial Fund. (2024b, February 29). https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[5] https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[6] Horstman, C., & Lewis, C. (2023, April 13). Engaging Primary Care in Value-Based Payment: New Findings from the 2022 Commonwealth Fund Survey of Primary Care Physicians. https://www.commonwealthfund.org/blog/2023/engaging-primary-care-value-based-payment-new-findings-2022-commonwealth-fund-survey

[7] *The health of US Primary Care: 2024 Scorecard Report - No One Can See You Now*. Milbank Memorial Fund. (2024b, February 29). https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[8] CMS Innovation Center. States AHEAD Model Primary Care Investment Methodology-Est. Medicare FFS PC Spend 2021. https://www.cms.gov/files/document/ahead-primary-care-investment-methodology.xlsx

[9] *Relationships Matter: How Usual is a Usual Source of Care*. Primary Care Collaborative. (Nov. 2022). https://thepcc.org/resource/evidence2022?utm_source=link&utm_medium=link&utm_campaign=2022-evidence

As described in the NASEM Consensus Report, "The relative prices set by the Medicare Physician Fee Schedule (PFS) have profound effects on prices paid by Medicaid, commercial payers, and others."[10] Medicare's approach to paying for services relies on expert opinions and surveys to assess relative values and fails to capture the diverse and nuanced factors that affect the value of healthcare services. Leveraging metadata, evidence-based data, and modern data analytics tools may provide a more accurate, comprehensive, and transparent basis for relative value determinations.

The status quo payment approach has contributed to growing health disparities based on geography, race and ethnicity.[11] At a minimum, this persistent under-resourcing of primary care undermines the health of Medicare beneficiaries and the sustainability of the primary care workforce. This persistent underinvestment represents a drain on the entire health care system and contributes to negative health outcomes for millions of Americans. Moreover, because all Medicare Alternative Payment Models (APMs) and most of their commercial counterparts are built upon the Medicare Physician Fee Schedule, shortcomings in Medicare's support for primary care are magnified throughout the nation's entire healthcare ecosystem.

Better Health-NOW greatly appreciates the actions, under existing statutory authority, that CMS has taken to support primary care, including the implementation of the G2211 code to support complex care. Through new models such as ACO Primary Care Flex, and Making Care Primary, the CMS Innovation Center is testing promising approaches that, while limited in duration, offer new pathways for participating primary care practices. The American healthcare payment paradigm, however, has generated unfortunate incentive distortions that systematically undercut investment in primary care available in the underlying Medicare program.[12] Only Congress can provide the leadership and legislative action needed to pursue a better path.

Supporting Chronic Care in the Primary Care Setting – Establish a Hybrid Payment Alternative in Medicare

Better Health – NOW supports – and urges the Committee to consider - efforts to rapidly transition primary care payment from a predominantly fee-for-service (FFS) approach to one based upon prospective population-based payment (hybrid) models. These new models should include upfront and ongoing investments, as well as guardrails to assure quality and access in both rural and underserved communities.

For this reason, we appreciate the Committee's leadership and attention to primary care. **The Finance Committee should advance legislative solutions that make a well-constructed primary care hybrid payment option broadly available,**

---

[10] The National Academies of Sciences, Engineering and Medicine. (2021, May). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Nationalacademies.org. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

[11] McNeely, L., Douglas Megan, Westfall, N., Greiner, A., Gaglioti, A., & Mack, D. (2022). PRIMARY CARE: A Key Lever to Advance Health Equity. The Primary Care Collaborative. https://thepcc.org/sites/default/files/resources/PCCNCPC%20Health%20Equity%20Report.pdf

[12] MedPAC (Medicare Payment Advisory Commission). 2006. Report to the Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission.

alongside the reforms addressing budget neutrality and integration of behavioral and social care in primary care as described below. Under such a hybrid payment approach, payment for a defined set of primary care services would be provided upfront to practices each month, when furnished by primary care clinicians and teams to patients in a primary care setting. This would be coupled with FFS payment for other services not paid for in the population-based payment.

It is critical that establishment of a broadly available hybrid payment option in Medicare Part B not be offset through reductions in primary care reimbursement elsewhere in Medicare. **We therefore urge the Committee to address concerns regarding budget neutrality in the PFS in tandem with the establishment of a hybrid option.** The zero-sum budget neutrality requirements applicable to the Physician Fee Schedule should not be allowed to undermine the scope and viability of substantial reforms to Part B payment, such as the hybrid payment recommended here.

