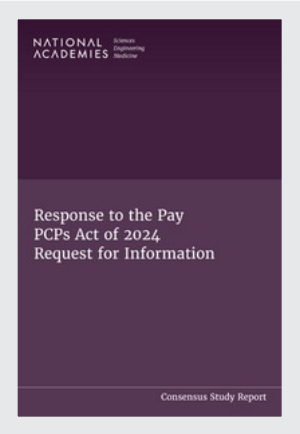

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Response to the Pay PCPs Act of 2024 Request for Information

Lauren Hughes, Mary Wakefield, and Marc Meisnere, *Editors*

Committee on the Response to the "Pay PCPs Act of 2024" Request for Information

Board on Health Care Services

Health and Medicine Division

Consensus Study Report

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This Consensus Study Report was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published report as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process.

We thank the following individuals for their review of this report:

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Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations of this report, nor did they see the final draft before its release. The review of this report was overseen by **PATRICK H. DELEON,** Uniformed Services University of the Health Sciences, and **WALTER R. FRONTERA,** University of Puerto Rico School of Medicine. They were responsible for making certain that an independent examination of this

report was carried out in accordance with the standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the authoring committee and the National Academies.

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Response to the Pay PCPs Act of 2024 Request for Information

U.S. Senators Sheldon Whitehouse and Bill Cassidy introduced the Pay PCPs (primary care providers) Act of 2024 in May 2024, which seeks to address ongoing challenges with payment models for primary care.[1] The proposed legislation was accompanied by a request for information (RFI). The National Academies of Sciences, Engineering, and Medicine (the National Academies) appointed the Committee on the Response to the "Pay PCPs Act of 2024" Request for Information to prepare this consensus report.[2] The committee's statement of task, which includes select questions from the RFI, is in Appendix A. The complete RFI is in Appendix B. The draft Pay PCPs Act of 2024 is in Appendix C. Committee member, fellow, and staff biographies are in Appendix D. RFI text the committee is responding to is denoted below in boxes.

HYBRID PAYMENTS FOR PRIMARY CARE PROVIDERS[3]

> The Medicare Physician Fee Schedule is comprised of activities and services that are currently ill-suited to support primary care.

[1] See https://www.whitehouse.senate.gov/wp-content/uploads/2024/05/KEL24351.pdf (accessed July 9, 2024).

[2] The committee members make up a subgroup of the National Academies Standing Committee on Primary Care, which was appointed in August 2023 to advise the federal government on primary care policy.

[3] Hybrid payments and primary care providers are defined in section 3 of the Pay PCPs Act of 2024 (see Appendix C).

Primary care requires ongoing care coordination and relies upon routine activities that are under- or non-reimbursed in the Fee Schedule. This legislation encourages CMS to adopt "hybrid payments" for primary care providers in the Fee Schedule, accelerating ongoing efforts in CMMI [Centers for Medicare and Medicaid Innovation] models. Hybrid payments give primary care providers in Medicare steady, upfront, and value-based payments for under-reimbursed activities, while maintaining some traditional FFS [fee-for-service] payments for certain services. Hybrid payments allow primary care providers to innovate and more easily integrate diverse care activities to improve care quality and reduce costs.

- 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?
- How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?
- How should the legislation address beneficiaries who routinely see two or more providers who could each plausibly be the "primary" care provider? For instance, a beneficiary who routinely visits both a family medicine provider and an OBGYN.

Committee Response

- The Centers for Medicare & Medicaid Services (CMS) has more than a decade of experience in successfully attributing Medicare patients to primary care providers (PCPs) within alternative payment models, including the Medicare Shared Savings Program (MSSP) and Center for Medicare & Medicaid Innovation (CMMI) primary care alternative payment model demonstration programs for Medicare beneficiaries such as Comprehensive Primary Care Plus (CPC+) (CMS, 2021).
- **Recommendation 1: CMS should prioritize voluntary patient attribution over other methods. When voluntary attribution is not feasible to ascertain due to beneficiaries not reporting information or other administrative reasons, CMS should use claims-based measures to attribute beneficiaries (including those routinely used**

by CMS in MSSP). These two methods should form the basis of attribution models under the Pay PCPs Act.

- Voluntary patient attribution is the most compatible attribution method with the goals of high-quality primary care, by virtue of engaging people and their preferences, yet the process is administratively complex and may not always be feasible (Health Care Payment and Learning Action Network, 2016; NASEM, 2021). CMS should promote proactive approaches to systematically collect beneficiary-reported identification of their PCP and facilitate connection to a PCP for beneficiaries without a regular source of primary care.
- Claims-based attribution based on care patterns can be prospective, meaning that clinicians are given a list of whom they are responsible for in the beginning of the year, or retrospective, when they are notified at the end of the year (National Association of ACOs, 2018; Riley et al., 2023). Most attribution rules assign patients based on the plurality of their outpatient visits, while some focus specifically on primary care services (CMMI, 2019; NASEM, 2021).
- Attribution models should be sensitive to team-based care models in which more than one primary care clinician may participate in providing comprehensive primary care services. An example might be a primary care medical group in which one clinician serves as the usual continuity provider but a primary care clinician colleague in the practice provides medication management for opiate use disorder for the same patient. Additional research on attribution methods is needed to continue to refine methods to appropriately identify care teams and distribute prospective payment components fairly among clinician team members.
- Involuntary disruptions in primary care have been shown to result in poorer health outcomes for Medicare beneficiaries (Sabety et al., 2021). Medicare and Medicaid beneficiaries risk not having a stable primary care workforce due to turnover from burnout and poor recruitment and retention into the field (Primary Care Collaborative, 2023; Willard-Grace et al., 2019). To prevent such involuntary disruptions, CMS could minimize administrative barriers to continuity of care by investing in the resources needed to attract and retain the enhanced PCP workforce required to serve Medicare and Medicaid beneficiaries (NASEM, 2021). Payment reform that increases investment in primary care is critical for providing incentives for more trainees to enter primary care fields and for resourcing advanced

primary care teams that make primary care a more sustainable career (Helfrich et al., 2017; Willard-Grace et al., 2014).

- Hybrid payment models should not prevent a beneficiary from voluntarily changing to a different care provider who might better meet their needs. Research shows that voluntary change in PCP occurs relatively infrequently among beneficiaries (Biniek et al., 2022). As noted above, under CMMI Medicare primary care demonstration models, CMS has successfully administered hybrid payment models that allow patients to change PCPs (CMMI, 2019).
- **Recommendation 2: When a beneficiary receives a service from a PCP who is not their attributed provider, the non-attributed provider should receive the full Medicare fee-for-service payment for that service. Similarly, if a beneficiary receives care from an obstetrician–gynecologist, for example, in addition to receiving services from the attributed PCP, the obstetrician–gynecologist should receive payment under standard Medicare fee-for-service payments for those services.**

RISK ADJUSTMENT

- What factors should Congress be considering when setting risk adjustment criteria?
- Should beneficiaries on Medicare Advantage be considered as part of the calculation or should Congress limit the pool to FFS only?

