Milbank Memorial Fund

Using evidence to improve population health

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Ron Wyden, Chairman
Mike Crapo, Ranking Member
U.S. Senate Committee on Finance
50 Constitution Avenue NE
Washington, DC 20510

Dear Senators Wyden and Crapo:

Thank you for your thoughtful white paper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B" (May 17, 2024). This letter is a response to the opportunity to comment on its policy concepts and options.

The Milbank Memorial Fund is an endowed operating foundation whose mission is to improve population health and health equity by connecting leaders and decision makers with evidence and sound experience. Given the foundational importance of primary care to a high-performing health system in general, and effective treatment of chronic conditions in particular — as well as the weak state of US primary care — we at Milbank have worked on initiatives to strengthen primary care over the last 12 years.

Our activities have included convening state officials and payers participating in three different CMMI primary care payment models, advancing state level policies to measure and increase primary care spending levels (the portion of health care expenses going to primary care), producing the annual National Scorecard on Primary Care, and fostering the development of state-level primary care scorecards.

Our responses to the questions posed in your paper are informed by these experiences as well as by the National Academy of Sciences, Engineering, and Medicine's (NASEM) 2021 report, *Implementing High Quality Primary Care*. The National Academies were chartered by the federal government to be an independent source of scientific information and knowledge. To that end, the NASEM primary care report assessed the best scientific evidence available on how to strengthen primary care, and its recommendations on these topics are both relevant and authoritative.

This document will respond to each set of questions in the white paper, set by set.

PFS Conversion Factor (CF) Updates

1. As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?
2. Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?
3. What targeted policies should Congress consider pursuing to offset the costs associated with an alternative CF framework?

Response:
The NASEM report prioritizes the implementation of a mandatory hybrid payment model for primary care in Medicare, as does the newly introduced Pay for PCPs Act (S4338) introduced by Senators Whitehouse and Cassidy. Annual conversion factor updates governing the accompanying primary care fee for service (FFS) payments should be a lower priority because they encourage a policy focus on outdated payment methodologies.

Maintaining Budget Neutrality

1. What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes?
2. Should the Committee consider additional parameters to align the statute's budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?

Response:
Relevant to the Medicare Physician Fee Schedule (PFS), the NASEM report recommends the following:

> *"The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:*
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> a. *accelerating efforts to improve the accuracy of the Medicare physician fee schedule by developing better data collection and valuation tools to identify overpriced services, with the goal of increasing payment rates for primary care evaluation and management services by 50 percent and reducing other service rates to maintain budget neutrality; and*
> b. *restoring the Relative Value Scale Update Committee to the advisory nature as originally intended by developing and relying on additional independent expert panels and evidence derived directly from practices."*

Better data collection tools would reduce the likelihood of inaccurate utilization assumptions. This data collection should extend to the Medicare Advantage program.

It would also be reasonable to charge an independent advisory panel (discussed further later) to do its valuation work within the parameters of budget neutrality.

Reforming Medicare Payments for Primary Care

1. In considering a new design for future A-APM bonus payments, are there existing demonstrations that structure A-APM incentive payments to reward providers that attribute beneficiaries to the A-APM?
2. What methodology should form the basis for incentive bonuses, if not total PFS revenue for all providers participating within an A-APM? What bonus structure best encourages new providers participating in A-APMs?
3. Should the bonus continue to require participation thresholds, or modify or eliminate thresholds to allow for greater participation? How?
4. Are there other A-APM programmatic designs that would make participation more attractive for providers?
5. How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?
6. What programmatic flexibilities, with respect to A-APMs or smaller models or pilots, would help to ensure a broader and more diverse array of options for clinicians?
7. Are there other A-APM programmatic designs that would make A-APMs more attractive to beneficiaries to increase attribution and thus support A-APMs?

Response:

Comprehensive high-quality primary care improves outcomes for patients with chronic conditions, and payment reform for primary care is essential to produce it. After reviewing the research on payment models to support these goals, the NASEM report recommended:

> *"Payers—Medicaid, Medicare, commercial insurers, and self-insured employers—using a fee-for-service (FFS) payment model for primary care should shift primary care payment toward hybrid (part FFS, part capitated) models, making them the default method for paying for primary care teams over time. For risk-bearing contracts with population-based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care. Hybrid reimbursement models should:*
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> a. *pay prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations;*
> b. *be risk-adjusted for medical and social complexity;*
> c. *allow for investment in team development, practice transformation, and the infrastructure to design, use, and maintain necessary digital health technology; and*
> d. *align with incentives for measuring and improving outcomes for attributed populations."*

Implementing hybrid payments as the base reimbursement model for primary care, as proposed by S4338, will reduce or eliminate the need for more provider payment options, which are costly to administer and confusing to providers. Enrolling all primary care clinicians in an A-APM also eliminates the need for complex, contested participation incentives. Most importantly it makes possible all the benefits of per-beneficiary payments noted by NASEM that promote team-based care and better chronic care management.

The CPC, CPC+, MCP, and ACO Primary Care Flex payment models from CMMI are all A-APMs, with some form of the NASEM-recommended hybrid payment model. Our experience with these CMMI payment models confirms the NASEM recommendation that the model become mandatory for all primary care services and clinicians in Medicare. Particularly when aligned with commercial payments, and contrary to CMMI's Medicare-only evaluations, evidence from CPC+ regions indicated lower costs and improved quality.

Medicare-wide implementation of hybrid payments for primary care can occur regardless of practice enrollment in a more comprehensive payment model. Oversight should be implemented to assure hybrid payments to health systems with employed physicians truly accrue to primary care.

Good primary care requires trusting relationships between primary care teams and their patients. Medicare can and should facilitate the development of those relationships (in effect "making the right choice the easy choice") by developing value-based benefits that reduce or eliminate patient cost-sharing in Medicare Part B for care provided by a beneficiary's designated usual source of care.

Quality Improvement in FFS

1. What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?
2. Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?

Response:

(As we are supportive of the NASEM report's recommendation to make a hybrid payment model the base for all primary care clinicians and services, we will address these questions in the context of the hybrid payments section that follows.)

Implementing Hybrid Payments for Primary Care

1. In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus the PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?
2. Should a hybrid model design include a hybrid-specific risk adjustor for primary care?
3. How can such a policy account for quality?
4. Are there benefit design flexibilities that would ease financial burden for ACO-attributed beneficiaries who require chronic care management?
5. If Congress were to pursue such a hybrid model design, should policymakers also differentiate the CF, budget-neutrality adjustments, and other mechanisms to promote team-based care and appropriately account for distinctions in payment models across specialties and subspecialties?
6. If so, how should Congress structure such differentiation?

Response:
The NASEM report did not directly address the relative volume of payments administered as fee-for-service and capitated, nor a risk adjustment methodology. While the CPC and CPC+ models made capitated payments, they were insufficient in size relative to fee-for-service to promote team-based care. The proposed payment methodology in S4338 applies the lessons from the CMMI payment models and is more comprehensive and specific about both services included in the hybrid model and risk adjustment. We believe it supplies a proper template for the Senate Finance Committee's queries.

In doing so, we strongly encourage Congress to attend to two factors:

1. More comprehensive reporting to CMS of payment amounts and methodologies for Medicare Advantage health plans, to ensure program alignment and promotion of congressional policy priorities
2. As recommended by the NASEM report, regular monitoring of the portion of total spending going to primary care ("primary care spending") in Traditional Medicare and Medicare Advantage to assure adequate investment in the foundation of a high-performing health system.

Regarding monitoring and improving the quality of care in a hybrid payment, Congress can and should define its goal. The NASEM report provided a definition of high-quality primary care:

> *"High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."*

CPCI and CPC+ provided lessons on how to implement and attain this standard of high - quality primary care, which are directly applicable for all of Medicare.

In the CPCI, high-quality primary care was encouraged through the following strategies:

- Increasing the depth and reach of care management
- Increasing patient access to care
- Delivering chronic and complex disease management
- Creating a culture of improvement in the participating practices

Incorporating lessons learned in the CPC, the CPC+ promoted high-quality primary care through facilitation of the following additional strategies:

- Addressing health-related social needs
- Integrating behavioral health with primary care
- Providing medication management
- Providing advance care planning
- Engaging patients and caregivers in guiding practice improvement
- Advancing integrated information technology
- Advancing multi-payer alignment

Both CPCI and CPC+ funded market-level "learning collaboratives" for participating practices to help them learn how to effectively provide team-based care. This approach proved particularly valuable for small and under-resourced independent practices. Health systems with employed physicians, however, should be expected to provide these practice supports — and incented to through adoption of A-APMs.

Based on these lessons learned in CMMI models, quality reporting and attainment of minimum risk-adjusted performance levels for a simplified set of measures should become a threshold for primary care clinician hybrid payments. Again, this would simplify current problematic CMS practices. This process must be accompanied by regular, timely, and reliable reporting back to practices on their performance on these measures as feedback facilitates improvement.

Finally, it is important for Congress not to over-specify this work in statute. We think one of the lessons from years of Medicare quality measurement is that congressional statute should set forth clear intent and principles in its direction to CMS, expect design specifics consistent with those principles, and conduct regular program oversight. Rigid compliance requirements in either statute or regulation impede the necessary rapid learning required to effect needed modifications to innovative strategies.

As noted previously regarding beneficiary engagement and financial relief, we support the waiving of all or substantially all beneficiary cost-sharing for services provided by a beneficiary-designated usual source of care. Implementation of this value-based benefit design in self-employed populations has resulted in increased use of outpatient services and decreased inpatient admissions.

Regarding budget neutrality adjustments, Milbank's experience with CMMI multipayer payment models reinforces the need to regularly update any payment method to reflect macroeconomic trends. Given the historical under-investment in primary care by Medicare and its importance for chronic care management, consideration should be given to prioritizing those adjustments for primary care providers and services so as not to further exacerbate existing underpayments.

Medicare Benefits to Improve Chronic Care Outcome

1. Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?
2. What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?

Response:

We understand these questions to be related to enhancing or altering Medicare benefits to improve cost and quality outcomes for Medicare beneficiaries with chronic conditions. The evidence from 25 years of implementing the Chronic Care Model in a variety of settings shows that this goal is best accomplished by facilitating the development of meaningful beneficiary relationships with high-quality, comprehensive primary care through the areas already discussed in the white paper: *payment reforms, quality reporting, and benefit design*. These will prove far more effective than additional Medicare benefits.

Although not strictly speaking a Medicare benefit, we want to use this opportunity to highlight Medicare's influence in producing a clinician workforce skilled in improving chronic care outcomes, primarily through its financing of Graduate Medical Education (GME). The NASEM report noted the ineffectiveness of current Medicare GME funding for accomplishing these goals and made the following recommendations:

> *"The Centers for Medicare & Medicaid Services, …should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments. The revised funding model should be sufficient in size to improve access to primary care and ensure that training programs can adequately support primary care pipeline needs of the future support primary care pipeline needs of the future.*
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> a. *HRSA funding (via Title VII and Title VIII programs) for other health professions training should be increased and prioritized for interprofessional education.*
> b. *The U.S. Department of Health and Human Services, enabled by Congress as needed, should redesign the graduate medical education (GME) payment to support training primary care clinicians in community settings and expand the distribution of training sites to better meet the needs of communities and populations, particularly in rural and underserved areas. Effective HRSA models (e.g., Teaching Health Centers, Rural Training Tracks) should be prioritized for existing GME funding redistribution and sustained discretionary funding.*
> c. *GME funding should be modified to support the training of all members of the interprofessional primary care team, including but not limited to nurse practitioners, pharmacists, physician assistants, behavioral health specialists, pediatricians, and dental professionals.*"

Improving the Accuracy and Effectiveness of Medicare Rate Setting

1. What structural improvements, if any, would help to bolster program integrity, reliability and accuracy in CMS's RVU and rate-setting processes?
2. For more than 25 years, a Refinement Panel provided a relative value appeals process for CMS's annual PFS processes. Should the agency consider reinstating such a panel, and if so, what modifications, if any, would help to ensure independence, objectivity, and rigor?
3. What third-party entities could produce the most credible and reliable analysis of CMS's RVU determination and rate-setting processes, and what key areas should such analysis examine?

Response:

In addition to program integrity, reliability, and accuracy, we think a fourth standard for Medicare's rate setting is called for: *program effectiveness.* We also think that the third-party analysis of the RVU posed above has already been conducted. In the NASEM Primary Care Report, a thorough review of published research on Medicare rate setting for clinician services resulted in the following findings:

"The relative prices set by the Medicare PFS have profound effects on prices paid by Medicaid, commercial payers, and others. The RUC exerts significant influence on the relative prices assigned by CMS.

- *The RUC, together with the structure of the PFS, have resulted in systematically devaluing primary care services relative to other services and its population health benefit, reflected in large and widening gaps between primary care and specialty compensation.*
- *The widening compensation gap between primary care and other physician specialties is associated with reductions in medical trainees' likelihood of choosing primary care careers and with hospitals' graduate medical education training priorities.*
- *With adequate resources and leadership, CMS has the authority to address these weaknesses and internalize the functions of the RUC (data collection and valuation tools) to generate payment levels aligned with high-quality primary care."*

These findings ground the report's recommendation directly relevant to this question:

"Restoring the Relative Value Scale Update Committee to the advisory nature as originally intended by developing and relying on additional independent expert panels and evidence derived directly from practices."

The expertise represented on the panel(s) should reflect the three standards articulated above: program integrity, reliability accuracy, and effectiveness. A truly independent panel of experts would produce decisions better reflecting the public interest than a panel with a financial interest in the outcomes, as has been noted by the Government Accountability Office in its assessment of the Relative Value Scale Update Committee. S4338 contains provisions consistent with this recommendation.

Although not directly part of the Committee's questions in the RFI, we want to underscore the importance of Congress holding the Executive Branch accountable for ongoing, persistent coordination of its practices and activities to strengthen primary care, improve outcomes for chronically ill beneficiaries, and improve the effectiveness of the Medicare program. We encourage the Committee to look for opportunities to advance this accountability through the establishment of an HHS Secretary's Council on Primary Care, which the NASEM report identified in one of its final recommendations:

"The U.S. Department of Health and Human Services (HHS) Secretary should establish a Secretary's Council on Primary Care to enable the vision of primary care captured in the committee's definition.

a. *(Membership)*
b. *The council should coordinate primary care policy across HHS agencies with attention to the following responsibilities: (1) assess federal primary care payment sufficiency and policy; (2) monitor primary care workforce sufficiency including training financing, production and preparation, incentives for federally designated shortage areas, and federal clinical assets/investments (health centers, rural health clinics, the Indian Health Service, and the U.S. Department*

of Veterans Affairs); (3) coordinate and assess the adequacy of the federal government's research investment in primary care; (4) address primary care's technology, data, and evidence needs, including interagency collaboration in the use of multiple data sources; (5) promote alignment of public and private payer policies in support of high-quality primary care; and (6) establish meaningful metrics for assessing the quality of primary care that embrace person-centeredness and health equity goals. Additionally, the council should coordinate implementing the committee's recommended actions that target federal agencies.

c. *As part of its coordination role, the council should verify adequate budgetary resources are allotted in respective agencies for fulfilling these responsibilities.*
d. *The council should annually report to Congress and the public on the progress of its implementation plan and performance on each of these six responsibilities."*

As the Committee has signaled, promoting improved chronic care is necessary for the effectiveness of the Medicare program and will only happen through the implementation of high-quality primary care. The Executive Branch must be held accountable for the implementing the payment, benefit design, and clinical quality improvement policies advanced by Congress and discussed here.

Thank you for the opportunity to offer comments on this issue of vital importance. We hope that they prove useful.

Sincerely

Christopher F. Koller