July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
Washington, DC 20515

The Honorable Bill Cassidy, M.D.
United States Senate
Washington, DC 20515

Dear Senator Whitehouse and Senator Cassidy:

On behalf of the Primary Care Collaborative (PCC) and the Better Health – NOW Campaign, we appreciate the bipartisan focus you have brought to the acute need for bold reforms of America's primary care financing system. We also appreciate the process you established to solicit stakeholder feedback via a Request for Information (RFI) in conjunction with the introduction of S. 4338, the Pay PCPs Act. PCC and our Better Health – NOW campaign partners believe comprehensive primary care must be at the center of a well-functioning American healthcare system and are pleased to respond to several important issues raised by the legislation and RFI.

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 a strong foundation of primary care: 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 of any national strategy to address chronic physical and mental health conditions and the constant, unaffordable costs they generate.

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] Within the Medicare Shared Savings Program (MSSP), primary care-centric ACOs (those ACOs consisting of 75% or more primary care physicians) dramatically reduced preventable downstream costs compared to other ACOs, producing twice the shared savings as other, high-revenue ACOs.[2] The Congressional Budget Office's (CBO's) 2024 report reviewed the evidence and agreed that, "Medicare ACOs with a higher proportion of PCPs, advanced primary care practices … or patient-centered medical homes… were more likely to generate larger savings."

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**[3], a decline from 5.4% in 2014.[4] In 2023, an estimated one in four (28.7%) Americans said they lack a usual source of care[5] (generally understood to be primary care).

Medicare Part B is no exception. In fact, status quo Medicare Part B payment policies are the heart of our challenge. CMS data indicates the share of Medicare Part B expended on primary care ranges from 2.96 to 5.79% across the fifty states.[6]

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 types of coverage, including Medicare. In addition to disturbing disparities observed across states, rural/urban locations and racial or ethnic groups, nearly 10% of dually eligible beneficiaries lacked a usual source of care.

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

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

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

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

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

[6] CMS Innovation Center, *States AHEAD Model Primary Care Investment Methodology-Est. Medicare FFS PC Spend 2021*. Accessed July 2024. https://www.cms.gov/files/document/ahead-primary-care-investment-methodology.xlsx

Medicare payment policies that underinvest in primary care have an outsized effect across the health care system. 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."[7] 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. In addition, Medicare's current approach exclusively focuses on inputs to determine the value of services; it's approach should also consider the outputs that the various services produce as part of its valuation framework.

As promising as certain primary care payment models have been, they have not reached most Americans' source of primary care. According to a Commonwealth Fund survey, the majority of primary care practices report no participation in either shared savings or population-based payment – and must rely solely on FFS payment mechanisms with all their flaws.[8] Moreover, because all relevant Medicare Alternative Payment Models (APMs) and most of their commercial counterparts are built upon the Medicare Physician Fee Schedule, shortcomings in Medicare policy are magnified – even in the most innovative or promising alternative payment models.

More must be done. Better Health-NOW has appreciated the actions that the Center on Medicare and the CMS Innovation Center have taken to support primary care under its existing statutory authority, including the implementation of the G2211 code to support complex care and opportunities for a subset of Medicare practices to participate in models like ACO PC Flex and Making Care Primary. Nevertheless, due to unfortunate incentive distortions in the underlying Medicare statute that systematically undercut investment in primary care, only Congress can provide the leadership and legislative action necessary for Medicare payment policy reform to strengthen rather than undermine primary care.

Establish a Hybrid Primary Care Payment Alternative in Medicare

Better Health – NOW supports 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. Within 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

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

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

setting. This would be coupled with FFS payment for other services not paid for in the population-based payment.

In a previous Request For Information Response to the May 17, 2024 White Paper published by Senators Wyden and Crapo, we called on the Finance Committee to advance legislative solutions that make a well-constructed primary care hybrid payment option broadly available, alongside reforms addressing budget neutrality and integration of behavioral and social care in primary care described below.

Budget Neutrality

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 encourage you to work with the Finance Committee to address concerns regarding Physician Fee Schedule (PFS) budget neutrality 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 well-designed hybrid payment options.

Principles for a Broadly Available Hybrid Payment Option in Medicare Part B

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. Better Health – NOW has identified six principles which a primary care hybrid payment within Medicare Part B should reflect:

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.

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).

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).

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.)