Committee Response

- **Recommendation 3: The risk adjustment method for the prospective payment component under a hybrid payment model should include a few basic demographic characteristics such as age and gender and heavily weight social factors predictive of high need for primary care services (Huffstetler and Phillips, 2019; NASEM, 2017), using place-based measures and geocoding of beneficiary residence to assign small area (e.g., census block) measurements of social factors to the individual beneficiary. Incorporating social risk factors should lead to an upward adjustment to the base payment to ensure that resources are adequate to meet needs. Of note, individual low-income status, indicated by dual eligibility for Medicare and Medicaid, is proposed by CMS as a measure for adjusting payments in the new Advanced Primary Care Management Services bundled payment (CMS, 2024).**

- While patient-reported data are highly valued by patients and federal agencies, they are not universally or uniformly collected (National Quality Forum, 2020). Given this challenge, place-based measures may be more reliable and consistent.
- The risk adjustment method should not replicate the Hierarchical Condition Category/Risk Adjustment Factor (HCC/RAF) method used by CMS for adjusting payment to Medicare Advantage plans and for other risk-sharing contracts. This method was not designed to predict primary care service use and has proven to be susceptible to manipulation to inappropriately increase CMS payments to Medicare Advantage plans (MedPAC, 2024).
- The risk adjustment method should be developed and tested based on data for beneficiaries in the traditional Medicare program and not those in Medicare Advantage plans. The new payment method will only be used for traditional Medicare and not for Medicare Advantage plans and should therefore be developed using data on beneficiaries in traditional Medicare. Moreover, CMS has direct control of Part A and Part B claims data that would be used for developing and testing a risk adjustment method and would not need to rely on plan intermediaries in Medicare Advantage to provide individual patient-level data on beneficiaries in those plans.
- The risk adjustment model should be developed to reflect primary care service needs, not to predict total costs of care. The goal of the new payment method is to fairly compensate primary care teams for comprehensive primary care services and to recognize the powerful influence of social drivers of health care need. Thus, the adjustment model should focus on predictors of need for appropriate primary care services. This approach to risk-adjustment would better match payments to primary care practices to the care they are responsible for. Primary care practices should only be at financial risk for the primary care services included in the hybrid payment model (see section below on included services) and not for total costs of care or costs for non-primary care services. An example of a variable that may predict total costs of care, but not primary care need, is a diagnosis of advanced cancer, which predicts high hospital and specialty service use but not necessarily high primary care service use.
- In developing a primary care risk adjustment method that heavily weights social factors, care must be exercised that these methods do not reinforce historical inequities. Many of the same social factors that predict high need for primary care are

also associated with barriers to accessing primary care and may thus predict both higher than average need and lower than average utilization of primary care. Risk adjustment models must carefully consider the outcome for the model to not introduce inequitable algorithmic bias.

- As an example, Cherokee Health Systems (CHS), a federally qualified health center in Tennessee, designed a method of assessing individual patients' risk via its Biopsychosocial Assessment (BPSA) (O'Brien, 2018). The BPSA uses weighted measures of individual patients' social needs (e.g., housing security, food security, transportation access), psychological diagnoses and indicators of care levels (e.g., recent inpatient treatment for psychological crises, types of services received including medication management), and medical diagnoses and indicators of care levels to predict the level of care a patient may require during any given clinical encounter (Peterson et al., 2015).

QUALITY MEASURES

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.

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

Committee Response

- Patient experience is an important measure to include as high-quality primary care should highly value patient knowledge and understand individual needs (NASEM, 2021).
- **Recommendation 4: To capture patient experience (and patient reported outcomes), the committee recommends using the validated, patient-reported Person-Centered Primary Care Measure**

(PCPCM PRO-PM) (AMA, 2022; American Academy of Family Physicians, 2022; Etz et al., 2019).

- The PCPCM PRO-PM is a reliable, comprehensive, and parsimonious measure of the high-value tenets of primary care, as assessed by the patient (AMA, 2022; Etz et al., 2019). The PCPCM PRO-PM was created in response to an identified gap between available measures and the elements most critical to high-quality primary care, including an absence of focus on how to prioritize care, accurately recognize problems, manage patient complexity, center on patient preferences and goals, invest in longitudinal relationships, and adapt care based on personal and community social determinants of health (Etz et al., 2017). The PCPCM PRO-PM is included in CMMI's new Making Care Primary demonstration model (CMS, 2023).
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, administered by the Agency for Healthcare Research and Quality (AHRQ),[4] as they are currently designed and administered, have some limitations related to declining response rates, difficulty introducing new measures, speed of delivering results, the length of the questionnaire, and adjusting payment based on "topped out" measures that do not provide meaningful distinctions among clinicians (Bland et al., 2022). Many of these challenges are methodological and may occur regardless of the instrument used. The implementation of any measure of patient experience will need to address these challenges if payment is being tied to performance. Approaches to address these challenges include use of innovative sampling methods, addressing nonresponse through survey and statistical methods, implementing web modes, and incorporating stakeholder feedback (Bland et al., 2022).

- **Recommendation 5: While clinical quality measures are critical to include, the committee recommends prioritizing measures of the key functional attributes of primary care (e.g. continuity, comprehensiveness, coordination, and access) rather than only using disease-specific quality measures. This approach was supported by *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (NASEM, 2021).**
  - Continuity of care refers to an ongoing relationship between a patient and their interprofessional care team over time (Merenstein, 2021; NASEM, 2021). Continuity has been linked to improved trust and decreased downstream health

[4] See https://www.ahrq.gov/cahps/index.html (accessed July 9, 2024).

care use (e.g., in emergency departments and hospitals) and costs (Bazemore et al., 2018). A continuity measure is included in the Merit-based Incentive Payment System (measure ID: ABFM12, CBE #3617)[5,6] and could be considered.
    - Comprehensiveness refers to the extent to which a PCP and primary care team recognize and meet most of a patient's health care needs (O'Malley et al., 2019). Increased comprehensiveness has been linked to decreased emergency department visits, lower hospitalization rates, and decreased Medicare expenditures (Bazemore et al., 2015). A comprehensiveness of care measure is being reviewed for national endorsement this year, and depending on the outcome, could be considered (Center for Professionalism and Value in Health Care, 2023).
    - Clinical measures should disaggregate data to identify disparities that may exist across demographic categories, such as race and ethnicity, rural or urban location, and geography. This provides more focused insight into the effect of services across groups of service recipients (National Academy of Medicine, 2022).
- Some service use measures in these areas should be considered. However, rather than measures of total hospital or emergency department (ED) use, they should be limited to measures of preventable hospital and ED episodes (also known as ambulatory care sensitive use measures). Additionally, the CAHPS survey could be updated to include patient experience questions related to team-based care in the ambulatory primary care setting to better understand how team-based delivery can affect service use.[7]
- **Recommendation 6: The committee recommends *not* including referrals as a measure of quality of care.**
    - Measures are available (see above) to directly assess the comprehensiveness of primary care in the ambulatory setting, which should be used if endorsed, rather than considering referral rates to be a proxy (inversely) for primary care comprehensiveness (O'Malley and Rich, 2015). There may also be unintended consequences by possibly creating disincentives to appropriate referrals if high rates of referrals are considered *ipso facto* a marker of lack of comprehensiveness of primary care (Vimalananda, 2018).

