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

Submitted via email to physician_payment@cassidy.senate.gov

RE: Request For Information on Primary Care and the Pay PCPs Act

Dear Senator Whitehouse and Dr. Cassidy,

United States of Care (USofCare) is pleased to submit the following comments in response to your Request for Information on primary care and S.4338, the Pay PCPs Act. We appreciate the opportunity to provide feedback as you consider changes to primary care physician payment that accelerates the transition toward accountable care in order to lower costs, improve health outcomes, support primary care providers, and prioritize patients.

USofCare is a nonpartisan, nonprofit organization working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from real people engaging with the health care system to amplify on both the state and federal levels.

Our listening work has shown that people desire affordable, high-quality health care. They crave more time with providers and an approach in which their providers communicate with each other to provide them with more personalized, holistic care, involving the patient in the decision-making process. We call this "patient-first care" (or value-based care) to underscore the importance of patient engagement and involvement before, during, and after care delivery and model development.

> *"I'm thinking that if you get into the performance part of it …somebody come in and they got issues instead of prescribing them medicine they'll say hey 'Can you go to a gym? Can you take this? Let's look at your diet… maybe you eat too much of this, try this, try that'. Instead of being so quick to give out pills… That is what I really think it's about, really take the time to know you versus insurance, 'if I do this extra procedure, I'll get paid for it.'"*
> *~ Black patient who has had mostly negative experiences receiving health care*

Any shift toward patient-first care must be rooted in primary care. USofCare applauds the Congressional focus on efforts to promote access to comprehensive,

longitudinal primary care for all people through Medicare primary care payment reform. Primary care is the foundation of the health care system. Certain providers, including family physicians, nurse practitioners, and physician assistants, are trained to provide comprehensive primary care services for patients and may coordinate care with specialists, treatments, medications, and social supports to improve overall health. Greater access to primary care improves health outcomes, lowers overall costs, and can narrow health inequities for both people and the health care system at large.

Despite these demonstrated benefits, primary care has long been subject to chronic underinvestment in the United States. The U.S., on average, spends approximately one-third of that of what other high-income countries spend on primary care. Primary care is the preferred point of entry into the health care system for many, including for people of color and individuals with limited English proficiency; more primary care physicians practice in rural areas than non-primary care physicians. It is evident that increased investment into primary care is direly needed. Senator Cassidy's 2018 white paper entitled "Ideas to Make Health Care Affordable Again" calls for a realigning of the health care system to "focus on prevention, primary care, and the social determinants of health that lead to bad outcomes and expensive chronic conditions." **We encourage Congress to pursue meaningful investments in primary care in order to build upon this recommendation.**

We urge Congress to incorporate the many lessons learned from states that are focused on supporting primary care. States like Louisiana have engaged in many initiatives to strengthen primary care, such as through participation in the Comprehensive Primary Care Plus (CPC+) model and by establishing patient-centered medical homes (PCMHs) to reduce costs and improve outcomes. Similarly, Senator Whitehouse's home state of Rhode Island has been a pioneer within this space, becoming the first state to require issuers to invest more in primary care. The results speak for themselves – Rhode Island has a higher rate of primary care providers per capita and a higher percentage of people with regular access to primary care.

The Pay PCPs Act is one of a growing number of legislative and regulatory proposals to build on and improve primary care delivery for both patients and providers nationwide. In order to ensure people have access to quality care that meets their needs, it is critical to invest in patient-first care models that focus on delivering high-quality care that improves outcomes and lowers costs instead of incentivizing volume of services provided. This begins with changing the way care providers are paid to deliver care, and we are pleased to see Congress begin to consider potential solutions to improve care for people through this RFI and other comment opportunities.

Our responses to the questions for consideration included in this RFI center the patient perspective identified through our years of listening work, and we hope these critical perspectives continue to be at the forefront of any policy changes considered by the Senators and Congress more broadly. To that end, our comments center on the following areas:

I. Hybrid Payments for Primary Care Providers
II. Cost-Sharing Adjustments for Certain Primary Care Services
III. Technical Advisory Committee to Help the Centers for Medicare & Medicaid Services (CMS) More Accurately Determine Fee Schedule Rates

I. Hybrid Payments for Primary Care Providers

It's hard to understate how ill-equipped our nation's existing fee-for-service system is to provide quality, comprehensive primary care services to all people. Fee-for-service undervalues primary care, leading to an overutilization of low-value, high-cost services that do little to improve health outcomes and create financial instability for practices that rely on health care volume rather than improved health outcomes to keep their doors open. As a result, the number of independent physician practices across the U.S. is declining, in part due to the current system forcing physicians to consolidate with larger, corporate entities just to keep their practices afloat. In fact, the fee-for-service system is often cited as a major driver of these trends, none of which benefits primary care providers and the patients they serve.

