AMERICA'S PHYSICIAN GROUPS

July 15, 2024

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

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Whitehouse and Cassidy:

America's Physician Groups (APG) salutes your efforts to strengthen primary care, and appreciates the opportunity to respond to the request for information on possible provisions of S. 4338, the Pay PCPs Act. APG welcomes your openness to stakeholder input on this important proposal and your ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization and our interest in the proposed legislation, followed by (II) our responses to comments posed in the Request for Information issued May 15, 2024. Together they reflect the voice of our membership and our commitment to working with the you to ensure that all Medicare beneficiaries have consistently accessible, high-quality, equitable, person-centered health care, built on the all-important chassis of a strong and robust primary care system.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members are chiefly primary and multispecialty care practices, and collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

APG members are generally large primary and multispecialty care groups that are accomplished at operating in risk-based models, such as two-sided risk arrangements with Medicare Advantage plans and the more advanced alternative payment models, such as ACO REACH. As such, it is unlikely that they would participate in the type of hybrid fee-for-service payment arrangement contemplated under the Pay PCPs Act. However, APG believes strongly that is imperative to strengthen primary health care in America, and also to equip primary care physician practices with the tools and capabilities to move into more risk-based alternative payment models over time.

Thus, APG fully supports the concepts behind the Pay PCPs Act, and is happy to respond to the Senators' RFI in the interest of further fleshing out the legislation. In the wake of the recent Supreme Court decision rejecting the Chevron deference doctrine, it will be critical to provide as much specificity as possible in the legislation to avoid further legal minefields as regulations are crafted and implemented by the Centers for Medicare and Medicaid Services and/or other executive branch agencies.

II. APG's Responses to the Questions Posed in the RFI (questions are in *italics* below)

A. *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?*

To correctly identify the primary care providers to be paid under the hybrid payment model proposed and match them with the appropriate beneficiaries, APG recommends that the legislation include a provision for signed voluntary beneficiary alignment as in ACO REACH. Under this approach, beneficiaries would align to a participant provider by attestation through Medicare.gov, or by submitting a Voluntary Alignment Form to their primary care provider. If a beneficiary selected more than one participant provider as his or her primary clinician or main source of care, the most recent valid attestation or submitted form would take precedence. APG further recommends that a beneficiary's main source of primary care be verified retrospectively through submission of claims.

B. *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.*

APG does not believe that it will be possible to devise a perfect alternative in the case of patients who frequently switch primary care providers, or who use more than one provider for the provision of primary care, such as a family medicine provider and an ob/gyn. Beneficiaries should be able to determine which provider is their primary source of primary care through the signed voluntary process, and this could be further validated through retrospective examination of claims. The best deterrent to patient switching will be (1) forming a holistic care relationship between a provider and patient, which the infrastructure that clinicians participating in the hybrid model will be better able to create than those not in the model, and (2) reductions in beneficiary cost-sharing, which will be unavailable to beneficiaries who leave a participating practice and go to another not participating in the hybrid payment model.

C. *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?*

APG lacks the actuarial expertise internally to answer this question definitively, but our advice would be to retain the services of a leading actuarial firm, such as Milliman, to model different approaches to discern the likely impact on potential provider payment rates.

D. *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?*

Given the rapid and likely ongoing growth of enrollment in Medicare Advantage, if MA enrollment is not included in the risk adjustment calculation, then that calculation will over time be based on a shrinking pool of enrollees, and not reflect the totality of the Medicare population.

Beyond this reality, a major concern will be devising a new risk adjustment (RA) system that avoids some of the deleterious incentives in the current HCC-based model for MA toward upcoding or overcoding. At minimum, the proposed legislation has the opportunity to avoid some of the worst features of the current RA system in MA, such as making use of Health Risk Assessments and chart reviews carried out by clinicians and other entities that are not patients' primary physicians. We also note that other, simpler alternatives have been advanced, such as using prior utilization of primary care E/M visits and minor procedures as a basis for the risk-adjusted hybrid payment, or even a "simple patient-reported health status survey such as 'How's Your Health'."[1]

Devising a new RA system for the purpose of this legislation that derives diagnoses directly from electronic health records and accompanying patient care plans would appear to be the optimal solution in the long run, to eliminate added burdens on providers. However, this particular approach is likely to be problematic to implement with this population of providers in the short run, given their reliance on older or less robust EHR systems. In the meantime, APG is aware that certain entities are working on AI-based systems to improve Medicare Advantage RA, which may be able to be in place at the time any legislation takes effect. It would be desirable to explore additional technology-based alternatives that could reduce clinician burden as more elaborate RA systems are developed for the hybrid model.

E. *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 domains of quality measures listed above are appropriate, but to the maximum degree possible, the quality measures that accompany this new payment model should be (1) parsimonious in number and reflective

[1] Robert A Berenson, Adele Shartzer, Hoangmai H Pham, Beyond demonstrations: implementing a primary care hybrid payment model in Medicare, *Health Affairs Scholar*, Volume 1, Issue 2, August 2023, qxad024, https://doi.org/10.1093/haschl/qxad024

of measures that make the greatest difference in outcomes for patients; (2) closely correlated with other measures that practices now report; (3) harmonized with Universal Foundation principles; and (4) should be claims based and/or digital to reduce provider burden. If MIPS is revised, as seems likely, replacement quality measures that accompany that program should be reflected in the hybrid payment model. In developing the quality measures for this model, attention should be paid to the fact that many practices entering the model may be unlikely to have sophisticated electronic health record systems that can make quality reporting more seamless than it is otherwise.