[5] See https://qpp.cms.gov/mips/traditional-mips (accessed July 10, 2024).
[6] See https://p4qm.org/measures/3617 (accessed July 11, 2024).
[7] See https://www.ahrq.gov/cahps/consumer-reporting/measures/index.html (accessed July 11, 2024).

- **Recommendation 7: To reduce the reporting burden on PCPs participating in the hybrid model, the committee recommends that measures be minimal in number, reflect the core functions of primary care, and that CMS rely on claims-based administrative data where possible.**
  - This approach will better align measurement with the core tenets of high-quality primary care, including continuity and comprehensiveness, and is supported by findings of the 2021 National Academies' report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (NASEM, 2021).
  - Claims-based measures of continuity and comprehensiveness are available and have been validated by researchers (Pollack et al., 2016). Self-report metrics are burdensome for practices to collect, especially for under resourced practices without the necessary resources to fulfill the reporting requirements.
- **Recommendation 8: To identify and ultimately help reduce disparities, the committee recommends that equity also be included as an additional measure of quality by stratifying data by race and ethnicity and other characteristics.**
  - The Institute of Medicine's 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century* identified equity as a key domain of quality (IOM, 2001), and this committee feels it is critical to include to help ensure that high-quality primary care is accessible to all. The measure could incorporate creative strategies to address health inequities with several practical examples documented in a publication from 2018 (Anderson et al., 2018).
- Of note, it is important that all measures consider services rendered *as a team* rather than as individual providers (NASEM, 2021). If interprofessional team-based care is necessary to provide high-quality primary care services (NASEM, 2021), payment models should reflect the nuanced interactions that enable team-based care to be successful.

INCLUDED SERVICES IN HYBRID MODELS

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?
  - Will including these services in a hybrid payment negatively impact patient access to service or quality of care?

Committee Response

- The committee applauds the inclusion of care management services, communications outside of the office visits between patients and their providers, behavioral health integration services, and coverage of office-based evaluation and management visits regardless of modality. The committee agrees that these services are essential to the work of PCPs, but in current payment models these are either not reimbursed or not reimbursed adequately to ensure uptake (Galewitz and Hacker, 2024; Hartnett et al., 2023; Holtrop et al., 2015; Ma et al., 2022; O'Malley et al., 2017; Rotenstein et al., 2021).
- The committee agrees with the inclusion of communications such as e-mails, phone calls, and messaging patients and caregivers via portals in hybrid payments. However, it is also important to include other administrative work not currently reimbursed under fee-for-service such as filling out paperwork for patients, completing prior authorizations, and reviewing records, all of which are known to be onerous and time consuming and disproportionately affect primary care compared to other specialties (AMA, 2024; Rao et al., 2017). Including these additional activities not currently accounted for in the fee schedule will require additional resources.
- Remote physiologic monitoring and remote therapeutic monitoring could also be considered as a covered service, but additional research is needed (Ferrante et al., 2023). Theoretically, allowing primary care to offer these services could help keep care local and close to home, especially for rural patients.
- The committee agrees with the inclusion of behavioral health integration.[8] To help ensure that primary care delivery sites can successfully develop integrated behavioral health services, for practices that need it hybrid payments should include financial and infrastructure support for workforce development and training, as start-up and ongoing costs associated with integration can be substantial (Nagykaldi et al., 2023; Wallace et al., 2015). This financial

[8] See Peek and The National Integration Academy Council (2013) for a definition of behavioral health integration and the services it should include.

assistance should include (but not be limited to) training behavioral health providers to work in primary care and assisting practices in advancing along the integrated care continuum to provide increasingly more comprehensive and integrated care (Galbreath et al., 2024; NASEM, 2021, 2023; SAMHSA-HRSA Center for Integrated Health Solutions, 2020).

- **Recommendation 9: In addition to the proposed services for hybrid payments, the committee recommends including services delivered by all members of the interprofessional team that are essential to delivering high-quality primary care. This includes services provided by community health workers, pharmacists, peer-support specialists, physical therapists, doulas, and others. Each primary care practice across the country serves a unique community with unique needs and finite resources so interprofessional team composition can vary greatly across settings. Any type of hybrid payment model should allow for flexibility for primary care practices to cover services by professionals they deem essential to the health of their community. This approach is highly aligned with findings, conclusions, and recommendations from the National Academies' report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (NASEM, 2021).**
    - Tiered prospective payment rates based on the robustness of the primary care team is one team-based payment approach that enables most practices to benefit regardless of their baseline capacity and robustness of their team-based resources. MassHealth (the Massachusetts state Medicaid program) is doing this and is a potential model to consider (Farlow and Schwarz, 2023). Whatever approach is used, it is important that it is evidence-based and results in improved care.
- Strategies to prevent prospective payment from reducing provider incentive to provide services (and thus reducing patient access to services) include:
    - Ensuring that payment is sufficient to support comprehensive team-based care (see above) (NASEM, 2021); and
    - Tracking of measures on access, comprehensiveness, and PCPCM to identify deficiencies that may result in excluding the provider or practice from continuing in the hybrid model. While primary care constitutes 35 percent of all health care visits to physicians, it receives only 3.9—5.6 percent of the health care dollar, depending on the insurer (Jabbarpour et al., 2024; NASEM, 2021). The current physician fee schedule has not provided sufficient reimbursement to support high-quality, team-based primary care, and the hybrid payments

should include services that have not been reimbursed under the physician fee schedule (NASEM, 2021). It has been estimated that more than 25 percent of primary care activities are not reimbursed under the fee schedule (Berenson et al., 2020). Tying the hybrid payments to increased investment in primary care may help mitigate unintended consequences that may limit patient access to care.

TECHNICAL ADVISORY COMMITTEE TO HELP CMS MORE ACCURATELY DETERMINE FEE SCHEDULE RATES

The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has a process in place to regularly review the inputs needed to calculate Fee Schedule rates, which it sends as recommendations to CMS for adoption in the Fee Schedule. CMS has deferred to nearly all the RUC's recommendations, accepting them unaltered almost 90 percent of the time between 1994 and 2010. However, according to a 2015 GAO report, the RUC's recommendations to CMS may not be accurate due to process and data-related weaknesses. This legislation creates a new advisory committee—separate and distinct from the RUC—within CMS to advise the Agency on new methods to more accurately determine those rates and correcting existing distortions which lead to under-reimbursement for high-value activities and services. The legislation also provides for the inclusion of primary care and family medicine providers to help provide the perspective of those stakeholders. Finally, the bill ensures that the new advisory committee develop new methods that help address health disparities, quality of care, and Medicare beneficiary access to services.

- 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?

