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Convening + Uniting + Transforming

PCC Better Health NOW Committee Meeting

Tuesday, March 18, 2025 | 2:30 – 3:30 PM ET

agenda

I. Welcome & Announcements	Larry McNeely, Primary Care Collaborative
II. Sharing Insights and Intel from Hill and HHS	Larry McNeely, Primary Care Collaborative All Participants
III. Improving Medicare Valuation & NASEM's Standing Committee on Primary Care	Asaf Bitton Ariadne Labs

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Welcome & Announcements

Larry McNeely | Primary Care Collaborative

Save the Date



CALENDAR HOLD

June 4-5, 2025
Washington, DC

Chronic Care Issue Brief

- Releasing **February 27** via email, social media and our website
- Explains how primary care plays a major role in **preventing and treating** chronic illness
- Emphasizes the need to treat the whole person – including behavioral and mental health
- Demonstrates how **fee-for-service** has failed primary care and **undermines chronic care**
- Provides policy makers with bipartisan, pragmatic solutions – such as hybrid payment – that can be implemented to address chronic conditions by strengthening primary care

PCC / BHN Policy Activity

- PCC/BHN Letter of Support for the COMPLETE Care Act
- Letter to HHS Secretary on Chronic Care & Medicare Payment Reform
- PCC Statement: *PCC Urges Congress to Reconsider Budget's Impact on Medicaid*
- The House passed H.R. 919 - the Chronic Disease Flexible Coverage Act

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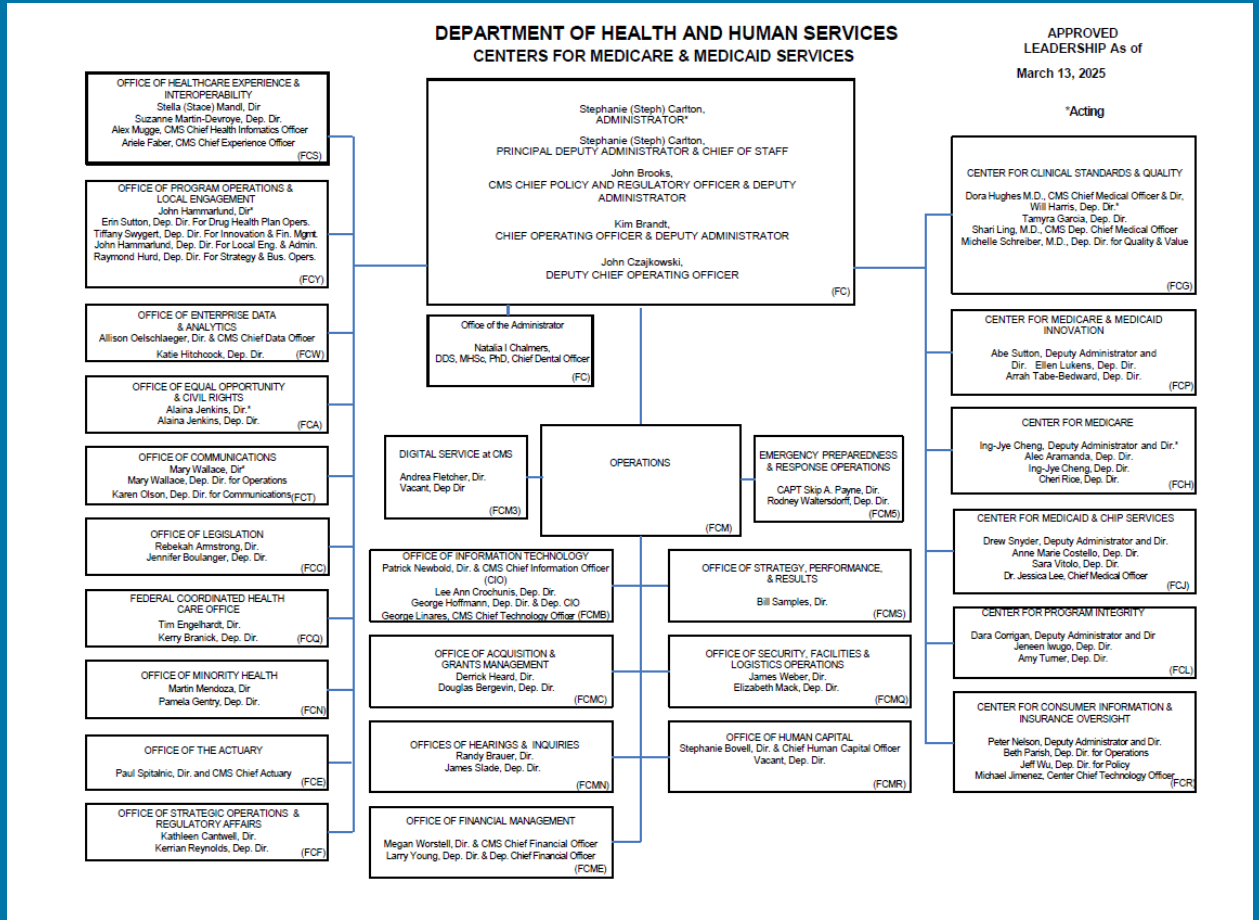
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Sharing Insights and Intel from Hill and HHS

