



July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
530 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

RE: Feedback on the Pay PCPs Act

Senators Whitehouse and Cassidy,

Thank you for the opportunity to respond to your Request for Information (RFI) regarding the Pay PCPs Act.¹ I appreciate your leadership on this effort to strengthen primary care payment.

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable. I lead our Delivery System Reform program with a focus on strengthening primary health care, particularly for underserved populations.

Primary care is the only health service [associated with](#) improved life expectancy and reduced health care disparities. Evidence is clear that improving the capacity and quality of primary care so that it can improve the health and wellbeing of persons and whole populations is essential to successfully addressing the nation's most pressing health crises. Patients with a usual source of care [are more likely](#) to receive recommended preventative screenings and services and primary care has been found to [improve detection, management, and outcomes](#) for people with diabetes, cardiovascular disease, and hypertension.

But in the U.S., several indicators suggest that the sustainability and future of primary care is at risk. [Three in ten people](#) report not having a usual source of care – a declining number, despite increased access to insurance. Compared to other high-income countries, U.S. patients are [among the least likely](#) to have a usual source of care or a longstanding relationship with a primary care provider. This trend is only likely to worsen as the supply of primary care providers shrinks, particularly in communities with historically few primary care clinicians, such as rural areas.

¹ The views presented here are those of the author and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

There is growing consensus that changing *how* and *how much* we pay for primary care is a critical next step for policymakers to reverse these trends and strengthen primary care in the U.S. As the National Academies for Sciences, Engineering, and Medicine (NASEM) identified in their 2021 landmark report “[Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#)”, which the Commonwealth Fund co-funded, the growing issues facing primary care — including workforce shortages and poor access — are in large part due to the continued [dominance of fee-for-service](#) (FFS) payment, which discourages team-based, coordinated care, and decades-long underinvestment.

As one of the largest insurers in the U.S., Medicare plays a critical role in leading the charge by increasing our nation’s investment in primary care services and changing the way we pay for them, moving towards more population-based approaches. Congress has the opportunity to implement specific changes to the Medicare Physician Fee Schedule (MPFS) to act on the evidence and expert opinion from the NASEM report.

Below we respond to select questions from your RFI. For each of the below, Congress can consider the recent Supreme Court decision, *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, by consulting with relevant agencies about what authorities may need to be explicitly codified in legislative language so that any policies passed by Congress are able to be implemented.

Hybrid Payments for Primary Care Providers & Cost-Sharing Adjustments for Certain Primary Care Services

Background

Population-based, prospective payments are critical for giving clinicians greater flexibility to innovate, budget, and more easily coordinate care with other providers. These payment approaches have been tested in several large-scale primary care reforms by the Centers for Medicare and Medicaid Innovation (CMMI) including Comprehensive Primary Care, Comprehensive Primary Care Plus (CPC+), and Primary Care First. In evaluations of these models, [participating practices](#) emphasized that reliable prospective payments were invaluable for budgeting, hiring staff, and providing services otherwise not paid for. Interviews with practices in these models revealed that prospective payments were particularly important during the COVID-19 pandemic. By giving practices stable, consistent revenue, they protected against staff layoffs and allowed practices to maintain critical service delivery, like care management and care coordination for high-need patients, with minimal financial losses.

Evidence suggests that reorienting our current health care spending towards primary care and shifting to prospective, population-based payment approaches could reduce high-cost forms of utilization like emergency department visits and inpatient hospitalizations while improving outcomes of Medicare beneficiaries, including those with chronic conditions. [Several analyses](#) have found a correlation between an increased supply of primary care physicians and lower total costs of health services, including in Medicare. [Another study](#) found that one additional primary

care physician per 10,000 people leads to 5.5% fewer hospital visits, 11% fewer emergency department visits, and 7% fewer surgeries. The CPC+ program, which included per-member, per-month payments similar to those proposed in this response, was beginning to produce small reductions in total Medicare expenditures in its fourth year, [with evaluators noting](#), “If this trend is sustained or becomes stronger in performance year 5, CPC+ could show cost savings even after accounting for the enhanced payments.”

The private sector, recognizing the benefits of prospective, population-based payments for primary care, have engaged as well. [Over 20](#) private payers participated in CPC+, and commercial payers have [successfully launched](#) separate models and initiatives.

CMMI recently announced two new models which will again test prospective, population-based payments for primary care including ACO Primary Care Flex and Making Care Primary, but [experts](#) have called for enabling these payments in the MPFS and making them available to all primary care clinicians. Congress can implement the recommendations of the NASEM report and enable hybrid payments for primary care - which combine prospective, population-based payment and FFS - in the MPFS. To do so, as the Pay PCPs Act calls for, Congress can grant CMS the authority to pay population-based payments for primary care clinicians’ attributed patients on top of billing for individual patient services under the MPFS.

Responses to Select RFI Questions:

1) What factors should Congress be considering when setting risk adjustment criteria?

As indicated in the legislation, Congress can direct CMS to adjust population-based payments to reflect the health and social complexity of primary care clinicians’ attributed patients. Congress could specifically call for CMS to leverage validated, readily available community-level measures of [social risk or social deprivation](#), which [have successfully been](#) added to risk adjustment methodologies, including in Massachusetts’ Medicaid program and Maryland’s all-payer program, and which are currently being pilot tested in the [ACO REACH model](#).

2) The legislation proposes to allow the Secretary to define quality measures for hybrid payments and suggests four which may be pursued: (1) patient experience, (2) clinical quality measures, (3) service utilization, including measures of rates of emergency department visits and hospitalizations, and (4) efficiency in referrals, which may include measures of the comprehensiveness of services that the primary care provider furnishes.