Committee Response

- **Recommendation 10: Membership of the technical advisory committee should include:**
  - **Medical specialty representation that reflects the ecology of care delivery in the United States. As stated previously, approximately 35 percent of all health care visits in the United States are to a primary care physician (NASEM, 2021). At**

a minimum, this percentage of physicians on the committee should represent primary care.
    - **Interprofessional primary care team members, such as clinical pharmacists, community health workers, integrated behavioral health professionals, to ensure that the time, effort, and complexity of team-based care delivery is understood and accounted for.**
    - **Health economists and actuaries to advise on coding approaches, bundling, and the assessment of practice expenses (Berenson et al., 2023).**
    - **Health information technology and artificial intelligence experts to advise on how to use technology to better capture objective data (Berenson et al., 2023).**
    - **National and/or state-level primary care policy and research experts to advise on innovative empirical methods of data collection and policy considerations (Berenson et al., 2023).**
- The above members of the committee should include perspectives representing geographic diversity (e.g., rural, urban), as well as such other measures of diversity as race and ethnicity, career stage, and gender.
- **Recommendation 11: The structure of the technical advisory committee should include:**
    - **Use of empirically collected data rather than reliance on provider-reported surveys for time and practice expense calculations, as the latter are known to be subject to bias (Berenson and Hayes, 2024; Berenson et al., 2023; MedPAC, 2011; Zuckerman et al., 2016).**
    - **Clear processes for revisiting and revising prior determinations.**
    - **Transparency of decision-making processes and data to interested stakeholders and the public and be compliant with the Federal Advisory Committee Act (FACA)[9] (Berenson and Hayes, 2024; Berenson et al., 2023; GAO, 2015).**
- CMS could take a more active role in fee-for-service rate setting overall by overseeing this newly proposed FACA-compliant advisory committee and by continuing to innovate with streamlining primary care coding for Medicare as it has done in the recently proposed rule for Advanced Primary Care Management Services (CMS, 2024).

[9] See https://www.gsa.gov/policy-regulations/policy/federal-advisory-committee-management (accessed July 11, 2024).

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A

Statement of Task

The National Academies of Sciences, Engineering, and Medicine will develop a written response to a Request for Information (RFI) for the Pay PCPs Act of 2024 issued by Senators Bill Cassidy and Sheldon Whitehouse on payment-related primary care challenges. The committee will produce a report with recommendations in response to the following questions from the RFI.

This legislation encourages CMS to adopt "hybrid payments" for primary care providers in the Fee Schedule, accelerating ongoing efforts in CMMI models. Hybrid payments give primary care providers in Medicare steady, upfront, and value-based payments for under-reimbursed activities, while maintaining some traditional FFS payments for certain services. Hybrid payments allow primary care providers to innovate and more easily integrate diverse care activities to improve care quality and reduce costs.

- 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?
- How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?
- How should the legislation address beneficiaries who routinely see two or more providers who could each plausibly be the "primary" care provider? For instance, a beneficiary who routinely visits both a family medicine provider and an OBGYN.

- What factors should Congress be considering when setting risk adjustment criteria?
- Should beneficiaries on Medicare Advantage be considered as part of the calculation or should Congress limit the pool to FFS only?

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.

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

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?
- Will including these services in a hybrid payment negatively impact patient access to service or quality of care?

This legislation creates a new advisory committee—separate and distinct from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)—within CMS to advise the Agency on new methods to more accurately determine physician fee schedule rates and correcting existing distortions which lead to under-reimbursement for high-value activities and services. The legislation also provides for the inclusion of primary care and family medicine providers to help provide the perspective of those stakeholders. Finally, the bill ensures that the new advisory committee develop new methods that help address health disparities, quality of care, and Medicare beneficiary access to services.

- 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?

B

Request for Information for the S.4338—118th Congress Pay PCPs Act of 2024 Issued by Senators Bill Cassidy and Sheldon Whitehouse

May 15, 2024
To Whom It May Concern:

For decades, Congress has struggled to strike an appropriate balance between ensuring physicians are fairly compensated for providing care and keeping Medicare spending at a reasonable rate.

To date, delivery system reforms incentivizing value-based payment—rather than the current fee-for-service (FFS) payment physicians receive—have demonstrated the potential to reduce excess health costs in Medicare by eliminating low-value care. However, reforms are required in order to replicate savings at scale.

Primary care is associated with better health outcomes, improved health equity, and reduced health spending. Well-resourced and organized primary care teams can prevent, diagnose, and efficiently coordinate patient-centered care, directing services to higher-value care.
Despite the bedrock importance of primary care, the US continues to spend less on primary care as a share of total health spending than any other OECD country. Three in ten people report not having a usual source of primary care. This shortage is even more dire in medically underserved areas with worse health outcomes.

To address these challenges, Senators Sheldon Whitehouse and Bill Cassidy, M.D., introduced S. 4338, the Pay PCPs Act. This legislation serves

as a marker for future primary care legislation and is intended to solicit feedback on a number of important policy questions.

The Pay PCPs Act would encourage CMS to accelerate its existing efforts to support value-based primary care and improve the adequacy of pay for primary care providers in Medicare. Below is an outline of the legislation along with questions we seek responses to:

Hybrid payments for primary care providers:
The Medicare Physician Fee Schedule is comprised of activities and services that are currently ill-suited to support primary care. Primary care requires ongoing care coordination and relies upon routine activities that are under- or non-reimbursed in the Fee Schedule. This legislation encourages CMS to adopt "hybrid payments" for primary care providers in the Fee Schedule, accelerating ongoing efforts in CMMI models. Hybrid payments give primary care providers in Medicare steady, upfront, and value-based payments for under-reimbursed activities, while maintaining some traditional FFS payments for certain services. Hybrid payments allow primary care providers to innovate and more easily integrate diverse care activities to improve care quality and reduce costs.

- 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.
    - How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?
    - How should the legislation address beneficiaries who routinely see two or more providers who could each plausibly be the "primary" care provider? For instance, a beneficiary who routinely visits both a family medicine provider and an OBGYN.
- What methodology should be used to determine the "actuarily equivalent" FFS amount for the purpose of the hybrid payment?
    - 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?
- What factors should Congress be considering when setting risk adjustment criteria?
    - Should beneficiaries on Medicare Advantage be considered as part of the calculation or should Congress limit the pool to FFS only?

- 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.
    - Are these quality measures appropriate? Which additional measures should Congress be considering?
    - What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?
- 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?
    - Will including these services in a hybrid payment negatively impact patient access to service or quality of care?

Cost-sharing adjustments for certain primary care services:
The legislation allows CMS to reduce co-insurance for Medicare beneficiaries who voluntarily designate a primary care provider who is their usual source of care by up to 50%. This encourages beneficiaries to make use of high-quality primary care and incentivizes primary care providers to adopt hybrid payments.

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

Technical Advisory Committee to Help CMS More Accurately Determine Fee Schedule Rates:
The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has a process in place to regularly review the inputs needed to calculate Fee Schedule rates, which it sends as recommendations

to CMS for adoption in the Fee Schedule. CMS has deferred to nearly all the RUC's recommendations, accepting them unaltered almost 90 percent of the time between 1994 and 2010. However, according to a 2015 GAO report, the RUC's recommendations to CMS may not be accurate due to process and data-related weaknesses.