F. *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?*

The types of services listed above are appropriate to include in hybrid payments and none of these should be excluded. In addition, it may be that the area of addressing health-related social needs is included in the definition of care services, but if it isn't, this additional aspect of service could be added to the list above. Primary care practices need to have team members who can coordinate and link with community-based organizations and others that can help to address health-related social needs (HRSNs) – transportation, food, and stable housing among them – that, if left unaddressed, can prompt people to need more health services. APG is aware that, in the 2024 final MPFS rule, payment was created for person-centered assessments/services designed to address HSRNs, as well as care integration with CBOs and community care hubs, but it is not clear whether these amounts of payment and care integration are sufficient to enable practices to meet the need.

In principle, adding all of the services listed above and providing hybrid payment for them will positively affect patients' quality of care and the outcomes they receive. We would simply caution that it remains unclear how many, or how much, of these services that practices will be able to provide, even with hybrid payment. Many smaller primary care practices do not actively participate in Medicare Chronic Care Management (CCM) because they lack the capacity to monitor patients outside of normal office visits, for example. Until the balance is shifted within the Medicare physician fee schedule toward higher payment for primary care, the amount of overall resources dedicated to primary care payment will remain suboptimal. Substantial advance, upfront payment may also be needed so that smaller physician practices can restructure themselves to provide these additional services.

G. *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?*

Given that Medicare Part B currently requires beneficiaries to first meet a deductible (currently $240), and then pay 20 percent coinsurance of the Medicare-approved amount for most outpatient services and durable medical equipment, APG's understanding of this aspect of the legislation is that the required coinsurance amount could be cut to 10 percent. APG suspects that this amount would be a meaningful reduction that would

encourage beneficiaries to adopt hybrid payments and, more particularly, to stay with a given physician practice in the model once they have experienced it. Subject to analysis by the Congressional Budget Office, APG suspects that such a reduction could prove to be budget neutral, or alternatively, not very costly, if it can be linked to superior patient health outcomes, such as reductions in avoidable emergency department use and hospitalization.

APG would add that, for some beneficiary services, such as CCM, it may be desirable to eliminate beneficiary cost-sharing altogether. A likely partial explanation for the low level of eligible Medicare enrollees participating in CCM is at least in part the monthly copayment required of beneficiaries who do not have a supplemental Medicare policy. Here again, a CBO analysis could evaluate cost-saving aspects of such a measure, particularly over a longer-term budget window.

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

Outside the realm of payment, coinsurance, and other financial incentives for providers and beneficiaries, APG believes that a public communications strategy would be core to the model's success. Primary care practices in the hybrid model could receive some special designation from the Centers for Medicare & Medicaid Services or other official entity that highlighted the services and capacities that they provide . CMS or another entity could build on the concept of a patient-centered medical home to persuade beneficiaries that landing with one primary care practice and committing to longitudinal care over time would be beneficial to their health. Overcoming Americans' apparent predilection for "choice" and freedom to see whatever health care providers they want in favor of committing to a particular practice over the longer term will require more than just getting the financial incentives for patients right. Additional incentives could include clarifying aspects of the Medicare Conditions of Participation requirements on facilities – such as the requirement to designate qualified professionals in the facility to coordinate and communicate about patients – without stipulating what role these professionals should play in communicating with patients' primary care providers. s

I. 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… 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… ***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?***

Unlike other groups representing American physicians, APG is wholeheartedly in favor of a new advisory committee within CMS that could advise the agency on physician payment within the Medicare fee schedule. First, there have been multiple issues regarding the nearly exclusive reliance on the RUC, leading to widespread calls on CMS to decrease its overreliance on the panel.[2] Second, in almost any complicated enterprise, there is seldom one lone source of insight or truth, and this goes for the RUC and its role in setting Medicare physician fees. The fee schedule has for all intents and purposes become the captive of proceduralists, and a constant

[2] See, for example, the report of the National Academy of Sciences, Engineering, and Medicine, Implementing High-Quality Primary Care Consensus Study Report, 2021. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

group of them, at that, since the same clinicians are routinely surveyed by the panel. It is critically important to include the input of more primary care, family medicine, and cognitively oriented as opposed to procedure-oriented providers to help feed the perspectives of these stakeholders into the fee schedule. An Advisory Committee composed on these broader lines may not be sufficient to offset the influence of the RUC, but it is necessary.

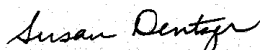
By weighing the input of such a group, CMS would inherently be taking a more active role in FFS payment rate setting than it is doing currently, as would also be the case with implementing the new hybrid payment model overall. Other changes that would augment the agency's role in FFS payment are almost certainly beyond the scope of this RFI, and would require statutory changes to accomplish, such as restructuring budget neutrality requirements. However, this and other measures should be actively considered as well in the context of a broader package of Medicare physician payment reforms.

III. Conclusion

APG has appreciate the opportunity to respond to this RFI and is grateful for the Senators' recognition of the importance of exploring hybrid payment for primary care. Our organization looks forward to continuing to work with you and your colleagues to flesh out details of your legislation and support its ultimate enactment by Congress.

Thank you very much.

Sincerely,



Susan Dentzer
President and Chief Executive Officer
America's Physician Groups