As a first step toward implementation of hybrid payment, it will be necessary to increase the Medicare Physician Fee Schedule budget neutrality threshold to no less than $53 million and to also provide updates at regular intervals thereafter. In this regard, **we urge the Committee's consideration of Section 5 of HR 6545, the bipartisan Physician Fee Schedule Updates and Improvements Act.** Additionally, legislation should establish look-back periods, whereby CMS can correct either over or underestimated utilization assumptions that drive budget neutrality adjustments.

The design and implementation of hybrid payment should invest in primary care capacity, support personalized, team-based care and pay for services tailored to the needs of the patient and the community. Responsive to the questions raised in the white paper, we offer the following six principles which a primary care hybrid payment within Medicare Part B should include:

1. Tier the value of payment based on the scope of services provided.

2. Allow for payment adjustments for clinical and social risk that is sufficient to support multidisciplinary primary care teams reflecting and meeting the needs of diverse populations. Overall payment should reflect a beneficiaries' social risk but avoid reinforcing historical patterns of underutilization driven by poor access to care in both rural and underserved communities (Q2)

3. Make a higher tier payment available to practices that deliver greater levels of integration of behavioral health and social care (e.g. community health integration) (Q1).

4. Incorporate and provide payment sufficient to support evidence-based behavioral health screening as well as referral and screening for the social determinants of health (SDOH). (Q1)

5. Provide for an accountability framework that:
    - Stresses comprehensiveness, first contact access, coordination and continuity

- Supports improvement of care for patient subpopulations facing greater social or economic vulnerabilities, (for example: by tracking utilization and quality by subpopulation)
- Streamlines metrics and avoids duplication or unnecessary measurement burden
- Tracks utilization of services (e.g. in-person evaluation and management visits, behavioral health integration services, SDoH screening and referral, etc.) (Q3)

6. Perhaps most importantly, allow for cost-sharing waivers applicable to primary care services reimbursed through a population-based hybrid payment. (Q4)

By reducing the incentive to maximize billing that is inherent in a fee-for-service system, hybrid payment strikes at a root cause of administrative burden. The documentation burdens required for many Physician Fee Schedule codes add to systemic costs and consume clinician time that could be better spent with patients. These documentation requirements may become less necessary and can be more easily alleviated to the extent the incentive to maximize volume of services delivered is reduced.

Supporting Chronic Care Benefits in Medicare PFS – Enhance Primary Care Affordability

As part of any Medicare payment reform legislation, Congress should remove financial barriers to comprehensive, whole-person primary care — the care beneficiaries need to prevent and/or manage common chronic conditions. **At a minimum, the Committee's legislative work product should include patient cost-sharing waivers for the services provided prospectively as part of any hybrid primary care payment.**

Better Health – NOW also encourages the Committee to work with stakeholders to reform MSSP's Beneficiary Incentive Program (BIP). This program was established in 2018 to help eliminate financial barriers to accessing care. Under the current BIP program structure, an ACO must furnish incentive payments in the same amount to each eligible beneficiary for all qualifying services. However, the program has proven challenging for ACOs to implement. In fact, HHS reported to Congress that as of October of 2023 no MSSP ACOs have established or operated a BIP.[13]

Better Health -NOW also supports:

- ✓ **Eliminating cost-sharing for Medicare's behavioral health integration services (Section 102 of S. 923 the Better Mental Health Care for Americans Act)**

[13] Department of Health and Human Services. REPORT TO CONGRESS Evaluation of the Accountable Care Organization Beneficiary Incentive Program Established in the Medicare Shared Savings Program Under Section 50341(c)(2) of the Balanced Budget Act of 2018. (Oct. 2023). https://www.govinfo.gov/content/pkg/CMR-HE22-00184510/pdf/CMR-HE22-00184510.pdf#:%7E:text=The%20purpose%20of%20the%20BIP%20is%20to%20allow,be%20no%20more%20than%2023%20dollars%20in%202023

- ✓ **Removing cost-sharing requirements for Chronic Care Management codes (HR 2829, the Chronic Care Management Improvement Act).**

These essential behavioral health integration and care management services improve outcomes and care coordination while reducing downstream specialty, outpatient and inpatient costs. Evidence suggests chronic care management[14] and evidence-based models of behavioral health integration[15] do not add to costs and may reduce them. In fact, by discouraging the provision of these services to lower income seniors, we are concerned cost-sharing may exacerbate observed disparities in CCM utilization by dual eligible status and race.[16] Continuing to apply coinsurance and deductibles to care management and behavioral health integration serves only to undermine both Medicare beneficiaries' health status and the fiscal health of Medicare.

