Purchaser Business Group on Health

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July 15, 2024

The Honorable Sheldon Whitehouse
530 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, M.D
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Whitehouse and Cassidy,

Thank you for your commitment to addressing primary care challenges and reforming physician payment to better support and pay for high-quality care. The Purchaser Business Group on Health ("PBGH") applauds your efforts to gather information from stakeholders on your proposed legislation and to ensure physicians are fairly compensated and deliver high-value care. We firmly believe that Congress and the Center for Medicare and Medicaid Services (CMS) can accelerate adoption of value-based care models and ensure our investments improve outcomes and reduce costs for patients.

While the Center for Medicare and Medicaid Innovation (Innovation Center) has seen some limited success, it is not commensurate with the investment of time or resources or need for change, nor does it adequately align to the commercial market. We believe it is appropriate for Congress to assess how to accelerate progress.

In the employer market we have seen how models that are properly designed and are centered around advanced primary care can reduce costs for patients, employers and government while improving care quality, access and outcomes for patients. We believe that closer partnership and alignment across sectors will accelerate care improvements. We hope to work hand-in-hand with legislators, CMS, and other stakeholders to share early learnings from innovative employers and public purchasers who have already invested in advanced primary care. We would also like to identify ways to align payment models and measurement to improve the health of all communities in the U.S. while reducing administrative cost and burden for clinicians.

PBGH is a nonprofit organization that represents 40 public and private purchasers that collectively spend $350 billion annually on health care and cover over 21 million employees and their beneficiaries. PBGH's mission is to advance a health care system that delivers quality outcomes and a seamless patient experience that is equitable and affordable for consumers and purchasers. Our goal is to be a change agent by creating and enabling increased value in the health care system through purchaser collaboration,

innovation, and action and through the adoption of best practices. PBGH's members represent diverse private sector industries as well as public sector purchasers.

The current health care system has incentivized *sick* care over *health* care, increasing costs for taxpayers, workers, and employers. These increased costs have very important implications for the average American and our economy by diverting funds from wages that could go directly to families. Increased health care spending also increases the costs of consumer goods and takes away from public investment in education, infrastructure and other key needs. We support efforts to transition to a system that emphasizes patient health and rewards providers for keeping patients healthy.

At PBGH, we believe advanced primary care is essential to a healthy workforce and employees' access to a high-value health care system. Research has proven that robust primary care systems can lower overall health care utilization, decrease rates of disease and mortality, and increase the use of preventive services, enabling a true *health* care system. However, primary care in the US is chronically underfunded; while primary care accounts for 55% of visits in the US, it receives only 4-7% of health care dollars, on average.[1] That is why we have invested in defining and promoting advanced primary care models that redirect existing health care spending to high-quality, equitable and evidence-based care while holding total cost flat.[2]

PBGH first launched its primary care improvement initiative in 2014. From 2014-2019, a CMS-funded multi-stakeholder driven quality program helped avoid nearly 50,000 hospital bed days, reduced emergency room utilization and generated about $186 million in total savings.[3] Based on our success with the CMS demonstration project, PBGH worked with our employer purchasers to reach consensus on a shared definition of advanced primary care, select priority measures, define optimal payment models and enable improved access. In addition to working with health plans to scale this approach, we have established innovative regional direct contracting relationships with primary care clinicians to deliver high quality advanced primary care. Through these efforts, we have repeatedly demonstrated that relationship based and longitudinal primary care that focuses on health outcomes, team-based care, integrated mental health care, health equity, and strategic referrals to the rest of the health care system can have dramatic improvements on population health measures and total cost of care savings. Through the experience of our employers, we know Advanced Primary Care works to improve outcomes and equity while reducing costs when done correctly. We look forward to working with CMS to further scale this approach.

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[1] PBGH (Dec. 2023) "End-of-Year Report: California Advanced Primary Care Initiative" *CQC* [Link]

[2] PBGH defines APC as including integrated mental health care and access. See PBGH's attributes here.

[3] PBGH (Dec. 2020) "Lessons in Scaling Transformation: Impact of California Quality Collaborative's Practice Transformation Initiative" *CQC* [Link] at **pgs. 11, 22**.

Additional Background: PBGH's California Advanced Primary Care initiative

PBGH's California Quality Collaborative and the Integrated Healthcare Association launched the California Advanced Primary Care initiative, a multi-payer effort where Aetna, Aledade, Anthem Blue Cross, Blue Shield of California, Health Net, Oscar, and United agreed to strengthen primary care together from 2022-2025. Through this initiative, we have developed a common value-based primary care model that provides prospective and performance-based payments, with the goal of increasing total potential payment for primary care providers by 30%. On October 1 of 2024 Aetna, Blue Shield of California, and Health Net will launch a demonstration project to test the model in up to 30 independent primary care practices throughout the state. This demonstration project is unique because commercial plans are funding technical assistance and a common reporting platform to help practices get the most out of the new payment model.

