Statement for the Record

For the U.S. Senate Committee on Finance Hearing:
Bolstering Chronic Care through Medicare Physician Payment
Held on April 11, 2024
From the Primary Care Collaborative and the Better Health-NOW Campaign
1101 Connecticut Ave, Ste. 1150
Washington, DC, 20036

The Primary Care Collaborative and our Better Health – NOW Campaign partners thank the Senate Finance Committee for convening the hearing and for this opportunity to submit a statement for the record. As it examines the sweep of issues related to Medicare payment, we urge the Finance Committee to put Medicare primary care at the center of its work.

High-quality, whole-person primary care is an essential foundation for any proactive strategy to address chronic physical and mental health conditions and the increasingly unaffordable costs they generate. The National Academies of Sciences, Engineering and Medicine's (NASEM) 2021 consensus report, *Implementing High-Quality Primary Care,* found that "primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."[1]

Primary care payment reform can unlock powerful improvements in quality and real cost savings, particularly in public programs that shape the entire marketplace Within the Medicare Shared Savings Program, primary care centric ACOs reduced preventable downstream costs compared to other ACOs and produced twice the shared savings as other, hospital-based ACOs.[2] For certain practices, states and geographies, the CMS Innovation Center has also introduced new or re-tooled promising primary care models, including Making Care Primary, ACO Primary Care Flex and ACO REACH.

Despite these bright spots, our overall health care system's priorities remain out of balance, devoting less than five (4.7) cents of each dollar to primary care in 2021.[3] Most primary care practices report no participation in either shared savings or population-

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[1] The National Academies of Sciences, Engineering and Medicine. (2021, May). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Nationalacademies.org. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
[2] *Improve Care in Medicare by Growing Primary Care in ACOS*. Primary Care Collaborative. (2024b, March). https://thepcc.org/resource/improve-care-medicare-growing-primary-care-acos
[3] *The health of US Primary Care: 2024 Scorecard Report - No One Can See You Now*. Milbank Memorial Fund. (2024b, February 29). https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

based payment.[4] In 2023, an estimated 1 in 4 (28.7%) Americans lack a usual source of care[5] and rural and underserved communities, in particular, face widening gaps in access.[6]

Reorient Medicare Payment toward Primary Care and Prevention

Over time, policy choices guiding Medicare Part B's fee-based payment structure have generated distortions that have systematically undercut investment in primary care[7] and contributed to growing health disparities, based on geography, race and ethnicity.[8] This persistent under-resourcing of primary care is an obstacle to the health of Medicare beneficiaries and the sustainability of the primary care workforce. Moreover, because all Medicare APMs and most private APMs are built upon the Medicare Physician Fee Schedule to one extent or another, shortcomings in Medicare's support for primary care are magnified throughout the nation's entire health care system.

To address the rising tide of chronic disease discussed in the April 11th hearing, policymakers must fix the underlying flaws in Medicare Part B's payment policies. Below, we detail our initial recommendations to the Committee in this regard.

Enhance Transparency: As noted above, America's allocation of health care dollars is deeply unbalanced, devoting just 4.7 cents for each dollar spent to primary care. **Congress should require HHS to follow the lead of more than twenty states[9] and report primary care spending as a share of total spending.** This requirement should apply to traditional Medicare, Medicare Part C and across federal programs.

Give Primary Care Practice a Choice: An Alternative to Fee-for Service: Better Health – NOW supports efforts to rapidly transition primary care payment from a predominantly fee-for-service model to predominantly population-based prospective payment (hybrid)

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[4] Horstman, C., & Lewis, C. (2023, April 13). Engaging Primary Care in Value-Based Payment: New Findings from the 2022 Commonwealth Fund Survey of Primary Care Physicians. https://www.commonwealthfund.org/blog/2023/engaging-primary-care-value-based-payment-new-findings-2022-commonwealth-fund-survey

[5] *The health of US Primary Care: 2024 Scorecard Report - No One Can See You Now*. Milbank Memorial Fund. (2024b, February 29). https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[6] *Rural-Urban Disparities in Health Care in Medicare - CMS*. Centers for Medicare and Medicaid Services. (2023, November). https://www.cms.gov/files/document/rural-urban-disparities-health-care-medicare-national-report.pdf

[7] MedPAC (Medicare Payment Advisory Commission). 2006. Report to the Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission.

[8] McNeely, L., Douglas Megan, Westfall, N., Greiner, A., Gaglioti, A., & Mack, D. (2022). PRIMARY CARE: A Key Lever to Advance Health Equity. The Primary Care Collaborative. https://thepcc.org/sites/default/files/resources/PCCNCPC%20Health%20Equity%20Report.pdf

[9] See PCC's State Primary Care Investment HUB for information on state based legislation measuring and reporting primary care spend, available at https://thepcc.org/primary-care-investment/legislation

models. These new models must include up-front and ongoing investments, as well as guardrails to assure quality and access in rural and underserved communities.

To that end, the Finance Committee should work with stakeholders toward legislative solutions that make a well-constructed primary care hybrid payment option broadly available. Under such an approach, payment would be provided to practices upfront each month to deliver primary care for patients with an ongoing relationship, coupled with FFS payment for other services. The design and implementation of hybrid payment should:

- invest in primary care capacity, support personalized, team-based care and pay for services tailored to the needs of the patient and the community;
- reduce or simplify the burdensome documentation associated with many FFS codes, which add to systemic costs and consume clinician time that could be better spent with patients;
- allow for additional, higher payment tiers based on the scope of services included in such payments, such as greater behavioral health integration and ability to address health-related social needs.