This legislation creates a new advisory committee—separate and distinct from the RUC—within CMS to advise the Agency on new methods to more accurately determine those rates and correcting existing distortions which lead to under-reimbursement for high-value activities and services. The legislation also provides for the inclusion of primary care and family medicine providers to help provide the perspective of those stakeholders. Finally, the bill ensures that the new advisory committee develop new methods that help address health disparities, quality of care, and Medicare beneficiary access to services.

- 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?

Please send your responses to physician_payment@cassidy.senate.gov by July 15, 2024.

C

S.4338—118th Congress
Pay PCPs Act of 2024

II

118TH CONGRESS
2D SESSION

S. 4338

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 15, 2024

Mr. WHITEHOUSE (for himself and Mr. CASSIDY) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Pay PCPs Act of 2024".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Transformation of primary care practices serves as an essential foundation for improving health and life outcomes for Medicare beneficiaries,

particularly for those with multiple chronic conditions and complex needs, mental health challenges, or living in rural and other socioeconomically challenged communities.

(2) Research has shown that 25 percent or more of primary care activities are not recognized for payment under most fee schedules, including the Medicare physician fee schedule, largely because these activities reflect a wide range of high frequency, brief activities that cannot efficiently be paid fee-for-service and because the billing costs for submitting claims for such services would usually exceed the value of payment.

(3) Fee-for-service is ill-suited to support many elements of practice transformation to produce effective primary care, such as developing and maintaining multi-disciplinary team-based care strategies that leverage clinicians such as nurse practitioners, physician assistants, nutritionists, and pharmacists, and coordinating care with other clinicians and social service providers.

(4) Research has shown that primary care represents a much smaller percentage of total health care spending by payers, regardless of type of insurance coverage, in the United States than in other

wealthy nations, and that higher percentage of total spending that is devoted to primary care services is associated with lower overall health care spending, and in the Medicare Shared Savings Program, with higher savings performance by accountable care organizations led by physician groups.

(5) A composite, prospective payment would provide primary care practices with more predictable and flexible revenues to support such elements of effective primary care and help appropriately value services and activities performed by primary care providers and critical services not currently paid for.

(6) Payments for some physician services under the Medicare program, including many that produce substantial spending under the Medicare program, have major distortions.

(7) Determination of payments for physician services under the Medicare program currently begins with subjective survey-based estimates of clinician time and effort per discrete service. This approach to valuing physician services is inconsistent with the comprehensive and continuous nature of primary care.

(8) Studies have found that payment levels in the Medicare physician fee schedule reflect estimates

of clinician time per service for a variety of services that are particularly inaccurate.

(9) The extreme complexity of having more than 8,000 billing codes in the Medicare physician fee schedule risks inaccuracy in estimations of relative values for closely related procedures and obscures distortions in pricing that grow over time for specific services.

SEC. 3. ESTABLISHING HYBRID PRIMARY CARE PAYMENT IN MEDICARE.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may establish within the Medicare physician fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)), hybrid payments only to be available to primary care providers, as defined in the shared savings program under section 1899 of such Act (42 U.S.C. 1395jjj).

(b) HYBRID PAYMENTS.—

(1) IN GENERAL.—Such hybrid payments may be comprised of the sum of—

(A) prospective, per-member-per-month payments; and

(B) fee-for-service payments.

(2) DETERMINATION OF AMOUNT OF PROSPECTIVE, PER-MEMBER-PER-MONTH PAYMENT.—

(A) IN GENERAL.—Subject to the preceding provisions of this subsection, the total prospective, per-member-per-month payment—

(i) may represent between 40 and 70 percent of expected annual total allowed charges derived from the Medicare physician fee schedule for primary care providers of services and suppliers;

(ii) should be at least actuarially equivalent to the applicable physician fee schedule amounts for the services included within the total prospective, per-member-per-month payment; and

(iii) should be calculated based on historic Medicare payments for those services which would be included as part of the prospective, per-member-per-month payment.

(B) APPLICATION OF CERTAIN FACTORS.—The Secretary may consider applying percentages different from those specified in subparagraph (A) for different types of primary care providers based on factors such as historical

fee-for-service revenue patterns or quality performance of the provider.

(C) RISK ADJUSTMENT.—The Secretary may assess the need to risk adjust the prospective, per-member-per-month payment and develop appropriate risk adjustment methodologies, taking into consideration only those factors that predict levels of primary care service utilization. Risk adjustment methodologies may incorporate clinical diagnoses, demographic factors, and other relevant information such as social determinants of health.

(c) CATEGORIZATION OF SERVICES.—

(1) IN GENERAL.—For such hybrid payments, the Secretary may create categories of different services that are wholly reimbursed under the Medicare physician fee schedule, but may not include services for which reimbursement occurs partly through other payment schedules under the Medicare program.

(2) SERVICES INCLUDED IN PROSPECTIVE, PER-MEMBER-PER-MONTH PAYMENT.—The Secretary may include the following types of services in the prospective, per-member-per-month payment under this section:

(A) Care management services.

(B) Communications such as emails, phone calls, and patient portals with patients and their caregivers.

(C) Behavioral health integration services.

(D) Office-based evaluation and management visits, regardless of modality, for new and established patients.

(3) CLARIFICATION REGARDING FEE-FOR-SERVICE PAYMENT FOR OTHER SERVICES .—For such hybrid payments, the Secretary may continue to pay through reduced fee-for-service payments for all other services not specified in paragraph (2) under the Medicare physician fee schedule, including screenings, preventive services, annual wellness visits (as defined in section 1861(hhh) of the Social Security Act (42 U.S.C. 1395x(hhh))), vaccinations, and initial preventive physical examinations (as defined in section 1861(ww) of such Act (42 U.S.C. 1395x(ww))).

(d) IDENTIFICATION OF QUALITY MEASURES.—The Secretary may identify quality measures with respect to primary care providers that receive hybrid payment under this section to safeguard health outcomes for Medicare beneficiaries, and reward high quality performance

through mechanisms such as annual bonus payments. Quality measures may be identified using existing mechanisms such as those approved for use in the Accountable Care Organization/Patient-Centered Medical Home/Primary Care Core Set agreed to by members of the Core Quality Measure Collaborative. Measurement may address areas such as—

(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.

(e) ATTRIBUTION.—The Secretary shall establish procedures under which a beneficiary is attributed to a primary care provider using historical claims data and the beneficiary affirms that the provider is their primary care provider.

(f) EXCLUSION FROM MIPS.—Section 1848(q)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(q)(1)(c)(ii)) is amended—

(1) in subclause (II), by striking ''or'' at the end;

(2) in subclause (III), by striking the period at the end and inserting "; or"; and

(3) by adding at the end the following new subclause:

"(IV) is a primary care provider that receives hybrid payments pursuant to section 3 of the Pay PCPs Act of 2024.".

SEC. 4. REDUCING BENEFICIARY COST SHARING FOR PRIMARY CARE SERVICES.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the "Secretary") may reduce by 50 percent any beneficiary cost sharing otherwise applicable under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for primary care services that may be reimbursed through the newly established prospective, per-member-per-month payment established under section 3, provided that the beneficiary designates a primary care provider as their usual source of care and informs the Secretary of who that provider is pursuant to the procedures established under section 3(e).

