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**Feedback**

"Bolstering Chronic Care Through Physician Payment:
Current Challenges and Policy Options in Medicare Part B"
White Paper
United States Senate Committee on Finance
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Thank you for the opportunity to submit feedback on the Senate Committee on Finance's Bipartisan White Paper, "Bolstering Chronic Care Through Physician Payment: Current Challenges and Policy Options in Medicare Part B".

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, including:

- Ending the decline in life expectancy in the U.S.;
- Addressing increased rates of chronic illness;
- Reducing the cost of health care for patients and families;
- Advancing health equity;
- Addressing a burgeoning mental health crisis;
- Responding to the opioid epidemic; and
- Identifying and mitigating the next health-related emergencies, including pandemics.

But in the U.S., several indicators suggest that the sustainability and future of primary care is at risk. According to the National Scorecard on the Health of Primary Care, the percent of people that report having a usual source of care is declining, even as access to health insurance has increased, with three in ten people now reporting not having a usual source of care. 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. Between 2012 and 2020, only one in five medical residents selected primary care and we are training more clinicians in hospitals rather than community settings, contributing to shortages particularly in rural and underserved areas.

**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 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 the Senate Finance Committee's White Paper.

## Incentivizing Participation in Alternative Payment Models

1. Should the bonus continue to require participation thresholds, or modify or eliminate thresholds to allow for greater participation? How?
2. Are there other A-APM programmatic designs that would make participation more attractive for providers?
3. How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options?
4. How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?
5. What programmatic flexibilities, with respect to A-APMs or smaller models or pilots, would help to ensure a broader and more diverse array of options for clinicians?

**Background**

The Medicare Access and CHIP Reauthorization Act (MACRA) made substantial progress towards moving providers to alternative payment models (APMs). But the program faced many barriers in implementation. The Merit-Based Incentive Payment System (MIPS) financial incentives have not effectively encouraged service reduction or lowering of costs - and the reporting requirements have been criticized for being overly burdensome while not meaningfully improving quality.

Given the design flaws with MIPS and the promise of APMs, experts have called for changing the Advanced APM (A-APM) pathway to bolster participation. There were several provisions in MACRA which limited A-APM provider participation, such as only allowing providers taking on downside risk to qualify for the A-APM pathway, requiring high percentages of Medicare Part B payments received through A-APMs or percent of Medicare patients seen through A-APMs to qualify, and A-APM bonuses being insufficient to encourage A-APM participation.

**Policy Options**

To encourage greater participation in A-APMs, particularly among smaller, rural, or independent primary care practices, Congress can consider the following:

- Offer higher bonuses for A-APM participation. This could be achieved without additional resources by cutting the size of MIPS bonuses, with the savings reallocated as per-beneficiary payments to providers participating in A-APMs.
- Expand the A-APM pathway to include less advanced APMs. For instance, Congress could consider developing tiers within the A-APM pathway that offer smaller bonuses for upside-only APM participation and larger for those that include downside risk (with MIPS having

the smallest bonuses). This would provide a continuum and support a broader array of providers in their move to A-APMs.
- Offer upfront, advanced payments to support participation in A-APMs, drawing on lessons from the ACO Investment Model.
- Lower or eliminate A-APM participation thresholds (i.e. percentage of Medicare Part B payments received through the A-APM or percent of Medicare patients seen through A-APM) to enable more providers to participate.

## Supporting Chronic Care in the Primary Care Setting & Supporting Chronic Care Benefits in FFS

1. In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?
2. Should a hybrid model design include a hybrid-specific risk adjustor for primary care?
3. Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?
4. What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?

**Background**

As the frontline of our health care system and the source of comprehensive, coordinated care, primary care is critical for the early detection and management of chronic disease. Evidence has found that patients with a usual source of care are more likely to receive recommended preventative screenings and services, both of which are critical for chronic disease management. And, primary care has been found to improve detection, management, and outcomes for people with diabetes, cardiovascular disease, and hypertension.

Population-based, prospective payments are critical for enabling clinicians to effectively address rising chronic disease by giving providers 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.

**Policy Options**

To support chronic care, Congress can implement the recommendations of the NASEM report and enable hybrid payments for primary care - which combine prospective, population-based payment and fee-for-service - in the MPFS. Options Congress can consider include:

- 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:
    - Population-based payments could cover activities primary care providers need greater resources and flexibility to provide, like addressing social needs and communicating with patients and caregivers; 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 not necessarily linked to office visits which currently carry high documentation burden, such as care management and coordination.
    - 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 fee-for-service.
    - Fee-for-service could continue to apply for underprovided, preventative, and clinically essential services where volume-based incentives are appropriate, such as immunizations.
- To ensure population-based payments are sufficient for primary care providers to sustainably and comprehensively deliver needed services, establish targets to increase average revenues of primary care practices and direct CMS to adjust population-based

payments to reflect the health and social complexity of primary care clinicians' attributed patients.
- To assist with patient attribution to primary care clinicians, direct the Secretary of HHS to establish a process for individuals to designate a primary care provider as their usual source of care on an annual basis, and as an incentive for doing so, waive any Medicare Part B beneficiary cost-sharing for services delivered by that provider.

## Ensuring the Integrity of the PFS

1. What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS's RVU and rate-setting processes?
2. For more than 25 years, a Refinement Panel provided a relative value appeals process for CMS's annual PFS processes. Should the agency consider reinstating such a panel, and if so, what modifications, if any, would help to ensure independence, objectivity, and rigor?
3. What third-party entities could produce the most credible and reliable analysis of CMS's RVU determination and rate-setting processes, and what key areas should such analysis examine?

**Background**

The portion of health care dollars going to primary care is low and decreasing over time across payers, with the U.S. spending an estimated 4-6% of total health expenditures on primary care. In Medicare, studies find primary care represents roughly 3% of spending despite the greater needs for care coordination and management of chronic conditions in the Medicare beneficiary population.

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 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.

**Policy Options**

As the NASEM report recommendations called for, to fix distortions in the MPFS and increase investment in primary care, Congress can direct the Secretary of HHS to establish a new expert advisory panel within CMS to provide guidance on modernizing the fee schedule. This group could:

- 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).
- Be comprised of 10-12 members with diverse expertise relevant to the fee schedule including health economics, clinical medicine, research design, and payment policy - and include practicing physicians, former members of the RUC, and those with operational experience as claims payers for public and/or private insurers.