Larry McNeely | Primary Care Collaborative

All Participants

CMS Leadership Team



CMMI Model Cancellations

- Making Care Primary
- Primary Care First
- Accelerating Clinical Evidence
- ESRD Treatment Choices
- Integrated Care for Kids
- Maryland Total Cost of Care
- Medicare $2 Drug List

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Improving Medicare Valuation & NASEM's Standing Committee on Primary Care

Asaf Bitton | Ariadne Labs

ARIADNE LABS

March 19, 2025

PCC Better Health – Now

Primary Care Payment Reform

Asaf Bitton, MD, MPH

Executive Director, Ariadne Labs

Harvard School of Public Health | Brigham & Women's Hospital



Primary Care Faces a Broken Production Model

20th Century Payment



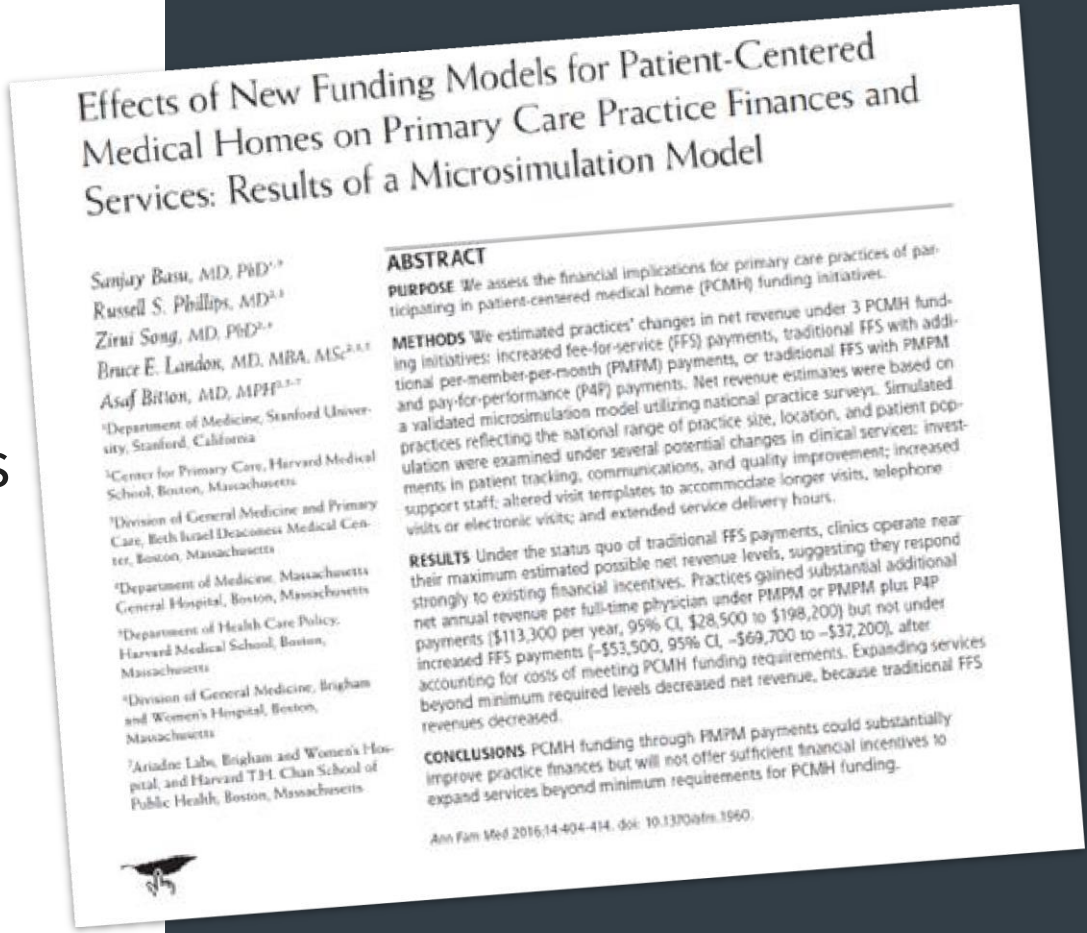
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21st Century Primary Care