As Congress discusses changes to primary care physician payment, USofCare stresses the importance of shifting toward alternative payment models (APMs) that move away from the fee-for-service chassis that has undergirded Medicare payment policy for more than 50 years. Traditional APMs, such as accountable care organizations (ACOs), emphasize provider payment based on outcomes. However, interested physicians – including safety net and independent providers – are often dissuaded from participating in them due to the associated financial risk. **USofCare encourages the adoption of "hybrid" payment structures within primary care, which contain elements of both fee-for-service and capitated payments.** Not only have hybrid models demonstrated improvements to quality of care for patients and long-term cost savings, they give providers a consistent stream of upfront payments, mitigating some of the financial risk that may prevent interested providers from participating. A 2021 National Academies of Science, Engineering, and Medicine (NASEM) report identified a need for hybrid models in primary care that include prospective payments for integrated team-based care, adjusted for medical and social complexity, to better deliver care.

The Pay PCPs Act and other legislative efforts to facilitate this transition are meaningful and represent clear thinking by Congress and other stakeholders on how best to incentivize providers to deliver innovative care to patients. At the same time, **this can't come at the expense of other efforts to address the shortcomings of fee-for-service** – namely, the inherent undervaluing of primary care and budget neutrality concerns that limit how physician and other provider payment reforms can truly be transformative for primary care. **Changes to the existing Medicare Access and CHIP Reauthorization Act (MACRA), the most significant adjustment to physician payment policy since the Affordable Act in 2010, must address this persistent undervaluing of primary care as part of any large-scale reform package.**

Below, and throughout the rest of our response, we consider several questions posed by the RFI and, guided by our experiences listening to people across the country, provide feedback to inform Congress as it considers changes to Medicare payment policy.

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?

> We know from our listening work that people value personalized care that meets their needs, yet far too often, the current fee-for-system takes a one-size fits all approach to care delivery that doesn't take into account whole person care or a person's unique circumstances and preferences. Part of this reflects the fact that Medicare doesn't pay

much, or at all, for the care management and coordination services that would make it possible for primary care providers to offer more personalized care. Without adequate reimbursement, it is difficult for primary care providers to provide this level of care they know patients deserve.

To ensure providers are incentivized to deliver quality care to all patients, we support the list of services included in the bill draft. Not only does the list of services capture the cost of the underlying primary care office appointment (or evaluation and management visit), it also covers other services, such as care management and behavioral health integration services, that are often underutilized under the current fee-for-service system. By granting some practices some financial certainty through a fixed hybrid payment, instead of relying predominantly on volume-based fee-for-service, this also may remove some of the incentives pushing physician practices towards consolidation with larger health systems that have been proven to increase costs for consumers.

Furthermore, incorporating various forms of communications under the hybrid payment will ensure that people, no matter their geographic location or ability, have access to needed primary care services. People who live in rural areas, who disproportionately tend to be lower-income, may live many hours from the closest primary care clinic. As a result, people in these areas and across the country increasingly rely on electronic formats, such as email or text messages, to schedule appointments or communicate with their primary care providers. Any hybrid payment proposal should include these forms of communication to "meet patients where they are" to ensure they have continued access to care in a way that is convenient and easy.

Should hybrid payments be based on historic averages across the entire FFS population? If so, are there risks that providers will receive an inappropriate payment rate for certain unusually high- or low-utilizing beneficiaries?

When considering various methodologies to determine actuarially equivalent fee-for-service amounts for various hybrid payments, Congress should be careful to pursue changes in a way that reduce health disparities, not exacerbate them. Basing hybrid payment rates on historic averages – even when using the entire Medicare fee-for-service population – can inadvertently perpetuate longstanding underinvestment in certain communities, such as those historically underserved by the health care system. **While payment rate calculations shouldn't discard historical cost data entirely, payments should take into account these historic disparities and establish adjustments to ensure that any hybrid payment rates are modified to account for decades of discriminatory policy choices.**

What methodology should be used to determine the "actuarially equivalent" FFS amount for the purpose of the hybrid payment?