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

We encourage you to embrace these principles as part of any further refinement of the introduced legislation and any final legislative product. To that end, a clear statement of intent may be helpful as you seek to provide the appropriate level of flexibility to the agency to refine the services and value of the PBPM payment. We encourage you to continue your robust engagement with a variety of stakeholders as the legislation evolves.

Types of Services Included in Hybrid Payment:

As introduced, S. 4338 enumerates several categories of services that may be included in (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management visits, regardless of modality, for new and established patients. While acknowledging that the legislation does not precisely define the parameters of these categories, they can be and frequently are components of high-quality primary care. We are aware of no evidence that inclusion of these services would generate negative impacts on patient care in an otherwise well-constructed hybrid payment approach. In fact, assessing the available evidence, the National Academies of Science, Engineering and Medicine has concluded, "With adequate time, hybrid reimbursement models show improvements in care and reductions in use, particularly for people with multiple complex chronic conditions."[9]

However, we encourage you to ensure that any final legislative language should take the following into consideration:

- Individual practices or clinics participating in hybrid payment should retain the ability to file claims under the fee schedule – either to support specific services not included in the PMPM (e.g. inpatient E & M services) or to support care for beneficiaries who have not been attributed to the practice.
- The Secretary should have the flexibility to designate additional services for inclusion in the PMPM, drawing as appropriate on experience of the Medicare program and other evidence.

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

Cost-sharing Adjustments for Certain Primary Care Services:

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.

As noted above, primary care is the only component of the health system that consistently leads to better outcomes. **To remove barriers to this high-value care any legislation should, at a minimum, include patient cost-sharing waivers of the full coinsurance and deductible for services provided prospectively as part of any hybrid primary care payment.** We know that cost-sharing relief reduces affordability barriers to primary care for individual Medicare beneficiaries – half of whom have incomes under $36,000 a year in 2023 and three in ten of which spent more than half their income on health care in 2022.[10] [11]

However, full cost-sharing relief is also essential if Congress hopes to shift the trajectory of a Medicare program. Today, a vicious cycle of foregoing preventive care, resulting in unnecessary ED visits, and ultimately avoidable hospitalizations end up degrading beneficiaries' health and eroding the fiscal solvency of Medicare. Access to primary care can reverse this pattern. Cost-sharing barriers to that care would only undercut the potential improvements in beneficiary health and long-term Medicare fiscal health.

Studies have shown that patient cost sharing requirements are associated with lower utilization of important primary care and preventive services and increased hospitalizations, thus increasing overall health care spending while disincentivizing high value care.[12] Patient cost-sharing requirements also hinder uptake of existing Medicare codes such as chronic care management. One study found that MPFS billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients.[13] The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.

PCC and our Better Health – NOW partners have recommended additional steps to enhance affordability, including removing cost-sharing for chronic care management and behavioral health integration services. For more information, please see the PCC/BHN response to the Senate Finance Committee RFI.

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[10] Alex Cottrill, Juliette Cubanski, Tricia Neuman, & Karen Smith, "Income and Assets of Medicare Beneficiaries in 2023", kff.org, Kaiser Family Foundation, Feb 5, 2024, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/.

[11] Nancy Ochieng, Juliette Cubanski & Anthony Damico, "Medicare Households Spend More on Health Care than Other Households", kff.org, Kaiser Family Foundation, Mar 14, 2024, https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/

[12] Roberts ET. The Unintended Cost of High Cost Sharing in Medicare—Assessing Consequences for Patients and Options for Policy. *JAMA Health Forum*. 2021;2(12):e213624.

[13] Sumit D. Agarwal, Sanjay Basu, & Bruce E. Landon. "The Underuse of Medicare's Prevention and Coordination Codes in Primary Care: A Cross-Sectional and Modeling Study". *Ann Intern Med*. (2022); 175:1100-1108. [Epub 28 June 2022]. doi:10.7326/M21-4770

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

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

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.

As a needed complement to this reform, Better Health – NOW has urged additional legislative steps to support primary care-behavioral health integration in the underlying Medicare Physician Fee Schedule. These include

- S. 1378 COMPLETE Care Act
- S. 3157 More Behavioral Health Providers Act
- Removing expenditures on the Psychiatric Collaborative Care Model (CoCM) and General Behavioral Health Integration codes from the expenditures compared against spending benchmarks in the Medicare Shared Savings Program

For more information, see the PCC/BHN response to the Senate Finance Committee RFI.

Helping CMS More Accurately Determine Fee Schedule Rates

As you work with others in Congress and the administration to provide primary care with viable alternatives to fee-for-service payment, it remains essential to maintain integrity in the Medicare PFS, ensure patients receive high-quality care, and determine accurate payment.

