July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
United States Senate
Washington, DC 20510

Re: Request for Information on Primary Care Provider Payment Reform

Dear Senator Whitehouse and Dr. Cassidy:

Thank you for the opportunity to respond to your Request for Information (RFI) associated with the release of S. 4338, the Pay PCPs Act. Collectively we believe that our nation's families should have access to high quality, equitable, and comprehensive primary care which is central to an effective health care system and to promoting the health and well-being of people, and we appreciate your dedication and commitment to advancing this cause.

Every person and family should have high quality health care that prevents illness, allows them to see a doctor when needed, and helps keep them healthy at a price they can afford. Yet, our nation's families are struggling in a health care system whose payment and delivery structures drive high-cost, low-quality care.[1] In particular, the fee-for-service (FFS) payment model that has long been the predominant model for how health care is paid in the U.S.[2] fundamentally incentivize high-volume and low-value care by reimbursing health care providers for each individual service delivered to a patient. As a result, health care providers are financially rewarded for performing a relatively higher number of procedures, especially high-profit or high-margin procedures – such as surgeries, hospital visits and medical tests – with limited to no accountability as to whether these procedures are cost-effective, improving patient health outcomes, or reducing health disparities[3]

In addition to incentivizing a higher volume of surgeries, hospital admissions and medical tests without any real link to the quality of care, the FFS structure also drives higher prices for these services. Fees for hospital admissions, procedures, office visits and tests are priced too high, while reimbursements for services that prevent illness and ensure care is accessible and effective, such as services provided by primary care providers, are often priced too low or at zero.[4] Moreover, patients can be billed "à la carte" for each additional service, driving up the total cost of their care. A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.[5]

Even more problematic is that FFS economics fail to adequately address factors that actually determine health. It is well-established that 80-90% of what drives variations in peoples' health is determined by the socioeconomic and environmental factors in their lives, yet the predominant models for how U.S. health care is paid for, including the majority of value-based

payment models, offer no payment for addressing the social drivers of health.[6] By definition, FFS provider payments (in Medicare Advantage, Medicaid managed care, private health insurance, or traditional Medicare and Medicaid) provide a very narrow view of health and health care by signaling to providers they can only be reimbursed for delivering the clinical care that drives 10% to 20% of health.[7] By offering no payment for services that address the social drivers of health and paying so much for hospital admissions and procedures, the economic incentives of FFS actually work against the professional responsibilities and desires of providers to improve health or reduce disparities.[8]

This historic underinvestment in primary care health care services through the current FFS payment system systematically undermines the provision of comprehensive primary care and other high-value services, such as behavioral health services.[9] This underinvestment is an important driver of the inadequate supply of primary care clinicians and reduced access to comprehensive primary care for too many families.[10] Our current health care system and its overreliance on FFS payment and high-cost specialty care needs to be drastically reformed in order to drive affordable, high quality and equitable care for all.

As such, **we applaud the introduction of S. 4338, the Pay PCPs Act. If enacted, the Pay PCPs Act would take a significant step to shift health care payment for primary care away from broken FFS economics and towards a payment and delivery system that values primary care providers and drives high-quality, affordable care.** Specifically, the bill would introduce a population-based hybrid payment for primary care providers through the Medicare Physician Fee Schedule (PFS) as well as establish a new physician payment technical advisory committee that would help to ensure payment rates to primary care providers reflect the true value and costs related to the care they provide to patients and their communities.

Shifting U.S. health care payment away from FFS provider payments and towards population-based payments should be a major focus of all efforts to reform physician payment across the U.S. health care system. By design, population-based payments involve paying a group of health care providers or a health system a single monthly payment, which covers some or most health care related costs for a set patient population.[11] Such a payment arrangement is then coupled with strong quality and outcome measures to ensure providers make money when they provide efficient, high-quality care, and lose money if they are being wasteful or provide poor-quality care. In this way providers are "at risk" for care that is wasteful and does not improve or protect patients' health, thereby incentivizing them to deliver well-coordinated, high-quality, person-centered care.[12] Moreover, these payments provide flexibility for providers to deliver a wider range of high- value services which are often historically undervalued or not paid at all under FFS, such as preventive health care, care coordination, wellness services, and services that address the social drivers of health.[13]