To establish hybrid payment rates for services that don't have an easily quantifiable Medicare equivalent, such as care coordination or management services, Congress may consider the example set by Colorado as part of its innovative Colorado Option standardized plan option. Should issuers in the state fail to meet mandated premium reduction targets, the Colorado Department of Insurance has the authority to set reimbursement rates for various services at a specific

Medicare threshold. Because some services, such as pediatrics or obstetrics, either don't have an existing Medicare reimbursement rate or have a lower volume relative to other services within Medicare, the state developed its own "equivalent rate" after consultation with hospitals, physicians, and other stakeholders. Congress could consider a similar approach, with proper beneficiary and caretaker input, to quantify services that would benefit patients as part of the hybrid payment that may not be represented within the existing fee schedule.

II. Cost-Sharing Adjustments for Certain Primary Care Services

By establishing a relationship with a primary care provider, patients are able to assume a greater role in their health care alongside physicians, nurses, and others that make up their care team. Despite this and other benefits associated with regular primary care access, however, an increasing number of Americans are going without a regular source of primary care. Health care costs – even as low as a dollar or two – have continued to be shown to be significant barriers to care for patients, especially for low-income people. Our listening work has shown that health care affordability remains the top concern for people about their health care. One in four people have skipped needed care because of cost and a disproportionate percentage of Black and Latino adults have said they're unable to pay an unexpected $500 medical bill.

To increase access to primary care, insurers have begun to remove financial barriers, such as copays and deductibles, to encourage people to seek high-quality, low-cost care (otherwise known as "high-value care") with demonstrated individual and population health benefits. **We strongly support proposals that lower people's cost-sharing obligations for these types of services.** Elements of this so-called "value-based insurance design" (VBID) can be found across the country: all plans offered on Covered California, the state's health insurance marketplace, are required to cover three doctor or urgent care visits without cost-sharing. They can also be used to reduce health disparities: plans offered on Washington DC's Health Benefit Exchange have eliminated cost-sharing for treatments of certain conditions, such as heart disease, that disproportionately impact communities of color.

> *"When you think about fragmented, especially when you're not under one roof…, you talk to one doctor, they talk about one thing, you go to a different doctor, totally different symptoms, they're prescribing medicine that don't even work together and one medicine makes you sick because you took the other. So that is what is fragmented and complicated, nobody talking to each other, nobody getting their records, you're responsible for carrying your records around. It's not a good look."*
> *~Black patient who has had mostly negative experiences receiving health care*

Our listening work has also shown that people desire a relationship with their physician or care provider, yet barriers often exist between provider and patient that prevent these relationships being established. This leads to care fragmentation, as well as a greater risk of adverse health outcomes and higher out-of-pocket costs should people seek care out-of-network. Oftentimes, this is through no fault of the patient. **We encourage Congress to develop policies that incentivize patients to maintain ongoing relationships with primary care providers, while ensuring the onus to make this designation is not on the patient.** To the extent possible, existing data sources should be used to identify patients' usual source of care, and providers should be able to be identified with little to no involvement. This will accommodate English language learners, people without consistent broadband or internet access, and people with limited technological literacy. While patients

should have an active role in choosing their provider to begin with, they should not be burdened with assisting with identifying their usual source of care for the purposes of provider reimbursement. To ensure takeup, supports should also be in place to ensure that primary care providers have the tools they need and that they do not experience unnecessary administrative burden in order to be included in hybrid payment.

What is the appropriate amount of cost-sharing to make the hybrid payment model attractive for beneficiaries and providers while constraining negative impacts on the federal budget?

To ensure people continue to seek care from a primary care provider, it is essential to address health care affordability. **Because even low levels of cost-sharing can discourage people from seeing their primary care providers, we encourage Congress to consider waiving or reducing cost-sharing for primary care services included as part of a hybrid or prospective payment mechanism.**

> *"There are many barriers in getting people the right care they need; whether it's a stigma, whether it costs too much money, or several other [possible] reasons."*
> *~White woman, rural North Carolina*

Simply put, if people perceive care to be too expensive, they will often not access or seek medical care from a primary care provider, even if they need it. **We support policies to lower or eliminate Medicare beneficiaries' cost-sharing obligations for those who designate a regular primary care provider** and believe this will not only benefit patients, who will gain access to more regular primary care, but also allow for additional buy-in and stability for providers, especially for those who practice independently, with disproportionately low-income populations, or with historically underserved patients.

