

August 1, 2022

Admiral Rachel L. Levine, MD, FAAP
Assistant Secretary of Health
Department of Health and Human Services
Washington, DC 20201

Judith Steinberg, MD
Office of the Assistant Secretary of Health
Department of Health and Human Services
Washington, DC 20201

Dear Admiral Levine and Dr. Steinberg:

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (the Campaign), we appreciate this opportunity to respond to the Request for Information. PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 66 organizational [Executive Members](#) ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships, and “upstream” drivers for a better patient experience and better health outcomes. (See the [Shared Principles of Primary Care](#)). In March 2022, PCC launched the Campaign to realize bold policy change rooted in a simple principle: We need strong primary care in every community so we can all have access to better health.

Overall Comments:

PCC and the Better Health – NOW Campaign applaud you and the OASH team for launching this important Initiative to Strengthen Primary Health Care. The Administration's overall access to care, health equity and population health goals can only be achieved with bold action to strengthen primary care for all communities – best achieved through a coordinated whole-of government approach. Primary care is the one component of the health care delivery system where increased supply is associated with improved population health, lower costs and more equitable outcomes.^{1,2} Yet despite growing chronic disease prevalence and persistent health disparities, the U.S. has devoted just 5% to 7% of health care dollars to primary care, a proportion that is trending down.^{3,4}

The RfI's goal state for primary care is broadly consistent with PCC's Shared Principles of Primary Care. The Shared Principles, published in 2017 and signed by 350+ organizations, outline an ideal vision for primary care that is person- and family-centered, continuous, comprehensive and equitable, team-based and collaborative, coordinated and integrated, accessible, and high value. We encourage you to consider the Shared Principles as you refine and pursue the goal state for primary care.

¹ Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med.* 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624

² Shi L. The impact of primary care: a focused review. *Scientifica (Cairo).* 2012;2012:432892. doi:10.6064/2012/432892

³ Greiner A, Kempfski A. Primary care spending: High stakes, low investment. Primary Care Collaborative. <https://www.pcpcc.org/resource/evidence2020>. Published April 20, 2022. Accessed April 15, 2022.

⁴ 2021 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; December 2021. AHRQ Pub. No. 21(22)-0054-EF.

The National Academies of Science, Engineering and Medicine's (NASEM's) 2021 report, *Implementing High Quality Primary Care* is the launchpad for this PCC Campaign, and we applaud your decision to ground HHS' 2-3 year plan in that report. Our 48 Campaign Participants and supporters have united around the following PCC Concordance Recommendations on Primary Care Payment and Investment, to help realize NASEM's payment, empanelment, and access recommendations in every community:

- 1. Primary care payment should create pathways to rapidly transition from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model** coupled with up-front and ongoing investments and guardrails to ensure that patients and communities most affected by health and health care inequities, and the primary care clinicians and teams that care for them, realize the benefits of a higher-value health system. These payment pathways should include adjustment for health status, risk, social drivers of health and social risk, historic under-investment, and other elements. Such hybrid models should be implemented and aligned across payers, while being mindful of practice heterogeneity, preserving the viability of primary care clinicians who have earned the trust of structurally disadvantaged communities, providing culturally congruent, care, and supporting greater adoption of telehealth. There should be a pathway for practices to voluntarily pursue higher levels of prospective payment at an even quicker pace with sufficient support.
- 2. To achieve rapid transition to and sustainability of comprehensive primary care practice models, overall healthcare spending, both in terms of ongoing payment and needed investment, must be rebalanced towards primary care.** Currently, primary care spending in the U.S. amounts to only approximately 5% to 7% of total cost of care and is trending down. There is strong evidence that countries that devote considerably more resources to primary care as a share of total health spending than the U.S. achieve more equitable health outcomes, better overall population health, and much lower per capita spending. Policymakers committed to slowing spending growth in our inefficient health system should implement needed resource shifts now, understanding that they will ultimately result in a more efficient, higher-value healthcare system.
- 3. Overall primary care funding levels (both ongoing payments and needed investments) must be risk-adjusted and sufficient to support multidisciplinary primary care teams that reflect and can meet the needs of diverse populations,** with an emphasis on providing high-quality comprehensive, integrated care to communities that are structurally disadvantaged by discrimination and other social drivers, as well as those with complex medical and behavioral health needs. Primary care teams should also be supported with resources to allow them to prioritize and proactively address equity within their practices, in partnership with the communities they serve.
- 4. To better support both patient-clinician relationships and accountability for population health outcomes, patients should be encouraged to choose a regular source of accessible, culturally centered primary care.** Patients may wish to change their source of care for varied reasons, including, but not limited to, evolving medical needs, negative experiences such as discrimination in any form, accessibility requirements, or convenience. Patients should continue to have the option of changing to another source of care if their needs are not being met.
- 5. Increasing Medicaid primary care payment to at least the level paid by Medicare is critical to address health inequities and a key step on the path to hybrid primary care Medicaid models.** The federal government should fully fund state efforts to achieve this standard of payment. Medicaid parity must be pursued in tandem with initial efforts to reform Medicare payment and investment detailed above and encourage commercial, Medicaid and other payers to align on policy initiatives and payment design. State innovations in

primary care payment reform and investment represent a learning lab for Medicare and other payers and should be encouraged through federal partnerships. Primary care safety-net provider organizations such as community health centers and rural health clinics rely on federally required payment structures like the Prospective Payment System (PPS) and All-Inclusive Rate (AIR) for their continued financial viability. It is critical that future policy protect these tools while supporting these organizations' participation in mutually agreed upon payment models that improve access and quality.