Doing the Math

You can't run an Advanced Primary Care Practice on a FFS chassis



Effects of New Funding Models for Patient-Centered Medical Homes on Primary Care Practice Finances and Services: Results of a Microsimulation Model

Sanjay Basu, MD, PhD[1,2]
Russell S. Phillips, MD[2,3]
Zirui Song, MD, PhD[2,4]
Bruce E. Landon, MD, MBA, MS[2,3,5]
Asaf Bitton, MD, MPH[2,5,6,7]

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[4]Department of Medicine, Massachusetts General Hospital, Boston, Massachusetts
[5]Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts
[6]Division of General Medicine, Brigham and Women's Hospital, Boston, Massachusetts
[7]Ariadne Labs, Brigham and Women's Hospital, and Harvard T.H. Chan School of Public Health, Boston, Massachusetts

ABSTRACT

PURPOSE We assess the financial implications for primary care practices of participating in patient-centered medical home (PCMH) funding initiatives.

METHODS We estimated practices' changes in net revenue under 3 PCMH funding initiatives: increased fee-for-service (FFS) payments, traditional FFS with additional per-member-per-month (PMPM) payments, or traditional FFS with PMPM and pay-for-performance (P4P) payments. Net revenue estimates were based on a validated microsimulation model utilizing national practice surveys. Simulated practices reflecting the national range of practice size, location, and patient population were examined under several potential changes in clinical services: investments in patient tracking, communications, and quality improvement; increased support staff; altered visit templates to accommodate longer visits, telephone visits or electronic visits; and extended service delivery hours.

RESULTS Under the status quo of traditional FFS payments, clinics operate near their maximum estimated possible net revenue levels, suggesting they respond strongly to existing financial incentives. Practices gained substantial additional net annual revenue per full-time physician under PMPM or PMPM plus P4P payments ($113,300 per year, 95% CI, $28,500 to $198,200) but not under increased FFS payments (−$53,500, 95% CI, −$69,700 to −$37,200), after accounting for costs of meeting PCMH funding requirements. Expanding services beyond minimum required levels decreased net revenue, because traditional FFS revenues decreased.

CONCLUSIONS PCMH funding through PMPM payments could substantially improve practice finances but will not offer sufficient financial incentives to expand services beyond minimum requirements for PCMH funding.

