primary care
collaborative

March 15, 2023

The Honorable Bill Cassidy
U.S. Senate
Washington, DC 20515

The Honorable Tim Scott
U.S. Senate
Washington, DC 20515

The Honorable John Cornyn
U.S. Senate
Washington, DC 20515

The Honorable Mark Warner
U.S. Senate
Washington, DC 20515

The Honorable Tom Carper
U.S. Senate
Washington, DC 20515

The Honorable Bob Menendez
U.S. Senate
Washington, DC 20515

Dear Senators Cassidy, Scott, Cornyn, Warner, Carper and Menendez

The Primary Care Collaborative (PCC) commends you for launching a bipartisan effort to improve care for individuals dually eligible for Medicare and Medicaid. We write today to offer our recommendations to improve coverage, care, and outcomes for these beneficiaries.

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).

We applaud your interest in addressing the failures of care coordination and program alignment that face Medicare beneficiaries with dual coverage. For those with complex care needs - like these beneficiaries, the promise of better outcomes at lower cost begins with whole-person primary care. Delivering on that promise will mean paying more and paying differently for primary care.

Primary Care and Dually Eligible Beneficiaries

Whole person primary care is foundational for the health of Medicare beneficiaries with dual coverage. Increased utilization of primary care has been linked to lower rates of preventable hospitalizations for dually eligible individuals aged 65 and older, especially for those with diabetes and congestive heart failure.[1]

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[1] Oh, N.L., Potter, A.J., Sabik, L.M. *et al.* The association between primary care use and potentially-preventable hospitalization among dual eligibles age 65 and over. *BMC Health Serv Res* **22**, 927 (2022). https://doi.org/10.1186/s12913-022-08326-2

High-quality, whole person primary care is rooted in an ongoing relationship with a primary care clinical team that is responsible for and can effectively coordinate care across settings and sources of care. When such a relationship is present, the impact is telling; Continuity of care is associated with patient satisfaction, preventive services, lower hospital and emergency department utilization, and lower costs.[2,3]

Unsurprisingly, the most successful models for dually eligible beneficiaries have leveraged strong, whole person primary care to produce better outcomes. The Program of All-Inclusive Care for the Elderly demonstrates lower readmissions and ER visits, as well as 15% lower Medicaid costs relative to other approaches to LTC.[4] Strong primary care teams that can help coordinate a full range of clinical and other services are core to the PACE model of care. Some Medicare Advantage Special Needs Plans and Medicare-Medicaid Plans (authorized under the Financial Alignment Initiative) have applied a similar, coordinated approach with demonstrated success.[5,6,7,8] Beneficiaries in Minnesota's Dual-Eligible-SNP (D-SNP) integration effort, the Minnesota State Health Options program, produced increased primary care utilization but fewer hospitalizations and ED visits.[9] Other states like Washington and Vermont have leveraged primary care-centered payment models to improve care for dually eligible beneficiaries.[10,11]

Unfortunately, these successes have yet to be replicated nationwide. For example, many of the counties with the highest concentration of dually eligible beneficiaries are primary care deserts-areas with limited access to primary care.[12] New evidence shows primary care access may be eroding, not improving. The percentage of dually eligible individuals with a usual source of care declined 10 percent between 2015 and 2019, according to PCC's 2022 Evidence Report, *Relationships Matter: How Usual is a Usual Source of (Primary) Care,* released in partnership with the AAFP Robert Graham Center for

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[2] Cabana MD, Jee SH. Does continuity of care improve patient outcomes?. *J Fam Pract*. 2004;53(12):974-980.
[3] Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL Jr. Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations. *Ann Fam Med*. 2018;16(6):492-497. doi:10.1370/afm.2308
[4] PACE by the Numbers. National PAC Association. December 2022. https://www.npaonline.org/sites/default/files/PDFs/infographic/NPA-infographic-dec2022.pdf
[5] Taking Stock of Medicare Advantage: Special Needs Plans. The Commonwealth Fund. March 2022. https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-special-needs-plans
[6] Kim H, Charlesworth CJ, McConnell KJ, Valentine JB, Grabowski DC. Comparing care for dual-eligibles across coverage models: empirical
evidence from Oregon. Med Care Res Rev. 2017;76(5):661-677.
[7] Chernof BA. Integrating Medicare and Medicaid: Successes to Date, Lessons Learned, and the Road Ahead. *Milbank Q*. 2019;97(1):31-35. doi:10.1111/1468-0009.12371
[8] Center for Health Care Care Strategies. Coordinating Physical and Behavioral Health Services for Dually Eligible Members with Serious Mental Illness: UPMC for Life Dual Plan. Dec. 2019. https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/
[9] Minnesota Managed Care Longitudinal Data Analysis. Office of the Assistant Secretary for Planning and Evaluation (ASPE). March 2013. https://aspe.hhs.gov/reports/minnesota-managed-care-longitudinal-data-analysis-0
[10] Vermont All-Payer ACO Model. Centers for Medicare and Medicaid Services. https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model
[11] Washington Managed Fee-for-Service Financial Alignment Model Demonstration. Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/financialalignmentinitiative/washington
[12] Xu WY, Retchin SM, Buerhaus P. Dual-eligible beneficiaries and inadequate access to primary care. *Am J Manag Care*. 2021;27(5):212-216. doi:10.37765/ajmc.2021.88581

Studies in Family Medicine and Primary Care.[13]Expanding the availability of successful integrated models like those described above to every dually eligible beneficiary will demand attention to the ways federal policies that impact primary care for Medicare beneficiaries with dual coverage. Policymakers must address

- The level of Medicare and Medicaid investment in primary care for dual eligibles and
- the payment models through which those investments flow.