This RFI poses a number of important policy questions to inform the continued development of the Pay PCPs Act. In response, we focus on two overarching areas that we believe are particularly important to ensuring the Pay PCPs Act is successful in establishing a sustainable reimbursement structure for high quality and comprehensive primary care that moves away from FFS economics. These include: the design of the hybrid payment for primary care providers, and the design of a new technical advisory committee to help the Centers for Medicare and Medicaid Services (CMS) more accurately determine PFS rates.

Our responses are detailed below:

Hybrid payments for primary care providers:

- *How can Congress ensure we are correctly identifying the primary care provider for each beneficiary and excluding providers who are not a beneficiary's correct primary care provider or usual source of care?*

As noted above, the Pay PCPs Act would institute a population-based hybrid payment system for primary care providers in the Medicare Physician Fee Schedule, which includes paying a group of health care providers (such as an ACO) a single monthly payment to cover some or most health care related needs and costs for a set patient population. A critical component of such a payment model – where providers are accountable for managing the full continuum of care and related costs for a given patient population – is patient attribution.[14] Patient attribution is the process of identifying and assigning a set of patients to a group of health care providers who are then held accountable to care for those patients and importantly whose health, health care quality and related costs are then used to evaluate the ACO's performance and hybrid payments.[15] This is a critical mechanism in realizing the promise of population-based payment models to incentivize the delivery of the high-quality, whole-person care that our nation's families need and deserve. Providers must know which patients they care for since a population-based payment is paid on a per *patient* basis and is adjusted based on that patient's health and health care outcomes.[16] Health care providers need to know which patients they will be held accountable for so they can effectively manage the health conditions and health care needs of their patients.[17] Importantly, accurate patient attribution is also essential to ensure that health care providers are *only* held accountable for the patients for which they are actually providing care and managing health conditions, and are not penalized for care delivered to patients they are not overseeing.[18]

There are a number of patient attribution methods and approaches that have been used throughout the health care system, including among commercial insurers and public health coverage programs such as Medicare and Medicaid.[19] The most common attribution methods include: 1) patient choice attribution: where patients themselves choose and indicate which provider they would like to be held responsible and accountable for their health care; 2)

geographic-based attribution: where patients are assigned to a provider based on their geographic location or proximity to a given provider; and 3) visit- or claims-based attribution: where patients are assigned to a provider based on their health care utilization as reported in health care claims data. One example of using a claims-based approach is to assign a patient to a given provider if they receive a plurality of their primary care visits from that provider with certain exceptions.[20] Each method has inherent strengths and weaknesses in its ability to appropriately assign a patient whose care is *truly* under the supervision of the selected health care provider.

Patient Choice Attribution. Patient choice attribution is considered the gold standard method for attributing patients to a provider practice, as it guarantees the patient is actively choosing their preferred and trusted provider to manage their care and in turn helps to promote engagement between the patient and the provider and health care system overall.[21] However, it is often difficult to solely rely on patients self-reporting their preferred provider. Patient choice attribution is associated with lower attribution rates (likely due to low response rates) with the vast majority of patients not successfully attributed to a health care provider, especially among patients with lower health care utilization or face-to-face time with any provider and those who may be too sick to make a decision of their own (e.g., cognitively impaired).[22]

Geographic-Based Attribution: Geographic-based attribution, while able to assign a higher proportion of patients (i.e., higher attribution rate) is less sensitive to where patients are actually receiving the majority of their care. As a result, patients may be inadvertently assigned to a provider that the patient does not consider to be their primary care provider despite being geographically close.