(b) REPORT TO CONGRESS.—Not later than 180 days after the date on which subsection (a) is first implemented, and annually thereafter, the Secretary shall sub-

mit to Congress a report on the implementation of such subsection, including an analysis of—

(1) whether the reduction of beneficiary cost-sharing under such subsection has impacted beneficiary utilization of primary care services that may be reimbursed through the newly established per-member-per-month payment; and

(2) whether the Secretary has observed any instances of fraud or abuse associated with the reduction of such cost-sharing, and whether the Secretary has taken steps to minimize any such fraud or abuse.

SEC. 5. ESTABLISHING A NEW TECHNICAL ADVISORY COMMITTEE ON RELATIVE VALUE UPDATES AND REVISIONS.

Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(P) ESTABLISHMENT OF TECHNICAL ADVISORY COMMITTEE ON RELATIVE VALUE UPDATES AND REVISIONS.—

"(i) IN GENERAL.—The Secretary shall establish a technical advisory committee (in this section referred to as the 'committee') within the Centers for Medi-

care & Medicaid Services to provide the Secretary with technical input regarding the accurate determination of relative value units under this paragraph.

"(ii) MEMBERSHIP.—

"(I) IN GENERAL.—The committee shall be composed of 13 members appointed by the Secretary from among individuals—

"(aa) reflecting diverse experiences in provider payment, including providers billing the Medicare program under this title, providers providing care under the laws administered by the Secretary of Veterans Affairs or the Secretary of Defense, and providers in primary care or family medicine (as defined for purposes of the shared savings program under section 1899); and

"(bb) with technical expertise in Medicare payment policies.

"(II) CHAIR.—1 of the members appointed under subclause (I) shall be

a representative of personnel of the Centers for Medicare & Medicaid Services, and that member shall serve as chair of the committee.

"(iii) STAFF.—The committee shall be staffed by personnel of the Centers for Medicare & Medicaid Services.

"(iv) DUTIES.—The committee shall advise the Secretary on an ongoing basis regarding the determination of relative value units under the physician fee schedule through duties such as the following:

"(I) Designing new valuation methodologies the Secretary may use to determine the time and resource use by health professionals associated with furnishing services or other new approaches to determining relative resources for each HCPCS code. The committee may prioritize furnished services that are most common or represent the services with the highest allowed charges.

"(II) Advising on research and development relevant to the deter-

mination of relative value units for individual HCPCS codes.

"(III) Providing recommendations with respect to changes in valuations of current HCPCS codes based upon any newly developed valuation methodologies.

"(IV) Evaluating whether existing HCPCS codes within the same family of services should be collapsed to result in fewer payment codes.

"(V) Identifying opportunities for bundling or unbundling services for payment purposes.

"(VI) Assessing the operational burden of new approaches on physicians and other suppliers and beneficiaries while also considering the vulnerabilities of new approaches on overt fraud and abuse.

"(VII) Assessing the impacts of these new approaches and potential adoption on beneficiary access, financial liabilities, quality of care, and health disparities.

"(v) FUNDING.—

"(I) IMPLEMENTATION.—The Secretary may provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out this subsection (other than research and development under clause (iv)(II)) (not to exceed $5,000,000) for each of fiscal years 2025 through 2029. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

"(II) RESEARCH AND DEVELOPMENT.—The Secretary may provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out research and development under clause (iv)(II) (not to exceed $10,000,000) for each of fiscal years 2025 through 2029. Any amounts transferred under the preceding sen-

tence for a fiscal year shall remain available until expended.

''(vi) DURATION.—The Commission shall terminate not later than the expiration of the 5-year period beginning on the date of its establishment.''.

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Committee, Fellow, and Staff Biographies

COMMITTEE

MARY WAKEFIELD, Ph.D., RN, FAAN (*Cochair*), serves on a number of nonprofit and government boards and committees including the Veterans Health Administration Special Medical Advisory Group, the Macy Foundation, the University of Washington Medical Advisory Board, MITRE Health Advisory Committee and Executive Board, and the UC Davis Moore Fellowship for Nurse Leaders. From the fall of 2022 through early 2023 she was a temporary HHS appointee serving as Senior Counselor to the Director of the Centers for Disease Control and Prevention. In 2021 she served as Senior Counselor to the HHS Secretary for the Unaccompanied Children program operated by the Administration for Families and Children. In the fall of 2020, she was a member of the President-elect Biden's transition team. In March 2015, Dr. Wakefield was named by President Obama to serve as the Acting Deputy Secretary of the U.S. Department of Health and Human Services, the second most senior position in the Department. She held this position through January 20, 2017. She led strategic department-wide initiatives in key health policy areas, with a particular focus on health and human service programs for vulnerable populations. Her domestic policy work largely focused on improving health status for underserved populations, including strengthening health programs for American Indians and Alaska Natives, and improving data analysis to better understand the health needs of rural populations.

From 2009 to 2015, Dr. Wakefield led and initiated program improvements as the Administrator of the Health Resources and Services

Administration to further strengthen the health care workforce, build healthier communities, increase health equity, and provide health care services to people who are geographically isolated or economically or medically vulnerable. Dr. Wakefield's public service career also includes more than 8 years working in the U.S. Senate as a legislative assistant and later as chief of staff to two North Dakota senators. Dr. Wakefield has extensive academic experience, including serving as associate dean for rural health at the School of Medicine and Health Sciences University of North Dakota, director of the Center for Health Policy, Research and Ethics at George Mason University in Fairfax, Virginia, and as a faculty member and area chair in the College of Nursing, University of North Dakota. Additionally, she worked on site as a consultant to the World Health Organization's Global Programme on AIDS in Geneva, Switzerland.

Dr. Wakefield is a member of the National Academy of Medicine (formerly the Institute of Medicine) and a fellow in the American Academy of Nursing. She has served on a number of public and not-for-profit boards and committees bringing expertise in nursing, health care quality, access to care, and the health workforce. Dr. Wakefield served on the IOM committee that produced the landmark reports *To Err is Human* and *Crossing the Quality Chasm*. She also cochaired the Institute of Medicine committee that produced the report *Health Professions Education—A Bridge to Quality* and chaired the committee that produced the report *Quality through Collaboration: Health Care in Rural America*.

LAUREN S. HUGHES, M.D., M.P.H., M.Sc., M.H.C.D.S., FAAFP (*Cochair*), is a family physician working as the State Policy Director of the Farley Health Policy Center and an associate professor of family medicine at the University of Colorado. In these roles, she leads efforts to generate and translate evidence to inform the design and implementation of evidence-based health policy at the state, national, and federal levels. She participates in the Primary Care Centers Roundtable, a volunteer collective of all of the primary care research and policy centers in the United States. Her research interests include improving rural health care delivery, strengthening primary care infrastructure, and advancing behavioral health integration. She cares for patients at a rural federally qualified health center north of Denver. Dr. Hughes previously served as Deputy Secretary for Health Innovation in the Pennsylvania Department of Health. In this role, she collaborated with the Centers for Medicare & Medicaid Services Innovation Center to codesign and launch the Pennsylvania Rural Health Model, a new payment and delivery model that transitions rural hospitals from fee-for-service to multipayer global budgets and transforms how they deliver care to better meet community health needs. She also oversaw the creation of the Prescription Drug Monitoring

Program for the Commonwealth and led the department to full accreditation through the Public Health Accreditation Board.