Below, we offer our recommendations on these crucial questions.

Alternative Payment Models and Continuous Coverage

Successive Congresses and Administrations have worked together on a bipartisan basis to advance new models of payment and delivery that shift from fee-for-service reimbursement based on volume towards population-centered care with accountability for cost and outcomes. As a long-time champion for advanced, comprehensive primary care, PCC supports these efforts.

As this process has unfolded across multiple public and private payers, stable, continuous coverage has emerged as indispensable to consistently successful implementation of population-based payment models. Without continuity of coverage, frequent changes in coverage status can cripple the ability of a practice to track and manage a patient's chronic conditions over time. Even when coverage is maintained by an individual, changes of plan or network often mean an individual cannot see that primary care clinician, specialist, or service provider – disrupting the usual source of care relationship that is fundamental to primary care.

Disruption or churn in Medicaid eligibility, therefore, represents a serious barrier to successful implementation of alternative payment models for dually eligible individuals as well as other Medicaid beneficiaries. For the beneficiary, frequent changes to Medicaid eligibility can impact the ability to retain coverage or retain access to their chosen source of primary care in-network. Disruption of eligibility also disrupts access to Medicaid-furnished long-term care, behavioral health, dental and other Medicaid wrap around services that improve outcomes and decrease unnecessary acute care and emergency department costs. For the primary care practice, frequent changes to eligibility present an administrative burden. Practices are forced to pull precious staff time from patient care and operations in order to resolve coverage issues.

PCC supports twelve-month continuous eligibility for *all* individuals on CHIP and Medicaid, including Medicare beneficiaries with dual coverage. At a minimum, we encourage you to extend continuous eligibility to dually eligible beneficiaries. Such a provision would be consistent with the 117th Congress' bipartisan work to extend continuous eligibility to children and post-partum individuals.

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[13] Jabbarpour Y, Greiner A, Jetty A, et al. Relationships Matter: How Usual is a Usual Source of (Primary) Care? Primary Care Collaborative and Robert Graham Center. November 2022. https://www.pcpcc.org/sites/default/files/resources/pcc-evidence-report-2022_1.pdf

Close Gaps in Primary Care Investment and Payment

Congress has a responsibility to assure that all Medicare beneficiaries, including those with dual coverage, have access to strong, relationship-based primary care. But Congress has failed to discharge that responsibility. This is due in large part to a quirk in federal Medicaid statute that allows so-called "lesser-of" payment policies**.** These policies often result in primary care practices receiving just 80 percent of typical Medicare reimbursement for services delivered to dually eligible beneficiaries.

Under lesser-of policies, state Medicaid programs can elect to not cover the full Medicare cost sharing amount of a certain service if the Medicaid payment allowance for that service is less than Medicare's allowance. As of 2018, only seven states covered the full Medicare cost sharing amount for dually eligible beneficiaries.[14] Once a beneficiary has met their annual deductible, Medicare Part B's 20% coinsurance can apply to primary care services. Practices are not able to collect Part B cost-sharing from most dually eligible beneficiaries. In the majority of states, that means practices may be paid up to 20 percent less for dually eligible individuals.

These lesser-of policies, currently permitted under federal Medicaid law, serve as a disincentive for primary care practices to locate in and serve communities with a high percentage of dually eligible beneficiaries. Clinicians are losing an estimated $3.6 billion in revenue each year.[15] This $3.6 billion federal penalty makes participation in cost-saving alternative payment models more challenging, particularly for safety net and rural practices. It renders primary care increasingly unsustainable in many communities – exacerbating the workforce shortages that constitute primary care deserts.[16]

Congress should act now to address lesser-of payment policies. As one step toward that end, we support enacting MedPAC' s recommendation to implement a 15% bonus for primary care services delivered to dually eligible beneficiaries and Low-Income Subsidy recipients along with a 5% bonus for specialty care delivered to those beneficiaries. Consistent with MedPAC's position, this policy should be a non-budget neutral add-on payment, not subject to beneficiary cost sharing. This is just one step towards remedying decades of systematic underinvestment in primary care. Because Medicare, Medicaid and private payer alternative payment models are built on Medicare's underlying reimbursement, these added resources can make alternative payment model participation more viable in underserved and rural communities where many dually eligible beneficiaries reside.

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[14] Roberts ET, et al. (2020). New evidence of state variation in Medicaid payment policies for dual Medicare-Medicaid enrollees. *Health Services Research*. https://doi.org/10.1111/1475-6773.13545

[15] Burton R, Winter A, Gerhardt G, Tabor L. (2022). Assessing Payment Adequacy and Updating Payments: Physician and Other Health Professional Services and Supporting Medicare Safety-net Clinicians. Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2021/10/Tab-E-Physician-Updates-8-Dec-2022.pdf

[16] Primary Care Workforce Projections. Health Resources and Services Administration (HRSA). August 2022. https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/primary-health

Behavioral Health Integration:

Among dually eligible beneficiaries, behavioral health conditions are substantially prevalent – touching both the under- and over-65 enrollee populations.[17] Overall, among a sample of dually eligible beneficiaries in 2015, 22.7 percent had serious mental illness and another 7.5 percent had other common mental health conditions.[18] Higher prevalence of opioid use disorder has been observed among over-65 dually eligible beneficiaries, compared to Medicare-only beneficiaries.[19]

To address the behavioral health needs of dually eligible beneficiaries, PCC encourages you to return to the well-vetted policy solutions developed over the last year by the Senate Finance Committee. In past correspondence, PCC has expressed support for provisions included in various discussion drafts, released during the last Congress. (See PCC's July 13, 2022 letter regarding telemental health and our December 8th, 2022 mental health integration workforce & integration letter.) Below, we highlight two PCC-supported policies of particular importance to dually eligible beneficiaries for consideration:

- **Section 15 of the Mental Health Care Integration and Crisis Care Improvement Act discussion draft would increase Medicare payment for behavioral health integration codes for three years to defray a portion of the startup costs associated with implementing integration.**
- **Section 13 of the Behavioral Health Workforce of the Future Act would increase Medicare's Health Professional Shortage Area from 10% to 15% for mental health and substance use disorder services and making the bonus available to other eligible practitioners in mental health workforce shortage designations.**

Together these policies would strengthen access to the behavioral health services that are so critical to dually eligible beneficiaries. **We urge you to pursue their enactment as part of or in coordination with any legislative effort to enhance care for dually eligible beneficiaries.**

We commend you for launching this effort, and we stand ready to work with you to enact the strongest possible legislation this Congress. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions or to discuss further.

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[17] Beneficiaries Dually Eligible for Medicare and Medicaid. A data book jointly produced by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. February 2023. https://www.macpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508.pdf

[18] Figueroa JF, Phelan J, Orav EJ, Patel V, Jha AK. Association of Mental Health Disorders With Health Care Spending in the Medicare Population. *JAMA Netw Open*. 2020;3(3):e201210. doi:10.1001/jamanetworkopen.2020.1210

[19] Shoff C, Yang TC, Shaw BA. Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013-2018. *Am J Prev Med*. 2021;60(6):850-855. doi:10.1016/j.amepre.2021.01.010

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative

PCC Executive Members

Below is a list of the Primary Care Collaborative's executive members that pay dues to the organization and support its mission. Membership does not indicate explicit endorsement of this letter.

AARP
Accreditation Association for Ambulatory Health Care, Inc.
Allways Health Partners
Alzheimer's Association
America's Agenda
American Academy of Child & Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Associates (AAPA)
American Association of Nurse Practitioners
American Board of Family Medicine Foundation (ABFM Foundation)
American Board of Internal Medicine Foundation (ABIM Foundation)
American College of Clinical Pharmacy
American College of Lifestyle Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Physicians
American Psychiatric Association Foundation
American Psychological Association
Amerihealth Caritas
Array Behavioral Care
Ascension Medical Group
Black Women's Health Imperative (BWHI)
Blue Cross Blue Shield Association
Blue Cross Blue Shield of Michigan
Brigham and Women's Hospital Primary Care Center of Excellence
CareFirst, BlueCross BlueShield
Catalyst Health Network
Community Care of North Carolina
Converging Health
Crossover Health
CVS Health
Elation Health
Elevance Health (Formerly Anthem)
Families USA
GTMRx Institute
Harvard Medical School Center for Primary Care
HealthTeamWorks
IBM
Innovaccer
Institute for Patient- and Family-Centered Care
Johns Hopkins Community Physicians, Inc.
Johnson & Johnson
Mathematica Policy Research
MedNetOne Health Solutions

Mental Health America
Merck
MGH Stoeckle Center for Primary Care Innovation
Morehouse School of Medicine - National Center for Primary Care
National Alliance of Healthcare Purchaser Coalitions
National Association of ACOs
National Committee for Quality Assurance (NCQA)
National Interprofessional Initiative on Oral Health (NIIOH)
National PACE Association
National Partnership for Women & Families
National Rural Health Association
Oak Street Health
PCC Pediatric EHR Solutions
Pediatric Innovation Center
Penn Center for Community Health Workers
Primary Care Development Corporation (PCDC)
Purchaser Business Group on Health (formerly Pacific Business Group on Health)
Society of General Internal Medicine
Society of Teachers of Family Medicine
St. Louis Area Business Health Coalition
Takeda Pharmaceuticals
UPMC Health Plan
Upstream USA
URAC
VillageMD