Visit-Based Attribution: Visit-based attribution is the most universally trusted and commonly used approach for patient attribution and is employed across a number of federal health care programs (e.g., the Medicare Shared Savings Program) and commercial payers. For example, Blue Cross Blue Shield of Massachusetts successfully attributes the vast majority (75%) of their patients using a claims-based approach, assigning their patients to a primary care provider based on patients' use of annual wellness visits within the past 12 or 24 months.[23] The challenge with visit-based attribution is that it can be administratively complex and dependent on the quality of the claims and billing data that providers report, which do not always represent every patient visit with reliability.[24] Moreover, visit-based attribution may be prone to health care industry gaming, where health care providers engage in adverse selection. In this case, health care providers attempt to avoid attribution of sicker or costlier patients and seek out attribution of healthier and less costly patients in order to inappropriately inflate their payments and quality scores.[25] For instance, according to the Medicare Payment Advisory Commission (MedPAC), providers may be incentivized to shift sicker

patients to other providers not subject to population-based payments and quality reporting if a patient is expected to need an expensive procedure, such as a knee replacement.[26] Similarly, providers may be incentivized to assign healthier patients who may not need as many services, such as by offering rewards (e.g., gift cards) to patients to come in for a visit so they become attributed to the provider group.[27] This gaming risk is particularly pronounced among certain visit-based attribution approaches that assign patients during the same year in which the providers' health care quality and cost performance are evaluated (i.e., retrospective assignment) – since the shifting or de-assignment of a sicker, more expensive patient or the assignment of a healthier patient will immediately impact the providers' health care cost and quality performance metrics.[28] This harmful behavior would undermine the ability of population-based payment arrangements to hold health care providers accountable for effectively managing a patient's health related needs and costs.

In response to many of these challenges, the Health Care Payment Learning & Action Network (HCP-LAN) – a public private partnership of health care leaders working to accelerate the adoption of alternative payment models – recommends a multi-pronged approach to patient attribution.[29] HCP-LAN recommends that the default approach should be patient choice attribution or patient self-identification as described above.[30] Then, if that approach is not sufficient to attributing an entire patient population, HCP-LAN recommends that payers, including CMS in the case of this proposed legislation, use a visit- or claims- based attribution approach to identify a patients' usual source of care and the provider in which they should be attributed.[31] Under a Medicare hybrid primary care payment, CMS could use historical claims data to identify new and existing patient-provider relationships and assign accountability of a patient's health to the necessary provider.

To accommodate the ongoing research and trial of various patient attribution approaches, we strongly recommend that **the Pay PCPs Act give the Secretary of Health and Human Services (HHS) substantial authority to make regular changes and updates to the design of the hybrid primary care payments to strengthen the model and adapt design features based on the model's performance, including the ability to make changes to patient attribution methods. We also recommend that Congress direct the Secretary to consider the potential risks for health care industry gaming of patient attribution processes, such as via adverse selection, and direct HHS to expand the use of patient choice attribution as the default patient attribution approach.**

- *Should hybrid payment rates 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?*

The Pay PCPs Act would institute a population-based hybrid payment system for primary care providers in the Medicare Physician Fee Schedule (PFS), which includes, in part, paying primary care providers (such as an ACO) a single per-member-per-month (PMPM) prospective payment to cover some health care needs and costs for a set patient population.[32] As outlined above, PMPM payments are a critical component of population-based payment models and their ability to drive the delivery of high-quality whole-person care that our nation's families need and deserve. These payments provide primary care practices with greater financial predictability and flexibility to deliver high-value care as well as put them "at risk" for wasteful or low-value care since these payments are fixed, adjusted based on health care quality and patient outcomes, and importantly, are not based on care volume.[33] Moreover, providers are able to anticipate their monthly income and allocate resources accordingly and, because of the less prescriptive nature of capitated payments, can adapt care to best meet patient needs.[34]

A critical question is how to calculate the payment levels for such a prospective payment. The most common method employed across payment models within Medicare and the CMS Innovation Center is to calculate prospective payment levels based on historical FFS claims data, considering both levels of utilization and prices – as set in the PFS – to inform the base rate of a monthly payment amount.[35] The initial discussion draft of the Pay PCPs Act also prescribes such an approach.[36] However, basing the prospective payment on historic FFS spending and prices has a number of significant downsides.