In January 2022, we also launched the Advanced Primary Care Measurement Pilot, which brought together four large purchasers in California – including Covered California, California Public Employees' Retirement System (CalPERS), eBay and San Francisco Health Services System – to test our advanced primary care measures for practice-level performance at the state level. The pilot, which concluded in 2023, is a great example of ways to ease the administrative burden on providers who wish to participate in value-based care models as it relies on existing data that is aggregated across purchasers and health plans to provide a more complete picture of practice performance. Through these efforts we established an Advanced Primary Care Measure Set of pediatric and adult quality measures categorized into five quality domains: health outcomes and prevention, patient reported outcomes, patient safety, patient experience, and high value care.[4]

We are excited about the future of advanced primary care and hope our learnings can inform others and shape future policy discussions as Congress looks to re-examine the Medicare Access and CHIP Reauthorization Act (MACRA) and the Medicare Physician Fee Schedule (MPFS) to better align around value-based care.

RFI Response

Hybrid payments for primary care providers

1. **How can Congress ensure we are correctly identifying the primary care provider (PCP) for each beneficiary and excluding providers who are not a beneficiary's correct primary care provider or usual source of care?**

[4] PBGH (Apr. 2021) "Advanced Primary Care Measure Set" *CQC and IHA* [Link] *(Revised Nov. 2023)*

The ideal method for PCP identification is the patient. In addition, we also recommend two quality checks to ensure the accuracy of the information provided:

a) For those who do not choose themselves, who did the patient see the most (plurality)?

b) For those who do choose, did the choice correspond with who they see the most? If there is a discrepancy, the default should be to defer to the patient.

Regarding the issue of beneficiaries who switch providers often, it could be due in part to a fundamental issue of how "primary care" is currently defined, a patient's understanding of that, and how certain medical practices and health plans are structured. Today many health plans seek to provide care management and coordination, when that role is most effective in primary care. Health plan and vendor outreach, along with access barriers, can create confusion and fragmentation for patients seeking appropriate care. We must have a clear definition of primary care that goes beyond just "who sees the patient the most," that captures the nature of the care provided.

Advanced primary care should be both comprehensive and able to coordinate care across settings. Not only does advanced primary care need to address most patient needs in the primary care setting, but a primary care team should be the point person and patient advocate that coordinates care for a patient across multiple treatment settings. This is why our definition of advanced primary care includes team-based care, integrated behavioral health, and helping the patient get referred only to specialists that have been identified through quality measures while also coordinating care back to primary care.[5] As these capabilities for both comprehensive care and care coordination are built, it is fair to expect a stronger relationship with the practice and greater clarity on attribution. Because this method of care often includes a reliance on non-physician providers (NPPs) such as nurse practitioners (NPs) and physician assistants (PAs) – especially in rural or underserved areas – it is also important to ensure any attribution method includes NPPs and not just physicians.

2. **What methodology should be used to determine the "actuarily equivalent" fee-for-service (FFS) amount for the purpose of the hybrid payment?**

[5] PBGH (Jun 2020) "Advanced Primary Care: Defining a Shared Standard" [Link] *(Revised Apr 2022)*

PBGH has worked with several companies that have incorporated an "actuarial equivalent" FFS amount into their practices and we'd be happy to help with outreach to gather reliable and actionable feedback on how those have been used. However using historic averages can exacerbate existing disparities given the highest utilizers are typically those that have the means and ability to access the health care system more often.

We also feel it is important to emphasize that part of embracing value-based care is encouraging a departure from FFS and incentivizing physicians to provide patient centered and population-based care, as opposed to unnecessary or low-value care. We should not replicate a broken system by building value-based payment models on the back of FFS.

3. **What factors should Congress be considering when setting risk adjustment criteria?**

   It is critical that risk adjustment criteria account for the social determinants of health (SDOH), including economic stability, education, social and community life, one's neighborhood and access to high-quality health. Currently, risk adjustment is purely based on diagnoses and this method poses two key problems: 1) It has caused up-coding of diagnoses, which in turn causes more administrative burden, and 2) it ignores the fundamental drivers of disease. According to the Centers for Disease Control and Prevention, SDOH have been shown to have a greater influence on health than either genetic factors or access to health care services.[6] It is time to ensure these are incorporated and collected in a standardized, meaningful way.

4. **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.**

   PBGH supports these categories of quality measures and suggests you consider others including health care worker satisfaction and health equity. Additionally, it is worth making clearer in the legislative text additional detail regarding quality measure selection, including cross-sector alignment on a set of streamlined metrics to ensure meaningful benchmarking while reducing unnecessary provider

[6] CDC (Jan. 17, 2024) "Social Determinants of Health (SDOH)" [Link]

burden. Measure alignment has been discussed for decades- it is time to insist on consistent use of a concise and meaningful measure set.