Enhance Primary Care Affordability in Medicare: As part of any Medicare payment reform legislation, Congress should remove financial barriers patients face in accessing the comprehensive, whole-person primary care necessary to manage their chronic conditions. **We support**

- **authorizing patient cost-sharing waivers for the services provided prospectively as part of any hybrid primary care payment,**
- **eliminating cost-sharing for Medicare's behavioral health integration services (Section 102 of S. 923 the Better Mental Health Care for Americans Act) and**
- **removing cost-sharing requirements for Chronic Care Management codes (HR 2829, the Chronic Care Management Improvement Act).**

Accelerate Primary Care – Behavioral Health Integration: Research has shown that evidence-based, primary care integration models, like the Collaborative Care Model and Primary Care Behavioral Health, can successfully improve outcomes while making better use of an overstretched mental health workforce. In 2016, Medicare established payment codes to support the delivery of the collaborative care model and general behavioral health integration services. The Centers for Medicare and Medicaid Services and Congress have taken steps in the years since to further support integrated care. Unfortunately, availability of evidence-based, integrated primary care has been badly outpaced by patients' growing need for mental health and addiction services.

To address the present crisis in behavioral health and strengthen the health of Medicare beneficiaries and their communities, **Better Health – NOW supports S. 1378, the COMPLETE Care Act** and **S. 3157 the More Behavioral Health Providers Act**. We appreciate the inclusion of these measures in the Better Mental Health Care, Lower Cost Drugs and Extenders Act of 2023, and urge all members of the Committee to press for enactment of these provisions this year. The More Behavioral Health Providers Act extends and expands the Health Professional Shortage Area program to help communities attract behavioral health clinicians needed to support integrated primary

care teams. The COMPLETE Care Act provides for technical assistance and enhanced reimbursement for integrated care services.

In light of the dual crises of mental health and addiction, we encourage the Committee to consider additional steps. One approach would be to remove expenditures on Collaborative Care Management (CoCM) and General Behavioral Health Integration codes from the expenditures compared against spending benchmarks in MSSP and other benchmark-based payment models. Accountable payment has the potential to support broader adoption of behavioral health-primary care integration. But because expenditures associated with delivering the services can increase spending over the short-term, benchmark-based payment models like MSSP have a built-in disincentive to the delivery of and billing for integrated behavioral health. We encourage you to explore how to address this issue.

(For more information, please see PCC/BHN responses to the Senate Finance Committee's bipartisan mental health legislative work here and here.)

Support Private Sector and State Payment Innovation:

Primary care practices rarely serve only traditional Medicare enrollees and rely on other payers to remain viable and sustain services for all their patients, including Medicare beneficiaries. To succeed, Medicare primary care payment innovations should align with payment innovations by state Medicaid programs, as well as those advanced by private market payers and purchasers. In tandem with its Medicare payment reform work, the Finance Committee should pursue targeted policy steps this year that support constructive state Medicaid and private market primary care innovations, including the following.

Strengthen Primary Care in Rural and Underserved Communities, leveraging Medicaid and CHIP:
Strengthening primary care for Medicaid and CHIP beneficiaries is an essential complement to reforming Medicare payment. Medicaid and CHIP cover more than 80 million Americans, including a disproportionate percentage of rural people, low-income seniors, people with disabilities, and people of color. Yet, Medicaid primary care payment averages just 78% of Medicare's. Congressional leadership is necessary to ensure practices and clinics serving these communities can sustain primary care access. The following represent essential and immediate steps:

- **Enact S.2556 the Improving CARE for Youth Act,** which eliminates payment restrictions on primary care and behavioral health services delivered on the same day for children in Medicaid/CHIP
- **Work with the Health, Education, Labor and Pensions Committee to provide longer-term funding for the Community Health Center Fund and increase the yearly outlay for the Fund to help Federally Qualified Health Centers reach more rural and underserved communities.**

(For more information on strengthening primary care in Medicaid, see PCC's report *Access and Equity in Medicaid*.)

Encourage Primary Care Access Innovations in the Private Market: According to the Centers for Disease Control and Prevention (CDC), in 2017 nearly a quarter of individuals with employer sponsored insurance were enrolled in high deductible plans without a health savings account.[10] Over 50 percent of individuals with an HSA live in zip codes where the median income is below $75,000 annually.[11] Yet HSA/HDHPs are barred from covering many primary care services until a patient meets their full deductible.

To address this barrier to primary care, Congress 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. **Better Health - NOW supports the following legislation, introduced in the 118th Congress:**

- **HR 7681, The Primary and Virtual Care Affordability Act**, which gives employers and health plan sponsors the flexibility to reduce or waive cost-sharing for primary care and extends the existing, waiver flexibility for telehealth services through 2026.
- **S. 655, The Chronic Disease Management Act,** which allows high-deductible health plans with HSAs to cover care for chronic conditions before exhausting the deductible.

Within the U.S. health care system, primary care is the level of care best positioned to beat back the endemic rates of chronic disease and spiraling costs. The need for bold Congressional action to champion primary care could not be more urgent.

We look forward to continuing to work with you to strengthen primary care. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions.

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[10] Cohen, R. A., Zammitti, E.P. (2018). High-deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-based Insurance Coverage. 317. https://www.cdc.gov/nchs/products/databriefs/db317.htm

[11] Cohen, R. A., Zammitti, E.P. (2018). High-deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-based Insurance Coverage. 317. https://www.cdc.gov/nchs/products/databriefs/db317.htm

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PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 70 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 Better Health – NOW (BHN) campaign to realize bold policy change rooted in a simple principle: We need strong primary care in every community to achieve better health for all.