First, this approach risks entrenching existing disparities in health care payments between primary care and specialty care into this particular hybrid primary care payment. As noted above, the current FFS payments used across public and private payers systematically underinvest in comprehensive primary care and other high-value services such as behavioral health services.[37] For instance, within the Medicare Physician Fee Schedule (MPFS), the Current Procedural Terminology (CPT) codes most commonly billed by primary care providers, including Evaluation and Management (E/M) service codes, are reimbursed at significantly lower rates than other specialty codes to the point that the payment rates do not reflect the true work and costs associated with delivering such services.[38] This distortion is even larger under commercial payers which largely base their payments off of Medicare rates.[39] Further, many services provided by primary care providers outside of the traditional office visit, such as home visits or telephone calls with patients, have long gone uncompensated under FFS.[40] As a result, the United States spends significantly less on primary care as a percent of total health care spending compared with other similarly developed nations, contributing to a national shortage of primary care providers and too many families not having access to high quality and comprehensive primary care.[41] As such, basing prospective primary care payments on historic FFS spending levels and PFS prices is not an appropriate long-term solution to setting hybrid or capitated payment rates as it could entrench existing disparities in payment and undermine the extent to which this hybrid payment model will strengthen primary care delivery to the benefit to our nation's families.

Second, using historical utilization and spending as the basis for setting hybrid primary care payments could inadvertently embed and worsen existing health inequities and disparities in health care access and utilization. Historic health care spending and utilization reflect long-term disparities in health care access and utilization experienced by rural and other marginalized communities.[42] Marginalized communities often use less health care overall and exhibit lower health care spending despite experiencing higher rates of chronic and acute illnesses.[43] For instance, Black and Hispanic families are more likely to skip or delay seeking care due to high health care costs, despite experiencing higher rates of diabetes, heart disease, and other chronic illnesses.[44] These individuals may have less income to spend on health care, have less comprehensive insurance coverage, be less aware of their health care needs due to lower health literacy, face greater barriers to obtaining care (for example, travel and time constraints), and/or encounter additional barriers from other manifestations of structural or interpersonal racism.[45] As such, basing prospective payments on historical spending and utilization, especially if adjusted on a provider-to-provider level, may lead to lower payments to primary care providers that are serving our nation's most marginalized communities. This approach risks reinforcing existing patterns of underinvestment and underspending on health care for historically marginalized communities thus exacerbating existing health inequities and widening disparities in health outcomes. The success of hybrid primary care payment hinges on calculating a PMPM rate in a way that both supports high-quality and equitable care and promotes more affordable health care spending over time for patients and the health care system at large.

As lawmakers continue to test, adopt, and refine new and alternative rate setting methodologies that move beyond historic FFS spending and utilization, it is critical that HHS have the authority to adopt new and alternative rate setting methods as they are developed and validated. At the same time, we acknowledge that the use of historic data remains an important baseline and data source for establishing base payments, particularly in the immediate term. **As such, we recommend the Pay PCPs Act give the Secretary of Health and Human Services the authority to make changes and updates to the design of the hybrid primary care payment model methodology and make updates to establishing adequate payment rates. We also recommend that the Secretary be given explicit authority to make adjustments to the payment model on an annual basis to account for disparities in access to care and historically low reimbursement rates for primary care services. These could be made in the form of health equity related payment adjustments or add-on payments, as well as up front infrastructure payments to primary care providers.**

- *What factors should Congress be considering when setting risk adjustment criteria?*

Risk adjustment is a critical safeguard for ensuring population-based payments work as intended. Risk adjustment is a payment adjustment based on the characteristics and health

status (i.e. diagnoses) of each patient to help account for differences in health care costs between healthier and sicker patients and to ensure providers are equally incentivized to treat patients regardless of health status and related costs. As noted above in the patient attribution section, providers who want to maximize profits may inappropriately attempt to engage in "adverse selection" or exclusively treat healthier patients while avoiding sicker patients that are associated with higher treatment costs. Risk adjustment mitigates this harmful behavior by ensuring providers who care for more medically complex patients are paid a "risk-adjusted" population-based payment — a relatively higher payment that accounts for the higher costs expected based on the health conditions and other factors/characteristics associated with that medically complex patient.