Incentivizing Participation in Alternative Payment Models – Reform the Advanced APM Incentive:

Federal statute can and must provide an incentive structure that supports primary care practices in the transition to population-based payment mechanisms. To achieve that goal, however, reform is necessary to the Advanced APM Incentive established under MACRA, which falls short of its original goals. We are particularly concerned that the current A-APM policy reinforces renumeration disparities between primary care and other services. Medicare's current Part B payment policies undervalue primary care while providing higher payment to more intensive services, yet the current policy is based on a percentage of Part B payment. **The Committee should explore basing APM incentives on a percentage of Part B revenue from a Medicare APM rather than overall Part B revenue as required under current statute.**

Incentive payments are currently too small, too far removed from the care delivered to be meaningful, and also lack guardrails in place to ensure money flows to employed primary care clinicians actually delivering care to Medicare. We believe mechanisms should be put in place to ensure that, within practices and other healthcare organizations, the clinical teams delivering primary care share in the financial rewards that accrue from their performance.

Encouraging Quality Care: Accelerate Primary Care - Behavioral Health Integration:

Payment policies that support comprehensive primary care, including the integration of behavioral health, are an important step toward

---

[14] Schurer, J. O'Malley, A., Wilson,C., McCall, N., Neetu, J. *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*. 2017) Mathematica Policy Research. https://innovation.cms.gov/files/reports/chronic-care-mngmt-finalevalrpt.pdf

[15] Wolk, C. B., Wilkinson, E., Livesey, C., Oslin, D. W., Connolly, K. R., Smith-McLallen, A., & Press, M. J. (2023). Impact of the collaborative care model on medical spending. The American journal of managed care, 29(10), 499–502.

[16] Gardner, R. L., Youssef, R., Morphis, B., DaCunha, A., Pelland, K., & Cooper, E. (2018). Use of Chronic Care Management Codes for Medicare Beneficiaries: a Missed Opportunity?. Journal of general internal medicine, 33(11), 1892–1898.

strengthening primary care. The presence of mental health and substance use comorbidities are associated with worse outcomes for a range of chronic physical conditions facing Medicare beneficiaries. Treating those comorbidities is simply indispensable to the effective prevention and management of heart disease, diabetes, kidney disorders and muscular skeletal conditions. Research shows that evidence-based, primary care integration models, such as the Collaborative Care Model and Primary Care Behavioral Health, can successfully improve outcomes while making better use of an overstretched mental health workforce.

Better Health – NOW thanks the Committee for its work to date, and in particular, its support for S. 1378, the COMPLETE Care Act and S. 3157, the More Behavioral Health Providers Act Which were reported out as provisions of the Better Mental Health Care, Lower Cost Drugs and Extenders Act of 2023. These bills certainly have the potential to extend the availability of evidence-based integrated care models. However, faced with the deadly toll of America's mental health and addiction crises, it is incumbent on the Committee to prioritize additional steps as part of its Part B payment reform and chronic care package.

At a minimum, we recommend removing expenditures on Collaborative Care Management (CoCM) and General Behavioral Health Integration codes from the expenditures compared against spending benchmarks in MSSP and other benchmark-based payment models. Accountable payment has the potential to support broader adoption of behavioral health-primary care integration. But because expenditures associated with delivering these services can increase spending over the short-term, benchmark-based payment models like MSSP have a built-in disincentive to the delivery of and billing for integrated behavioral health. The Committee's work to support as many Medicare clinicians as possible in the transition to APMs must not inadvertently reinforce siloed approaches to the management of physical and behavioral health conditions. **Additionally, as noted above, Better Health – NOW supports additional, higher payment tiers as part of a hybrid primary care payment within Medicare.** These tiers would be based on scope of services delivered, such as greater behavioral health integration and ability to address health-related social needs.

_____

Within the U.S. health care system, primary care is the level of care best positioned to reverse the endemic rates of chronic disease and spiraling costs simultaneously facing both Medicare beneficiaries and taxpayers. The need for bold Congressional action to champion primary care and enhance beneficiary affordability could not be more urgent and we thank the Committee for its leadership in developing critical solutions in these areas.

As always, we look forward to continuing to work on a bipartisan basis with the Committee and its Members to strengthen primary care both in Medicare and across the US health system. If you have further questions or would like to speak more in depth on any of these issues, please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org).

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative