July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
United States Senate
Washington, DC 20510

Dear Sen. Whitehouse and Sen. Cassidy:

On behalf of the American College of Physicians (ACP), we greatly appreciate you introducing the Pay PCPs Act, S.4338, on May 15, 2024. We commend you for recognizing the critical role that primary care physicians play in our healthcare system and the need for long-term policy solutions that would strengthen the primary care workforce. Your bill is an important initiative to ensure that physicians are able to work in a health care delivery system that facilitates high quality value-based care for our patients. Our sincere hope is that this important first step will eventually lead to legislative action based on bipartisan solutions that elevates primary care. ACP looks forward to continuing working with you and accordingly provides the feedback below about the Pay PCPs Act as introduced on May 15, 2024. We share your objective of enacting legislation that stabilizes payments to primary care physicians and creates a more affordable, sustainable, and equitable health system that improves patient access to primary care and concomitantly, health outcomes.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

structural issues with the Medicare PFS, which needs even more signi f cant reforms to address budget neutrality and to provide annual in f ationary updates to all services within the PFS, it is a strong step in the right direction.

The Centers for Medicare and Medicaid Services Innovation Center (CMMI) have already conducted several tests of hybrid payment via the

- "What methodology should be used to determine the "actuarily equivalent" FFS amount for the purpose of the hybrid payment?
    - Should hybrid payment rates be based on historic averages across the entire FFS population? If so, are there risks that providers will receive an inappropriate payment rate for certain unusually high- or low- utilizing beneficiaries?"

The PMPM could manifest in many ways, including salaries, direct contracting, and other variations that are deployed via compensation packages throughout the medical community. The capitation fee must be predictable and sufficient to cover the costs and practice expenses being incurred and appropriately adjusted for patients' health status and social drivers of health. ACP does not support a consideration for actuarial equivalence with current or historic FFS payments based on historic averages across the entire FFS population. Payments for primary care services, even with recent value increases for E/M codes, have historically been undervalued and remain so. With a PMPM payment potentially resulting in lowering FFS values, these services could be undervalued even more. Such payments should not impose additional administrative and reporting burdens on physicians that do not advance quality, value, or equity, nor should they require physicians and their teams to accept an unreasonable and unsustainable degree of financial risk for population-based outcomes.

In addition to the base capitation fee, financial incentives tied to value by using valid, appropriate measures must be sufficient to drive the desired change in care delivery and related investment in staffing, technology, and infrastructure, which existing research estimates to be 10 to 15 percent of physician compensation. Physicians should be separately paid via FFS for providing additional complex cognitive value-added services that exceed the scope of the capitated arrangement, such as performing social drivers of health assessments, behavioral health service assessments, and connecting patients with other appropriate services and counseling.

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social drivers of health (SDOH) needs that affect a patient's diagnosis and treatment. To ensure these needs are considered across the continuum of patient care, we recommended these needs be documented in the medical record and should also be included for a hybrid payment model.

ACP was also supportive of the CMS' proposal to include coding and payment (HCPCS code G0136) for SDOH risk assessments. By providing for separate coding and payment for these services, physicians and other practitioners can better account for the time and resources spent on assessments that ultimately impact patient care. Since SDOH needs undoubtedly impact patient care, the College also fully supported the agency's recommendation to make the SDOH assessment part of a patient's annual wellness visit, even if optional, and recommends that any hybrid payment model do the same.

Quality Measures In Hybrid Payments (From the RFI):

- "The legislation proposes to allow the Secretary to define quality measures for hybrid payments and suggests four which may be pursued: (1) patient experience, (2) clinical quality measures, (3) service utilization, including measures of rates of emergency department visits and hospitalizations, and (4) efficiency in referrals, which may include measures of the comprehensiveness of services that the primary care provider furnishes.
    - Are these quality measures appropriate? Which additional measures should Congress be considering?
    - What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?"

is often used interchangeably with , despite the two terms having

of the physician, practice, system, or payer, rather than measuring the true quality of care the patient receives. Additionally, the many required metrics used for current "value-based" reporting and payment programs are a strong contributor to care team burden and can

improvement in care delivery while reducing reporting burden. Along these lines, certain artificial intelligence (AI) technologies have the capability to enhance the clinical documentation process to reduce documentation burden on physicians and other clinicians; capture and increase the accuracy of coded data; and support other uses of the clinical documentation such as for research, performance measurement, and public health. In a recent position paper, ACP recommends that "in all stages of development and use, AI tools should be designed to reduce physician and other clinician burden in support of patient care." Additionally, the College states that new payment initiatives, especially those for value-based care, must support the use of AI technology as a mechanism to reduce burden and ideally improve quality.