Risk adjustment is already employed on a large scale in the U.S health care system, including under the Medicare Shared Savings Program, Medicare Advantage, and throughout a handful of CMMI models such as ACO REACH. The most common risk adjustment methods use a limited set of patient characteristics to estimate differences in health care spending by patient, including a patient's age, sex, enrollment status (e.g., whether a patient is dually enrolled in both Medicare and Medicaid), and medical history.[46] These characteristics and diagnoses are assigned a value – based on associated historical health care spending – which is then used to help calculate risk-adjusted payments for each patient.

However, current risk adjustment methods, including those described above, have significant flaws which actively harm patients and drive low-quality care and health disparities.[47] First, they underestimate the health care needs of many patients, particularly those with serious illnesses and social needs, too often not accounting for the full range of factors that affect an individual patient's expected health care costs (for example, socioeconomic variables, housing, food insecurity).[48] As a result, providers are disincentivized to treat the most marginalized and medically complex patients. Second, current risk adjustment methods are susceptible to industry gaming and upcoding due to relying on variables and data, such as health diagnoses, that can be easily manipulated and over-reported to inflate risk adjustment payments.[49] Not only has this led to billions of dollars in wasteful spending, it also hurts patients, as providers can manipulate the system to increase payments without providing commensurate increases in care to their patients.[50]

As the health care system moves away from FFS payments and towards population-based models, it is critical that the risk adjustment methodologies used to set payment adjustments are redesigned to prevent industry gaming and encourage the treatment of all types of patients, including high- and low-cost patients alike. Payment systems employing risk adjustment methodologies should also fully account for, and encourage the treatment of, patients with social risk factors and health-related social needs. It is critical that risk adjustment methods reflect and account for the full suite of care and services that marginalized and high-risk patient need to achieve their best health.[51] **As such, we applaud the inclusion of social**

drivers of health as a consideration in the design of risk adjustment methodologies under the proposed hybrid primary care payment in the Pay PCPs Act. We firmly believe that alternative payment models, such as the one proposed in the Pay PCPs Act, should work towards incorporating robust social needs and social services data into health care data systems and workflows. This allows additional measures of health-related social needs to be included in risk adjustment methods to more accurately account for expected health care costs among socially vulnerable and marginalized populations, driving towards equity and improved protections against adverse selection.

The most significant barrier to adequate social risk adjustment is a lack of reliable and consistent data on social needs, particularly on the individual level.[52] Efforts to incorporate social risk factors into risk adjustment often do so on the community level through metrics such as Area Deprivation Index (ADI), which map the relative socioeconomic conditions of communities using census data.[53] While community level data like ADI is integral to the allocation of resources to underserved communities, individual level data on social needs is also important to adequately account for a wide array of social needs, particularly in communities with large socioeconomic disparities.[54] Alongside the use of community level metrics, policymakers must work towards more detailed data collection through expanded collection of self-reported demographic and social needs data.[55] In the short-term, existing sources of data, including ADI, claims data, and administrative data should be leveraged to more accurately account for social risk. Specifically, Z-codes, which are diagnosis claims codes that document a wide variety of social drivers of health, can be better leveraged to inform Medicare risk adjustment methodologies. Z-codes provide a standardized system for documenting and sharing social risk data. Unfortunately, these codes have seen little uptake by providers.[56] Nevertheless, Z-codes represent an important opportunity to expand and streamline social needs data within a system that has historically neglected these aspects of health. As recommended by HCP-LAN, **a glidepath approach should be implemented to support providers in moving from imputed and population level data, towards more enhanced data collection such as social needs assessments and self-reported data**.[57]

<u>Technical advisory committee to help CMS more accurately determine Fee Schedule rates:</u>

- *Will the structure and makeup of the Advisory Committee meet the need outlined above?*
- *How else can CMS take a more active role in FFS payment rate setting?*

