

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 “actuarially 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.