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

Furthermore, we recognize that while costs play a large role in whether people are able to access needed care, the primary care physician and health workforce shortage nationwide also impacts care access and their ability to find a primary care physician. One-in-three Medicare beneficiaries looking for a new primary care provider found it challenging to find one, which was more than twice the percentage of people who said the same when looking for a new specialist. **In addition to cost-sharing reductions, we support efforts to increase investments in new residency slots and graduate medical education programs,** including nursing programs and specific rural-training tracks for physicians and other providers, to ensure that all Medicare beneficiaries, and all people, who seek care from a primary care provider can do so when and how they choose.

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

The absence of federal action limits the ability of states to fully reorient their own spending around primary care to benefit patients and providers alike. Because private payers in states across the country largely structure their own rates around those established by Medicare, the widespread undervaluation of primary care services within Medicare often bleeds into private

insurance markets and exacerbates primary care access challenges for people with private or public insurance alike.

This undervaluation manifests itself in significant ways. Primary care physicians are paid significantly less than their specialist counterparts, discouraging younger physicians from entering primary care, forcing many patients to turn to specialists for care likely better suited for the primary care setting. For example, in 1980, 62 percent of all Medicare physician offices visits were to primary care physicians with the remainder going to specialty care. By 2013, those numbers had flipped, reflective of a payment system that doesn't accurately represent and pay for the services provided by primary care physicians and others, such as care management services. People's preferences haven't changed – in fact, according to our own listening work, people desire a system where they have a relationship with their doctor, being treated as a whole person. In other words, they want a system grounded in primary care. Unfortunately, this persistent undervaluation of primary care services doesn't match patients' needs.

The source of this undervaluation can be traced, in part, to recommendations made by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), which makes recommendations on how to update the relative value units (RUVs) used to determine Medicare physician payments. In theory, the RUC's recommendations – which are almost always adopted by CMS – should avoid incentivizing one service over another, yet given the persistent undervaluing of primary care services, it is clear these physicians, and the patients they serve, emerge at a disadvantage.

The Senators' proposal would create a new technical advisory committee to sit alongside the RUC in order to prove an "accurate" determination of RVUs used to guide physician and other provider payment. **USofCare appreciates Congressional efforts to more fully capture the comprehensive and continuous nature of primary care by changing the way in which these services are valued for the purposes of provider payment.** Looking forward, we encourage Congress to consider the impacts on how any proposed solutions would interact with the RUC, especially in the event of a conflicting recommendation.

Will the structure and makeup of the Advisory Committee meet the needs outlined above?

> Given the outsized role that primary care providers play in keeping patients healthy and addressing a wide variety of complex chronic conditions, **we support expanding the role of primary care providers on any existing or proposed panel.** It is critical that any panel tasked with the responsibility of determining physician payment fully accounts for all services offered by primary care physicians that allow them to properly manage patients' overall health. CMS's finalization of code G2211, designed to account for the inherent complexity associated with many evaluation and management services visits, represents a small yet significant step toward proper valuation of primary care services.
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> **Given the impact that physician and other provider payment rates have on people's access to care, we urge Congress to consider how best to incorporate voices in addition to those of physicians, such as beneficiary and caregiver perspectives, when making recommendations on physician payment.** Furthermore, we believe it is critical that any existing or proposed panel reflect the diversity of patients across the country with respect to race/ethnicity, age, sexual orientation, gender identity, ability status, and geography. Advisory committees across the government on both the federal and state levels incorporate these viewpoints

either through public comment periods or through dedicated membership slots on relevant committees. For example, Colorado's Colorado Option Advisory Board, which provides feedback on the implementation and operation of the state's standardized benefit plan, requires at least one-third of its membership to be people of color and be made up of people from both urban and rural areas of the state. While beneficiaries may not have the coding or billing expertise of other members, they do represent the downstream effects of changes made related to physician payment and are uniquely positioned to speak to impacts on health care access, especially primary care access, in ways that physicians themselves cannot.

Conclusion

We appreciate the work of Senator Whitehouse and Dr. Cassidy to prioritize efforts to better facilitate and improve the transition toward patient-first care by rethinking Medicare primary care physician payment policy. Thank you for the opportunity to respond to this RFI, which builds towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care. Please reach out to Lezah Calvin, Senior Manager of Federal Affairs, at lcalvin@usofcare.org, or Eric Waskowicz, Senior Policy Manager, at ewaskowicz@usofcare.org, with any questions.

Sincerely,

Lisa Hunter (she/her)
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United States of Care