Rfl Topic 4: Proposed HHS Actions:

Leverage CMS Innovation Center learnings to advance wider policy change.

Primary Care First, ACO REACH, and additional advanced primary care models are important model tests; They also can be testbeds for delivery, benefit and payment features with broader applicability. These features should continue to be assessed for their impact on quality, cost, population outcomes and health equity, and eventually be implemented widely if deemed appropriate. But to bring success to scale, CMMI innovations, however promising, must be matched by bold leadership and prompt regulatory and administrative actions across permanent federal programs, including the proposed actions below. We ask that you consider including these ideas in your report.

1. Use Medicare payment policies to strengthen and enhance primary care

The failings of fee-for-service reimbursement are jeopardizing community-based primary care practices, eroding patients' timely, affordable access, and undermining health equity. Harnessing Medicare's size and influence to scale primary care payment innovation is indispensable to primary care's future. Without bold CMS action to comprehensively finance primary care, employers, plans, states, and clinical organizations will face barriers to the scale and reach of their primary care investment. NASEM has argued that "CMS should increase the overall portion of spending going to primary care" while transitioning to a hybrid payment model for primary care comprised of both prospective payment and fee-for-service payment. CMS should fully leverage its statutory authorities within permanent programs to move us closer to that goal. CMS should offer Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) the option of adopting hybrid primary care payments. CMS has existing authority to implement partial capitation or alternative payment methodologies. This hybrid payment option would help more practices move away from FFS.

2. Integrate primary care and behavioral health

The national mental health and addiction crises, along with glaring behavioral health disparities, have underlined the need for whole-person care that is responsive to medical, behavioral, and social needs. HHS must lead the way to a reformed payment system that enables primary care practices to sustain robust integration. Existing payment policies and time-limited grants, though important, remain incommensurate with the scale of this crisis. In January 2022, PCC shared detailed recommendations with CMS and HHS, summarized below:

- Over the medium- to long-term, HHS should use its various demonstration authorities to develop and test prospective primary care payment models, such as per-member per-month, that adequately support integrated advanced primary care inclusive of services addressing both physical and behavioral health care needs.
- To address the immediate crisis, CMS should reassess the existing payment values for Collaborative Care Management and General Behavioral Health Integration Codes and consider a limited waiver of the Medicare Fee Schedule budget neutrality requirements to support enhanced Primary Care - Behavioral Health Integration capabilities.
- HHS should work with Congress to develop and enact a broadly available program of forgivable loans to finance upfront practice costs and provide resources to states to convene payers and clinicians to align documentation, measurement, and payment innovations.

3. Strengthen community-oriented primary care through Medicaid and CHIP

Strengthening primary care for Medicaid beneficiaries is essential to disparity reduction and access to care. Congress should provide more resources to close the payment gaps between Medicaid and other payers, a key step toward a hybrid model. However, HHS has a crucial role as well. Our specific recommendations are summarized below and available in full [HERE](#).

- To support continuity of primary care and minimize coverage disruptions, maintain CMS' support for all available options to extend coverage, prioritize adoption of twelve-month continuous coverage for Medicaid and CHIP beneficiaries and limit eligibility redeterminations.
- Include measures of primary care access and spending in State Medicaid Scorecards and consider primary care access and investment in primary care in any future minimum access standards.
- Promote evidence-based models of primary care-behavioral health integration.
- Issue comprehensive guidance to states on payment for evidence-based community health worker services.
- Require higher-quality data collection and reporting from states regarding race/ethnicity data and other demographic data.

4. Leverage telehealth to support integrated primary care in the medical home

Telehealth technologies have the potential to contribute to safe, high-quality primary care, particularly if utilized in coordination with an individual's medical home. To enable such care, Medicare's in person visit requirement for tele-mental health services should be removed. CMS should also work with states to remove reimbursement barriers to the delivery of tele-mental health services to Medicaid beneficiaries by primary care practices. The decision of the appropriate care modality should be left to the patient and the care team's professionalism and training.

5. Remove cost-sharing barriers to primary care across public programs and the private sector

Cost-sharing can impede access to primary care – access that is essential to fighting today's simultaneous epidemics of poor mental health, substance use, cardiometabolic disorders and infectious diseases. Cost-sharing for chronic care coordination and integrated behavioral health services should be waived or eliminated in Medicare and other programs. Working with HHS, the IRS should broaden the preventive services safe harbor for High-Deductible Health Plans to facilitate pre-deductible access to comprehensive, whole-person primary care, inclusive of integrated behavioral health, in the private market.

As NASEM has argued, primary care is a public good. Foundational to public and population health, primary care knits together fragmented and uncoordinated parts of health care to produce better health. Assuring this public good is nurtured and sustained for all communities will require a sound plan and bold action – now. We stand ready to help. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions.

Sincerely,



Ann Greiner
President & CEO
Primary Care Collaborative