In 2018, Dr. Hughes was selected by Presidents Bill Clinton and George W. Bush as a Presidential Leadership Scholar. From 2022 to 2023, she served as chair of the American Board of Family Medicine Board of Directors. She also serves on the boards of directors of the Rural Health Redesign Center Organization and the American Medical Student Association Foundation. She is a member of the Primary Care Payment Reform Collaborative through the Colorado Division of Insurance and the Stakeholder Advisory Group for the Agency for Healthcare Research and Quality's National Center for Excellence in Primary Care Research. Dr. Hughes is a former Robert Wood Johnson Foundation Clinical Scholar at the University of Michigan, where she earned an M.Sc. in health services research. She holds a medical degree from the University of Iowa, an M.P.H. in health policy from the George Washington University, a master's in health care delivery science from Dartmouth College, and she completed her residency at the University of Washington. Since 2021, Dr. Hughes has been a member of the National Academies of Sciences, Engineering, and Medicine Board on Health Care Services.

RAMON CANCINO, M.D., M.B.A., M.S., FAAFP, is executive director of the University of Texas (UT) Health San Antonio Primary Care Center and senior medical director of Medical Management. Dr. Cancino also helps guide cancer prevention and screening strategies as the cochair of the joint UT Health San Antonio-MD Anderson Mays Cancer Center Cancer Prevention and Screening Committee. Prior to this role, he was chief medical officer of Mattapan Community Health Center, a federally qualified health center (FQHC) in Boston, Massachusetts. A family medicine physician with more than 10 years health care executive experience in academic and FQHC settings, Dr. Cancino has led all aspects of primary care, including value-based care, cancer prevention and screening, and workforce development. His research interests include use and quality measurement, use of novel cancer screening strategies, and digital health. He sits on the Texas Primary Care Consortium Advisory Committee where he guides the direction of statewide primary care initiatives, and he sits on the board of directors of the UT Health San Antonio Regional Physician Network ACO. He holds multiple national committee positions. He sits on the Society of Teachers of Family Medicine Practice and Quality Improvement Steering Committee, which guides the direction of relevant education for learners and clinician educators. He also sits on the Agency for Healthcare Quality Healthcare's Safety and Quality Research study section.

Prior to these roles, Dr. Cancino completed his residency training at Mayo Clinic, completed an academic medicine fellowship at Boston University School of Medicine, obtained a master of science in health services

research at Boston University School of Public Health, and completed his M.B.A. at University of Texas at San Antonio.

KAREN L. FORTUNA, Ph.D., M.S.W., is an assistant professor of psychiatry at the Geisel School of Medicine at Dartmouth and cofounder of the Collaborative Design for Recovery and Health. As an international collaborative of patients, community health workers, peer-support specialists, caregivers, policy makers, and payer systems, the collaborative uses community-based participatory research to facilitate the development, evaluation, and implementation of digital tools that use mobile health to address needs identified by community members from vulnerable populations at the intersection of race and disability status, including but not limited to older adults with multiple chronic health conditions and people with disabilities, rare diseases, and psychiatric disorders. Her work spans many settings from primary care to community-based care. Dr. Fortuna has received funding from the Patient-Centered Outcomes Research Institute (PCORI), National Institute of Mental Health, American Federation of Aging, Brain and Behavior Foundation, Japan Agency for Medical Research and Development, and the New York Academy of Sciences. Overall, she has been responsible for conducting or collaborating on more than 30 research projects including topics such as health disparities, self-management, patient engagement in digital technologies, participatory human-centered design, and has pioneered a new field of study: "digital peer support." She is the 2022–2023 Chair of the Patient Engagement National Advisory Council to PCORI.

Dr. Fortuna is an invited member to the American Psychological Association's Mental Health Technology Advisory Committee, American Psychiatric Association's Smartphone App Advisory Panel, Foundation for Opioid Response Efforts Advisory Panel, and Ludwig Boltzmann Gesellschaft Research Group Die Offene Tür's Open Innovation international advisory panel. Dr. Fortuna was the recipient of the Japanese Agency for Medical Research and Development Research Proposal of the year, Ally of the Year Award from the Western Mass Peer Network, Alvin R. Tarlov & John E. Ware Jr. Award in Patient Reported Outcomes, and the Faculty Achievement Award from the National Association for Gerontology Education in Social Work.

KEVIN GRUMBACH, M.D., is professor of family and community medicine at the University of California, San Francisco (UCSF). He served as Chair of the UCSF Department of Family and Community Medicine from 2003 to 2022. He is a Founding Director of the UCSF Center for Excellence in Primary Care and Director of the Community Engagement Program for the UCSF Clinical and Translational Science Institute. His research and scholarship on the primary care workforce, innovations in primary care, racial and ethnic diversity in the health professions, and community

health improvement and health equity have widely influenced policy and practice. Dr. Grumbach is a member of the American Academy of Family Physicians and California Academy of Family Physicians, and cochairs the California Academy of Family Physicians Task Force on Primary Care for All to develop policy positions on primary care coverage, investment, and payment. He is also a member of Physicians for a National Health Program. He is a gubernatorial appointee to the California Health Workforce Education and Training Council and a technical expert for the California Office of Health Care Affordability Payment and Investment Workgroup, both of which are uncompensated positions. With Tom Bodenheimer, he coauthored the best-selling textbook on health policy, *Understanding Health Policy—A Clinical Approach*, now in its eighth edition, published by McGraw Hill. He received a Generalist Physician Faculty Scholar award from the Robert Wood Johnson Foundation, the Health Resources and Services Administration Award for Health Workforce Research on Diversity, the Richard E. Cone Award for Excellence and Leadership in Cultivating Community Partnerships in Higher Education, and the UCSF Chancellor's Public Service Award. Dr. Grumbach has been an advisor to congressional committees and government agencies on primary care and health reform, and he has been a member of the National Advisory Council for the Agency for Healthcare Research and Quality, and currently serves on the California Health Workforce Education and Training Council. He cares for patients at the family medicine practices at San Francisco General Hospital and UCSF Health. He is a member of the National Academy of Medicine.