Types of Services (From the RFI):

- "The legislation allows the Secretary to include four types of service in hybrid payments: (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management visits, regardless of modality, for new and established patients.
    - Is this list of services appropriate?
        - Are there additional services which should be included?
        - Are there any services which should be excluded?
    - Will including these services in a hybrid payment negatively impact patient access to service or quality of care?"

ACP appreciates and supports including a robust range of services in the hybrid payments, but we strongly caution against including behavioral health integration services and believe they should be excluded from hybrid payments. While the College generally supports behavioral health integration efforts overall, including it the hybrid payment would have an adverse impact on access since these services are already undervalued and would be even more so with a hybrid payment.

Cost-sharing adjustments for certain primary care services (From the RFI):

- "What is the appropriate amount of cost-sharing to make the hybrid payment model attractive for beneficiaries and providers while constraining negative impacts on the federal budget?

- Besides, or in addition to, cost-sharing reduction, what strategies should Congress consider to make the hybrid payment model attractive for beneficiaries and providers?"

ACP appreciates the effort to lower barriers to primary care access for Medicare beneficiaries. ACP supports completely waiving beneficiary cost sharing for primary care

services in programs such as Medicaid and furnishing chronic care services within Medicare. We believe that high cost-sharing can create barriers to evidence-based, high value, and essential care and should be eliminated entirely, particularly for low-income patients and patients with certain defined chronic illnesses. Evidence clearly shows that even very low Medicaid copayments are associated with decreased use of necessary care. High deductibles may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis. ACP commends the Pay PCPs Act for reducing Medicare co-insurance by up to 50 percent. However, ACP also supports funding for research and the development of appropriate copayments and deductibles so that patients are also stakeholders in their delivery of care. While the 50 percent of Pay PCPs Act is a significant reduction in cost sharing, more information is needed to determine what would be appropriate to both eliminate a barrier to care and contain overutilization at the same time.

Technical advisory committee to help CMS more accurately determine Fee Schedule rates (From the RFI):

- "Will the structure and makeup of the Advisory Committee meet the need outlined above?
- How else can CMS take a more active role in FFS payment rate setting?"

ACP opposes a provision in the Pay PCPs Act that would establish a new Technical Advisory Committee on Relative Value Updates and Revisions as it is divisive in medicine and will only strengthen opposition to the final passage of this legislation.

We also have strong concerns with the scope of authority provided to the technical advisory committee in the legislation. Specifically, we are deeply concerned by the committee's proposed duties including the authority to evaluate and determine whether payment codes should be collapsed and whether certain services should be bundled or unbundled. Because of the complexity of issues involving the valuation of medical services, we strongly recommend that the proposed technical advisory committee should be excluded from the Pay PCPs Act of 2024.

We do strongly believe it is essential to maintain integrity in the Medicare PFS, ensure patients receive high-quality care, and determine accurate payment rates for physicians' services. ACP believes that part of this objective is to make sure we utilize and refine the most appropriate and adequate processes for doing so.

Despite the positive changes for internal medicine physicians as a result of the work of the RVS Update Committee (RUC), we remain concerned that it has a tendency to value codes primarily on the basis of physical skill involved which leads to the undervaluing of cognitive services (i.e., critical thinking involved in data gathering and analysis, planning, management, decision making, and exercising judgment in ambiguous or uncertain

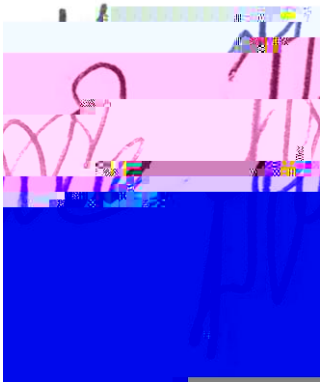
situations) are routinely undervalued. In fact, one study found that Medicare reimburses physicians 3 to 5 times more for common procedural care than for cognitive care. In that study, the authors demonstrated that two common specialty procedures, cataract extraction and screening colonoscopy, can generate more revenue in one to two hours of total time than a primary care physician receives for an entire day's work. Though cognitive services are not procedure

care and geriatric specialties, we acknowledged more needs to be done to ensure the RUC

ACP sincerely thanks Sen. Whitehouse and Sen. Cassidy for their ongoing leadership to address the issue of elevating primary care within the Medicare program. We greatly appreciate your inviting input from the health-care community and our hope is that the information we shared will provide you with a physician perspective. We stand ready to continue to serve as a resource and welcome the opportunity to continue to work with you in developing policy on health care and primary care payment in the 118th Congress. Please contact Jared Frost, Manager, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

Thank you.

Sincerely,



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