- a. Are these quality measures appropriate? Which additional measures should Congress be considering?**
- b. What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?**

While the proposed categories of quality measures are appropriate, Congress can further reduce reporting and administrative burden of primary care providers while improving the delivery of care for patients by directing CMS to apply a parsimonious set of quality measures. In a hybrid model, which has a goal of reducing adverse effects of pure payment models - including excessive care in FFS and stinting in pure population-based payments - reliance on quality measures is less to assure accountability. Therefore, Congress can move to a reduced, parsimonious set of quality measures, thereby reducing administrative burden.

In addition to limiting the number of quality measures applied, Congress can direct CMS to develop new or leverage existing measures which capture the core tenets and value of primary care delivery such as care coordination, comprehensiveness, accessibility, and patient experience.

Finally, Congress can direct CMS to base quality measures on lessons learned from previously tested primary care demonstrations at CMMI and align the measures as much as possible with other models to reduce the burden of managing various program requirements among PCPs participating in multiple models.

3) The legislation allows the Secretary to include four types of service in hybrid payments: (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.

- **Is this list of services appropriate?**
 - **Are there additional services which should be included?**
 - **Are there any services which should be excluded?**

The proposed list of services is appropriate. Experts have noted that population-based payments could cover primary care services not necessarily linked to office visits which currently carry high documentation burden, such as care management and coordination; services that most primary care providers deliver that would benefit from reduced volume-based incentives and increased delivery flexibility, such as minor office procedures and common labs and tests; and services primary care providers need greater resources and flexibility to provide, like communicating with patients and caregivers. As noted in the legislation, to simplify administrative burden while mitigating volume-based incentives and fraud, population-based payment could also apply to telehealth services as well as electronic communication with patients which cannot be accurately or effectively paid FFS. Congress could further include services to address patients' social needs as covered by the per-member, per-month payment.

Services that could be excluded from the population-based payment and which could continue to be paid FFS include those which are underprovided, preventative, and

clinically essential services where volume-based incentives are appropriate, such as immunizations.

4) Besides, or in addition to, cost-sharing reduction, what strategies should Congress consider to make the hybrid payment model attractive for beneficiaries and providers?

For the hybrid payment model to work as envisioned, [experts have suggested](#) that total primary care payment would need to be substantially higher than the [3.9% of Medicare expenditures we currently spend on primary care](#). Congress can establish targets to increase average revenues of primary care practices, which would serve to make the hybrid payment model attractive for providers and to ensure population-based payments are sufficient for primary care providers to sustainably and comprehensively deliver needed services. Increases in primary care payment could be achieved by reducing significantly overvalued procedures (see below section).

**Technical Advisory Committee to Help CMS
More Accurately Determine Fee Schedule Rates**

Background

As recent Medicare Payment Advisory Commission (MedPAC) [meetings and reports](#) confirm, primary care clinicians [are paid substantially less than specialists](#). Services that primary care clinicians commonly provide, like [evaluation and management \(E&M\)](#), are [undervalued](#) and therefore not sufficiently supplied by clinicians while others, such as care coordination, are not paid for at all. This is contributing to growing shortages of primary care physicians, with the number of primary care physicians per capita [declining](#).

There are common reasons [experts](#) have identified for this undervaluation of primary care services in Medicare. The Relative Value Scale Update Committee (RUC), which makes recommendations to CMS on updates to Relative Value Units (RVUs) in the MPFS, is dominated by specialists with few primary care and other non-procedural clinicians represented. In addition, the current process the RUC employs to inform its RVU recommendations relies heavily on [flawed estimates](#) of practice expenses and clinician time and work compiled through burdensome surveys completed by clinicians as opposed to empirical, reliable data. These surveys have been criticized by the [Governmental Accountability Office](#) for low response rates, biased survey samples, and concerns about conflicts of interest, as those completing the surveys could benefit from inflating estimates of the time and work required for procedures they deliver.

As the NASEM report and the Pay PCPs Act calls for, to fix distortions in the MPFS and [increase investment in primary care](#), Congress can direct the Secretary of HHS to establish a new Technical Advisory Committee (TAC) to provide guidance on developing processes for determining relative resources, consistent with current statutory authority.

Responses to Select Questions

1) Will the structure and makeup of the Advisory Committee meet the need outlined above?

The legislation calls for the TAC to be comprised of members with diverse expertise and specifically calls for primary care providers and those with technical expertise in Medicare payment policies to be included. In addition to these considerations, Congress can call for the Secretary to include members with backgrounds in health economics, clinical medicine, research design, and payment policy as well as former members of the RUC, and those with operational experience as claims payers for public and/or private insurers.

In contrast to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) which reports to the Secretary of HHS, and as noted in the legislation, experts have suggested it is critical the TAC be placed within CMS to ensure they can work cooperatively and closely.

2) How else can CMS take a more active role in FFS payment rate setting?

As noted in the legislation, to ensure CMS has a more active role in FFS payment rate setting, the TAC could be tasked with the following:

- Establish a new process to more accurately and empirically determine RVUs, including the identification and development of data collection and valuation tools to identify over- and underpriced services. For example, to obtain empirical data on physician time and work, CMS could establish a rotating panel of practices to source timely and objective information for determining RVUs. This could be collected through administrative data extracted from electronic health records for some services and through direct observation of practice or physician staff to document the time needed to provide services to patients.
- Guide CMS' development of a research agenda to inform fee schedule design, including testing and evaluating new coding and payment approaches.
- Identify strategies to simplify the fee schedule by collapsing the current 8000 service codes into a smaller number of payment code "families" with similar time and work valuations for related services (such as 21 different types of colonoscopies).

Thank you again for the opportunity to review and offer feedback. I am happy to discuss my comments with you at your convenience.

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