Ann Fam Med 2016;14:404-414. doi: 10.1370/afm.1960.

A Way Forward for Payment

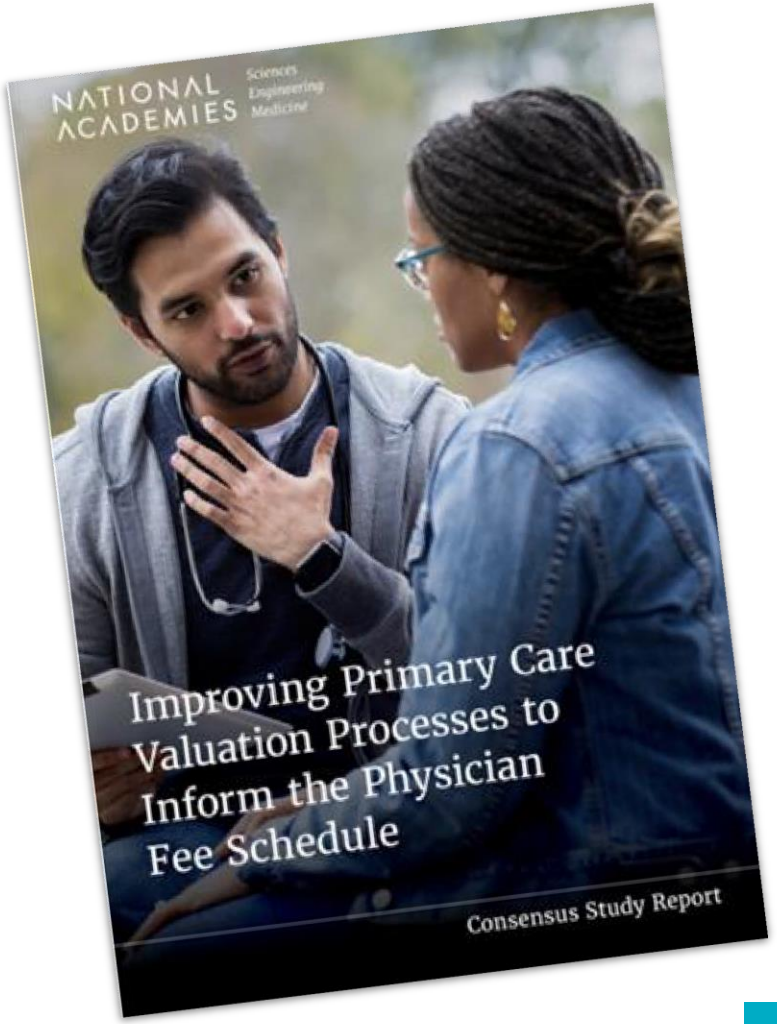


The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Improving Primary Care Valuation in Medicare

In late 2024, the National Academies Standing Committee on Primary Care was tasked with reviewing how CMS values primary care in the Physician Fee Schedule.

The committee examined current valuation methods and systemic flaws impacting primary care, with recommendations on a way forward.



Recommendation 1: Enhance Data for Physician Service Valuation

CMS should use a broader range of directly observed and reported data sources.

DATA SHOULD INCLUDE

- Electronic health record (EHR) audit logs
- Time-motion studies
- High-quality surveys