YALDA JABBARPOUR, M.D., is a family physician and Director of the Robert Graham Center for Policy Studies in Primary Care. In this role, she oversees a team of researchers who create and curate the evidence to support primary care. She conducts research on the primary care workforce, payment and investment in primary care, scope of practice for family physicians, factors contributing to primary care burnout, and the integration of public health and primary care. Dr. Jabbarpour first came to the Robert Graham Center as a Robert L. Phillips Health Policy fellow in 2015 and served as the Medical Director of the center from 2018 to 2022. Dr. Jabbarpour and her team at the Robert Graham Center, with support from the Milbank Memorial Fund, are responsible for authoring the primary care scorecards and creating the first national dashboard on primary care based on the National Academies report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. She sees patients clinically at the MedStar Family Medicine Center in Spring Valley. She participates in the Primary Care Centers Roundtable, a volunteer collective of all of the primary care research and policy centers in the United States. Dr. Jabbarpour received her undergraduate degree at the University of California, Los Angeles. She attended medical

school at the Georgetown University School of Medicine and completed her residency in Family Medicine at the Georgetown University/Providence Hospital family medicine residency.

CANDACE SPROTT, M.D., M.B.A., FAAP, FACP, practices comprehensive outpatient internal medicine and pediatrics at the Southern California Permanente Medical Group where she has been since 2016. She also serves as the medical director of her medical office and conducts peer review for the Department of Internal Medicine. Dr. Sprott is highly active in the American College of Physicians (ACP), the professional home for all Internal Medicine physicians. She is the chair of her local chapter's Early Career Physician Committee as well as a member of the ACP National Council of Early Career Physicians and the Diversity, Equity and Inclusion (DEI) Committee. In addition to these roles, she serves as Assistant Producer for the DEI shift podcast, a nationally recognized podcast hosted by the ACP that focuses on DEI topics within medicine. She's passionate about operations and strategic planning, enjoys connecting with her patients through curiosity and empathy, and loves the thrill of a great case. Dr. Sprott trained in a combined Internal Medicine and Pediatrics residency program at Christiana Care Health System and the Alfred I duPont/Nemours Children's Hospital in Delaware. After her chief year she completed a patient safety and quality improvement fellowship.

EBONI WINFORD, Ph.D., M.P.H., is the Director of Research and Health Equity and a licensed psychologist at Cherokee Health Systems (CHS) in Knoxville, Tennessee. She provides direct clinical care to patients, contributes to workforce development in community health centers, and oversees research initiatives including those funded by Health Resources and Services Administration, the Tennessee Department of Health, and National Institutes of Health. She is the Clinical Director for CHS's National Consultation and Training Program, which provides individualized onsite training to other health organizations as they seek to integrate their practices. She is on the board of directors for the Collaborative Family Healthcare Association, is the Chair-Elect of the American Psychological Association's Ad Hoc Health Equity Committee, is secretary of the American Pharmacists Association's Community Health Planning and Policy Development section, and serves as the 2nd Vice Chair of the National Association of Community Health Centers Committee on Service Integration for Behavioral Health and HIV.

Dr. Winford holds adjunct faculty positions in the Department of Family and Community Medicine at Meharry Medical College and in the Department of Psychology at the University of Tennessee Knoxville. She is a Robert Wood Johnson Foundation Interdisciplinary Fellow and a Health Equity Scholar in Cambridge Health Alliance's Center for Health Equity Education and Advocacy.

Dr. Winford earned her doctorate in clinical health psychology from the University of North Carolina at Charlotte and her Master of Public Health from the University of North Carolina at Chapel Hill. She is a proud life member of Zeta Phi Beta Sorority, Incorporated.

NATIONAL ACADEMY OF MEDICINE FELLOW

STEPHANIE GOLD, M.D., FAAFP, 2023–2025 Puffer/ABFM Fellow, is an associate professor in the Department of Family Medicine at the University of Colorado, a practicing family physician at a federally qualified health center in the Denver Health system, and a scholar at the Farley Health Policy Center. Her research and policy work focus on payment reform for primary care and integrating behavioral health with primary care, with the goal of system transformation to enable primary care to better and more equitably care for the whole heath of individuals, families, and communities.

Dr. Gold served as president of the Colorado Academy of Family Physicians (CAFP) from 2022-2023. Through the CAFP, Dr. Gold helped advance legislation to improve primary care investment in Colorado and has provided input on multiple state task forces and committees related to primary care payment reform. Dr. Gold coedited a book, *Integrated Behavioral Health in Primary Care: Your Patients Are Waiting*, which provides guidance on practice transformation to integrate care. She led the development of the Building Blocks of Behavioral Health Integration, a framework of care delivery expectations for use in practice transformation and alternative payment models. Dr. Gold also teaches policy and advocacy skills and has developed novel curricula for residents and international learners. Dr. Gold received her M.D. from the University of Virginia School of Medicine and completed her residency at the University of Colorado—Denver Health track. Following residency, she completed a health policy fellowship with the Farley Health Policy Center.

PROJECT STAFF

MARC MEISNERE, M.H.S., is a senior program officer on the National Academies of Sciences, Engineering, and Medicine's (National Academies's) Board on Health Care Services. Since 2010, Mr. Meisnere has worked on a variety of National Academies consensus studies and other activities that have focused on mental health services for service members and veterans, suicide prevention, primary care, and clinician well-being. Most recently, he was the study director for the 2021 National Academies report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* and the 2023 report, *Achieving Whole Health: A New Approach for Veterans and the Nation*. Before joining the National Academies, Mr.

Meisnere worked on a family planning media project in northern Nigeria with the Johns Hopkins Center for Communication Programs and on a variety of international health policy issues at the Population Reference Bureau. He is a graduate of Colorado College and the Johns Hopkins University Bloomberg School of Public Health.

ADAEZE OKORAOJUZIE is a senior program assistant with the Board on Health Care Services at the National Academies of Sciences, Engineering, and Medicine (the National Academies). Prior to joining the National Academies, she was the president of GlobeMed at Howard University, a grassroots organization that works directly with the Nancholi Youth Organization in Blantyre, Malawi. She is a certified birth doula who provided free doula services to young mothers in Washington, D.C., through the Community Doula Network. Through her content creator account "DazetheDoula" she creates awareness and educates her community on birth education. Ms. Okoraojuzie obtained her Bachelor of Health Sciences, magna cum laude, with a minor in biology and maternal child health from Howard University and she is an expected Master of Science graduate at Georgetown University Integrative Medicine and Health Sciences program August 2024.

SHARYL J. NASS, Ph.D., serves as Senior Director of the Board on Health Care Services and Director of the National Cancer Policy Forum at the National Academies of Sciences, Engineering, and Medicine (the National Academies). The National Academies provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine. To enable the best possible care for all patients, the board undertakes scholarly analysis of the organization, financing, effectiveness, workforce, and delivery of health care, with emphasis on quality, cost, and accessibility. The forum examines policy issues pertaining to the entire continuum of cancer research and care. For more than 2 decades, Dr. Nass has worked on a broad range of health and science policy topics that includes the quality, safety, and equity of health care and clinical trials; developing technologies for precision medicine; and strategies to support clinician well-being. She has a Ph.D. from Georgetown University and undertook postdoctoral training at the Johns Hopkins University School of Medicine, as well as a research fellowship at the Max Planck Institute in Germany. She also holds a B.S. and an M.S. from the University of Wisconsin–Madison. She has been the recipient of the Cecil Medal for Excellence in Health Policy Research, a Distinguished Service Award from the National Academies, and the Institute of Medicine staff team achievement award (as team leader).