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July 31, 2022

Admiral Rachel L. Levine, MD
Assistant Secretary for Health
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Information on HHS Initiative to Strengthen Primary Health Care
87 FR 38168, June 27, 2022

Dear Admiral Levine:

Thank you for providing the opportunity to submit input to the Department of Health and Human Services as you develop the HHS Initiative to Strengthen Primary Health Care.

What the HHS Initiative to Strengthen Primary Health Care Should Include

By far, the most important thing that HHS can and should do to strengthen primary care is to create a better payment system for primary care practices. To do this successfully, I urge that the HHS Initiative to Strengthen Primary Health Care include the following elements:

- **Create new Healthcare Common Procedure Coding System (HCPCS) codes to support delivery of wellness care, acute care, chronic condition care, and behavioral health care services by primary care practices.** These ***Patient-Centered Primary Care Payment*** codes should include, at a minimum:
  - a *Wellness Care Payment* that a primary care practice can bill for each month for each patient who is receiving proactive, evidence-based wellness and preventive care services from the practice. A separate HCPCS code should be created for wellness care delivered to those patients who have more preventive care needs or who require more assistance in receiving wellness care services so that a higher payment can be made for these patients.
  - a *Chronic Condition Care Payment* that a primary care practice can bill for each month (in addition to the Wellness Care Payment) for each patient who has one or more chronic conditions and is receiving both proactive and reactive evidence-based chronic condition care services from the practice. Separate HCPCS codes should be created for chronic condition care delivered to patients with newly diagnosed conditions and those with complex conditions so that higher payments can be made for these patients.
  - an *Acute Care Fee* that the practice can bill for each time a patient in the practice experiences a new acute problem and receives appropriate, evidence-based diagnosis and treatment services from the primary care physician.

- a monthly *Integrated Behavioral Healthcare Payment* that the practice can bill for each month for each patient in the practice (in addition to the Wellness Care Payment) if the primary care practice has appropriate staff to deliver integrated behavioral health services.

- **Establish dollar amounts for each of the Patient-Centered Primary Care Payment HCPCS codes in the Medicare Physician Fee Schedule that are adequate to enable a primary care practice of any size to deliver each of the services to each patient who needs them.** The amount for each billing code should be determined by:
  1. estimating the amount of time that will be needed to deliver that type of care to a patient in a high-quality way, including all appropriate evidence-based services;
  2. identifying which members of the primary care team (physicians, nurses, etc.) will likely be involved in delivering the services; and
  3. translating those times into costs based on competitive wage rates for each member of the primary care team and the overhead cost for the primary care practice.

  Initial dollar amounts that can be used for each of the codes can be found here: https://patientcenteredpayment.chqpr.org/PrimaryCare.html#F.Summary

- **Allow any primary care practice in the country to bill and be paid for primary care services to Medicare beneficiaries using the Patient-Centered Primary Care Payment codes (instead of current Evaluation & Management Services codes) if the practice wishes to do so.** There is no need to mandate participation, because most primary care practices want a better payment system than they have today and most practices will likely want to participate once they see that CMS is implementing Patient-Centered Primary Care Payment properly. On the other hand, there should be no limit on how many primary care practices can participate in the Patient-Centered Primary Care Payment system nor should primary care practices be required to apply and receive approval before they can participate.

- **Request and advocate for Congressional approval of the following statutory changes:**
  - **Exempt Patient-Centered Primary Care Payment codes from budget neutrality requirements.** Payments for the Patient-Centered Primary Care Payment codes and annual changes to the payment amounts should be exempt from the budget neutrality provisions in the Social Security Act. CMS should be able to establish and maintain adequate payments for primary care services without having to reduce payments for other physician services.
  - **Reduce cost-sharing requirements for beneficiaries who receive primary care services supported by Patient-Centered Primary Care Payment.** It does little good to pay the primary care practice adequately to deliver high-quality care if cost-sharing discourages or prevents patients from receiving that care, as current requirements often do. The Patient-Centered Primary Care Payment codes should be exempted from the current statutory requirement that Medicare beneficiaries pay 20% of the Medicare payment for a Part B service. Beneficiaries should not be required to pay any cost-sharing for the Wellness Care, Chronic Condition Care, or Integrated Behavioral Healthcare Payments. Beneficiaries should be required to pay at most a small co-payment for the Acute Care Fee; that co-payment should be lower than the standard cost-sharing amount for an Emergency Department or urgent care center visit.
  - **Exempt primary care practices from the requirements of the Merit-Based Incentive Payment/Quality Payment Program.** In return for receiving adequate, flexible

payments, primary care practices should be held to a higher standard of quality with less administrative burden than what is required under the MIPS/QPP program. If a primary care practice chooses to be paid using the Patient-Centered Primary Care Payment codes, the practice should not bill or be paid for a monthly Wellness Care Payment, an Acute Care Fee, or a monthly Chronic Condition Care Payment for an individual patient unless either: (1) the practice had delivered services to that patient consistent with applicable, evidence-based Clinical Practice Guidelines (CPGs) during the month or acute care visit, or (2) the practice deviated from the guidelines for patient-specific reasons and had documented those reasons in the patient's clinical record. In addition, in order to receive Wellness Care Payments or Chronic Condition Care Payments for a patient, the primary care practice would need to contact that patient regularly to assess the status of their health problems. This approach assures that each *individual* patient is receiving the most appropriate, high-quality care for *their individual needs*.