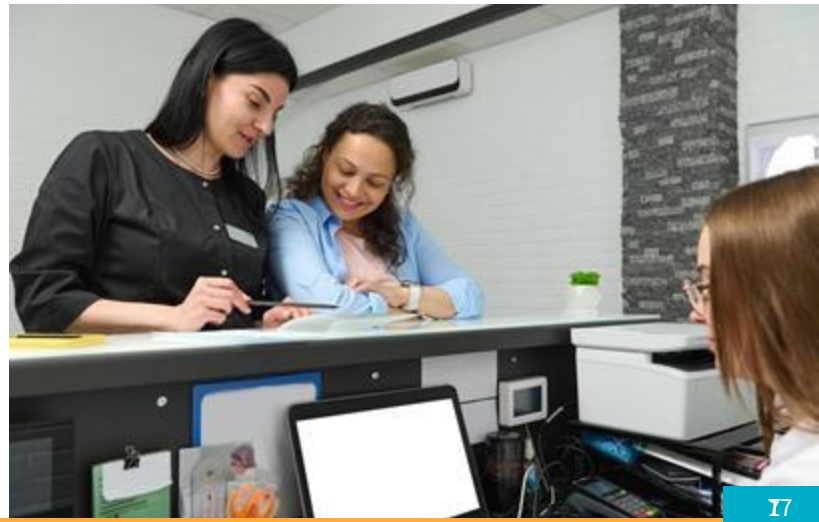
ANALYSIS SHOULD INCORPORATE METHODOLOGIES

- Time-driven activity-based costing
- Large language modeling

Recommendation 2: Expand Primary Care Valuation

- CMS should account for full range of value-enhancing primary care activities and services
- Include the efforts of the full interprofessional primary care team
- Include non-encounter-based work





Recommendation 3: Broaden Expert Input in CMS Valuation

- CMS should invite additional expert technical and advisory groups beyond the Relative Value Scale Update Committee.
- Options include:
  - Forming a separate internal or external expert group.
  - Involving contractors or researchers for independent analyses.



Recommendation 4: Strengthen APCM Evaluation

- CMS should annually assess Advanced Primary Care Management (APCM) to ensure accurate valuation.
- Evaluation should examine:
  - Usage of new APCM codes by practices.
  - Extent of beneficiary consent rates for APCM billing.
  - Sociodemographic characteristics of patients receiving APCM services.
  - Potential unintended consequences of APCM implementation.

CMS should take care not to rush to expand APCM payments without fully understanding uptake challenges and impact on alternative payment models such as accountable care organizations.

Thank You

Asaf Bitton, MD, MPH
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ARIADNE LABS is a joint center for health systems innovation at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health.

Brigham and Women's Hospital
Founding Member, Mass General Brigham

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EXTRA SLIDES

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Possible Primary Care Futures

"DEVOLUTION"

- Retail / Virtual / Urgent Care clinics
- Concierge care + Segmentation
- Widespread access/equity/workforce pitfalls

"EVOLUTION"

- What comes after the Patient-Centered Medical Home
  - high variation & continued new market entrants to fill gaps left by workforce shortage and high patient needs
- Incremental payment reform on FFS chassis using electronic quality measures

"REVOLUTION"

- Advanced Integrated Primary Care Teams Through Payment Reform and Care Model Innovation, Addressing Population Health & Social Drivers of Health
- Measure What Actually Matters / Better IT + AI / Prospective Risk-Adjusted Global Payment



Proposition: The Demise of Primary Care Has Been Too Often and Erroneously Foretold….

Every high-performing health system in the US and the world has a strong primary care foundation

There are proximal tipping points that can supercharge the ability to deliver better primary care

- Prospective Payment
- AI / EHR reform

People (and companies, and some countries) will pay for high-quality primary care when they know they will get it (i.e. concierge, PE, employer-based)

There are medium term shifts in workforce composition that can enable teams to care for people

- **What's the counterfactual to primary care??**

Areas Needing Near-Term Research & Policy Change

1. How can primary care work (especially by integrated teams) be valued differently and adequately?
2. How to translate and transmit prospective payment into MA and commercial plans?
3. What are effective ways for engaging purchasers to drive primary care investments and payment change?
4. What are effective models that leverage the growing NP/PA workforce better (i.e. networks of care) while prioritizing continuity?
5. How to catalyze safe, equitable, and effective uses of AI to create time and space for primary care teams to do more than document?
6. What are the best ways to scale what already works in primary care?