One of the largest influences on how CMS decides to value a health care service in the physician fee schedule is the Relative Value Scale Update Committee (RUC), a group of 32 volunteer physicians spanning medical specialties who provide recommendations to CMS on service valuation.[58,59] CMS relies on the RUC to collect cost data from physician practices to inform the Relative Value Units (RVUs) assigned to new and revised codes that will then form the basis of

the physician fee schedule.[60] The RUC uses physician specialty associations for estimates on the time and intensity of work as the basis for recommending work values to CMS.[61] Critically, this means that as a nation we are allowing specialists and entrenched interests of the professions to determine their own payment rates, clearly creating profound conflicts of interest in price setting practices. While CMS is not required to adopt the RUC's recommendations, there is currently no alternative data source used to vet or counter the RUC's recommendations, and as a result CMS adopts the vast majority of RUC recommendations.[62]

The nonpartisan experts at the Government Accountability Office (GAO) and MedPAC have asserted numerous times that the specialists sitting on the RUC have a financial interest to inflate their estimates, potentially leading to biased estimates of RVUs and distorted fees.[63] Thus, the use of the RUC in creating price determinations results in payments that are in the best interests of specialty providers rather than what is in the best interest of consumers. Evidence also shows that the periodic updates used by CMS to determine relative value units for a service have resulted in payments for services that do not reflect the actual underlying relative resources used in producing the services, causing some services to be overvalued (priced higher), and others to be undervalued (priced lower).[64] These distortions are not only blind to what consumers need, they often run directly counter to the interest of Medicare beneficiaries and families across the nation. For example, evidence demonstrates that the fees for procedures, imaging, and tests are priced too high, and those for time spent with patients, referred to as evaluation and management services, are priced too low, creating another distortion in the Medicare Physician Fee Schedule. This, in turn, creates a perverse incentive where physicians may provide a mix of services that often do not serve their patients. Patients want more time with their health care provider, such as longer office visits, but instead often are sent off for more lucrative tests and procedures.

We strongly support the creation of a technical advisory committee (TAC) aimed at evaluating and improving valuation methodologies within the physician fee schedule as it signals a promising step in rebalancing the existing distortions in the MPFS. However, it is critical that a new technical advisory committee moves away from the structure of the RUC to ensure a more transparent and accurate rate setting system. Specifically, **we recommend the Pay PCPs Act develop a technical advisory committee that includes a variety of health care payment experts, Including:**

- **Non-partisan health care economists**
- **Non-physician clinicians, such as registered nurses and physician assistants**
- **Consumer representatives**
- **Physicians across an array of medical specialties and primary care**

Congress must also ensure the TAC's recommendations, reasoning, and processes are fully transparent.

Conclusion

While FFS remains the predominant way we pay for health care in the U.S., more efforts must be taken to ensure rate setting and health care payments reflect the true value of health care services. However, this alone is not enough to ensure the delivery of high-quality health care to all patients. Ultimately, the U.S. health care system must move away from the inefficiencies of FFS provider payment and towards population-based payments that incentivize high quality, high-value care. By helping to move away from FFS economics and putting in place a hybrid population-based payment system for primary care providers in the Medicare PFS, the Pay PCPs Act would take a critical step towards putting in place payment incentives that show the greatest promise in driving the delivery of-high quality, equitable and affordable health care for all.

We are grateful for your leadership and the opportunity to discuss these critical components of the Pay PCPs Act. We stand ready to work with you to ensure that changes to payment and delivery of U.S. health care serve to improve access to the high-quality and affordable care. For more information, please reach out to Jane Sheehan, Deputy Senior Director of Government Relations (JSheehan@familiesusa.org) at Families USA.

Sincerely,

Families USA
ACA Consumer Advocacy
American Association on Health and Disability
American Muslim Health Professionals
Black Mamas Matter Alliance
Colorado Consumer Health Initiative
Consumers for Affordable Health Care, Maine
Doctors for America
Elephant Circle
Health Care Voices
Iowa Citizen Action Network
Lakeshore Foundation
National Partnership for Women and Families
NHMH - No Health without Mental Health
Primary Care Development Corporation, New York
Small Business Majority
Tennessee Justice Center
Transgender Awareness Alliance
Utah Health Policy Project
West Virginians for Affordable Health Care

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