- **Encourage all payers, including Medicare Advantage plans, state Medicaid programs, commercial insurance plans, and self-insured employers to make Patient-Centered Primary Care Payment available to primary care practices for the patients insured by those payers and to pay adequately for high-quality primary care services.** It is necessary but not sufficient for Medicare to change the way it pays for primary care. In order for *all* citizens to benefit from high-quality primary care, and in order for primary care practices to deliver that care, *all* payers need to make Patient-Centered Primary Care Payment available. At a minimum, HHS should take the following actions to encourage this:
  - **Collect and publish information on the methods and amounts Medicare Advantage plans use to pay primary care practices, and encourage Medicare beneficiaries to only enroll in plans that make Patient-Centered Primary Care Payment available to primary care practices and that pay adequate amounts for primary care services.**
  - **Encourage states to require that Medicaid Managed Care Organizations (MCOs) make Patient-Centered Primary Care Payment available to primary care practices.** CMS should establish a policy indicating that approval will automatically be given to states that want to establish this requirement.
  - **Encourage self-insured employers, and employers and individuals who purchase commercial health insurance policies, to only use insurance companies that make Patient-Centered Primary Care Payment available to primary care practices and pay adequate amounts for primary care services.** Most employers and citizens likely have no idea that the health insurance plan they are using is paying their primary care practice in a way that prevents the practice from delivering high-quality care.

There is much more detail on all of these recommendations in the report *Patient-Centered Payment for Primary Care* which is available at https://chqpr.org/downloads/Patient-Centered_Primary_Care_Payment.pdf and on the PatientCenteredPayment.org website.

What the HHS Initiative to Strengthen Primary Health Care Should *Not* Include

I strongly urge that the HHS Initiative to Strengthen Primary Health Care ***not*** include any of the following policies:

- **Do not create or encourage payment systems for primary care practices based solely on capitation payments or a "population-based payment."** Although fee-for-service

payment is routinely criticized for rewarding "volume over value," capitation and population-based payment has the opposite problem – it can reduce access to care and encourage stinting on services, since the primary care practice receives the same monthly payment regardless of how much care a patient needs or whether the patient's needs are met. In addition, population-based payment can make it difficult for patients who have complex needs to obtain primary care, because a primary care practice will not receive any additional payment to compensate for the additional time such patients require. Risk-adjusting the monthly payments does not address this, because typical risk adjustment systems only increase the monthly payment if a patient has multiple chronic diseases, not if they have a more severe condition, if they face non-medical challenges in managing their chronic condition(s) such as poverty or lack of transportation, or if they have frequent acute problems. This could increase disparities in health outcomes.

- **Do not create or encourage use of a "hybrid" payment model for primary care practices that pays smaller fees for all office visits plus a small per beneficiary per month amount that is not tied to any specific type of care.** This approach, which has been used in all Medicare primary care payment demonstration programs to date, not only fails to eliminate the weaknesses of fee-for-service for wellness care and chronic condition care, it adds the weaknesses of capitation to acute care and other services. This approach also creates significant additional administrative burden for practices because of the use of complex "attribution" systems to (inaccurately) determine which patients the primary care practice is accountable for and data submission requirements to support calculations of risk adjustment factors that have nothing to do with the amount of time and attention that patients need.
- **Do not create additional primary care payment demonstration programs through the Center for Medicare and Medicaid Innovation (CMMI).** Payment changes made available through CMMI are only available to a small subset of primary care practices, and because CMMI can only implement time-limited demonstration projects, any payment changes it makes are only temporary. No matter how much the participants in a CMMI primary care demonstration improve the quality of care for patients, the statute requires that the demonstration be terminated unless it has reduced Medicare spending, and it will be impossible for the CMS Actuary to ever certify that adequate, appropriate payments for primary care will reduce total Medicare spending. Consequently, CMMI is not and cannot be the appropriate mechanism for improving the way primary care practices are paid.

Thank you again for the opportunity to provide this input. I would be happy to answer any questions you may have about these recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

Harold D. Miller
President and CEO

cc: Judith Steinberg, Senior Advisor