Need to Improve Data Informing CMS Decisions

We remain concerned that existing sources of information tend to value codes primarily on the basis of physical skill or technology used, while undervaluing cognitive services necessary for the management of complex patients with multiple chronic illnesses (i.e., critical thinking involved in data gathering and analysis, including understanding patient needs and preferences, planning, management, decision making, and exercising judgment in ambiguous or uncertain situations).

In fact, one study found that Medicare reimburses physicians 3 to 5 times more for common procedures than for cognitive care. In that study, the authors demonstrated

that two common specialty procedures, cataract extraction and screening colonoscopy, can generate more revenue in one to two hours of total time than primary care receives for an entire day's work.[14] Although cognitive services are not procedure-intensive (e.g., the work involved in a spinal tap), such services are increasingly labor intensive due to technological innovations, substantial amounts of data to review, and the coordination of different services both across primary care teams and across settings of care, (e.g., care coordination for a high-risk patient). While clinicians who primarily provide procedural services also provide a degree of cognitive care, those who almost exclusively provide cognitive care are deprived of an appropriate accounting due to the reliance on the metrics of time, intensity, and practice expense alone.

At present, CMS often relies on Relative Value Update Committee (RUC) recommendations on the "resources needed to provide medical services" including time, intensity, clinical staff time, medical supplies, and professional liability. However, a focus on inputs alone may have contributed to less of the output Medicare beneficiaries and the Medicare program need most. To illustrate, a discussion of vaccination or smoking cessation with a trusted primary care clinician can require fewer inputs than specialty procedures (i.e., no medical supplies or fewer ancillary staff), but have the potential to generate comparable or even greater outputs for patients.

Importantly, these fundamental biases are averse to the critical role that primary care plays in health care and necessary reform to support the provision of continuous, patient-centered, relationship-based care. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels.
While Better Health – NOW organizations have a variety of perspectives on these challenges and optimal solutions, we encourage your offices to continue to dialogue with the individual primary care stakeholders represented among our participating organizations as you seek to understand and craft solutions.

Considering Payment in Light of Broader Access and Workforce Challenges

As the National Academy of Science Engineering and Medicine (NASEM) report points out, the nation's health is directly linked to the strength of its primary care delivery system and workforce. Unfortunately, the systemic undervaluing of cognitive (including primary care) services is problematic and widespread. As the current payment system drives down the value of primary care, there has been an attrition in the number of physicians practicing primary care, with a greater proportion of trainees choosing to go into procedure-based specialties. PCC's latest evidence report, *Health is Primary*, finds that the impacts of this attrition are shrinking the overall supply of primary care clinicians, even when the growing Advanced Practice Nursing and Physician Associate workforce is considered.[15] The primary care shortage will, and has had, a profound impact on the availability, access and quality of care and patient health outcomes,

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[14] Christine A. Sinsky & David C. Dugdale. "Medicare payment for cognitive vs procedural care: minding the gap". *JAMA internal medicine*, 173(18) (2013): 1733–1737. https://doi.org/10.1001/jamainternmed.2013.9257

[15]. Ann Greiner et al. "Health is Primary: Charting a Path to Equity and Sustainability", Thepcc.org, Primary Care Collaborative, Nov. 2023, https://bit.ly/PCCEvidenceReport2023

particularly for the nation's most vulnerable elderly patients with complex chronic conditions.

How Else Can CMS Take a More Active Role in Medicare Rate Setting:

We also remain concerned that CMS has routinely overestimated the utilization of new Medicare billing codes that were added to the fee schedule. The most prominent example of CMS overestimating utilization assumptions related to code revaluations occurred when transitional care management (TCM) services were added to the PFS in 2013. CMS estimated 5.6 million new claims would be submitted for these services. Actual utilization, however, turned out to be just under 300,000 claims for the first year and it was still less than one million claims after three years. As a result of this overestimation for TCM services alone, Medicare physician payments were reduced by more than $5.2 billion from 2013 to 2021. Congress should direct the Government Accountability Office (GAO) to conduct a study and report back to Congress on the utilization estimates and actual payments incurred from the implementation of new Medicare codes by the Centers for Medicare and Medicaid Services (CMS).

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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, which are simultaneously having a negative effect on both Medicare beneficiaries and taxpayers.

As always, we look forward to continuing to work on a bipartisan basis with you 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