PBGH's California Quality Collaborative (CQC) has articulated attributes of advanced primary care that result in high quality, high value primary care with patients at the center of every interaction. To help identify practices that have implemented these attributes, CQC, the Integrated Healthcare Association and stakeholders defined a measure set focused on patient health outcomes and experience of care. This concise measure set reflects purchaser and patient priorities and is available here. Of particular note is the incorporation of an equity focus into the clinical measure set by including an incentive payment for strong performance on four measures that tend to have greater disparities. We believe it is possible to incorporate an equity lens into each measure category – such as patient satisfaction – as opposed to having separate equity-focused measures.

While many existing measures can enable accountability on quality, cost and outcomes, innovation on patient experience measurement is needed. PBGH has run the largest patient experience data collection and reporting program in the country for over twenty years. It was the only patient experience data set large enough to identify disparities based on race, ethnicity and language. That program will sunset this year due to provider cost and burden. A new, innovative and simplified approach to collect and use patient experience data should be a national priority.

5. **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.**

   For primary care to be optimally effective it is critically important that these services be integrated within primary care and that payment not encourage further fragmentation. For example, telehealth that is not integrated into primary care practices may create redundant charges as well as fragmented care without full patient information. Payment models must reflect the need for integration.

   Additionally, this list requires refinement and clarification. One consideration is the wide breadth of activities that could be contained within "care management services" and that it may be helpful to make explicit what it entails, such as:

   - Research on a patient's behalf (e.g. for the right referral),

- Review of notes, charts and other related materials, and

- Communication amongst care team members on a patient's behalf (with broad definition of "care team," e.g. coordination with hospital staff during discharge).

Cost-sharing adjustments for certain primary care services

6. **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?**

   There should be no cost barriers to primary care and many employers have opted not to require cost-sharing for primary care. Typically, increased primary care has netted positive impacts on health care costs though it could take a few years to realize. However, there have been some cases where primary care has been especially effective with referral management or formulary management that has allowed savings to be seen sooner. Evidence shows that improved primary care translates into healthier, happier patients and lowers overall health care costs:

   - U.S. adults who regularly see a primary care physician have **33% lower health care costs** and **19% lower odds of dying prematurely** than those who see only a specialist.

   - The U.S. could save **$67 billion each year** if everyone used a primary care provider as their principal source of care.

   - Every **$1 increase** in primary care spending produces **$13 in savings.**[7]

   In addition to reduced cost-sharing, hybrid payment models enable a better experience for both patients and providers. For providers, less administrative burden with flexible, up-front reimbursement, and a focus on relationship- and team-based care; for patients, comprehensive, coordinated and accessible care that is person- and family-centered. All of these define PBGH's shared standards of Advanced Primary Care.

[7] PBGH (Oct. 4, 2021) "Using Primary Care's Potential to Improve Health Outcomes" [Link]

Technical advisory committee to help CMS more accurately determine Fee Schedule rates:

7. **Will structure and makeup of the Advisory Committee meet the needs outlined above?**

   In considering how to best determine "high-value" activities and services, we should think more broadly about other stakeholders who may have unique perspectives and expertise in this area, namely: patients and/or patient representatives, as well as payers and purchasers including those who have engaged in such evaluations and initiatives in other markets.

8. **How else can CMS take a more active role in FFS payment rate setting?**

   PBGH supports recommended policy actions proposed by the Nationals Academies of Sciences, Engineering and Medicine found here. This includes increasing the overall portion of spending going to primary care by:

   - Accelerating efforts to improve the accuracy of the Medicare physician fee schedule by developing better data collection and valuation tools to identify overpriced services; and

   - Restoring the Relative Value Scale Update Committee to an advisory nature by developing and relying on additional experts and evidence.

Other Policy Priorities to Advance Value-Based Care

PBGH envisions a future of health care that is patient-centered, team-based, and rewards providers based on the value of care, not the number of services provided. But if we are to promote meaningful change in how we pay for health care in the US, employers and health care purchasers must be part of the solution. Every day our members are innovating to create models that are patient-centered and focus on the value of care and they are finding success in improving the health of their members and lowering costs for all. We believe that removing barriers to high-value care and innovation will benefit the entire health care system. To do this, we must:

1. Enable purchasers to innovate by removing barriers for employers and other private purchasers to advance efforts in value-based care and contracting. PBGH supports policies and interventions that enable private purchasers to innovate, removing barriers to employers and other private purchasers to advance efforts in value-based care and direct contracting, increasing competition, reducing costs and driving quality and patient satisfaction.

We strongly encourage Congress to eliminate federal and state barriers that limit or discourage participation in alternative payment models across the employer market. Some employers are being hindered from adopting value-based care at the state level due to and a complex patchwork of regulatory oversight for health insurance that has evolved over time in service of several goals, some of which can be at odds with each other. Specifically, purchasers need more clarity from the Department of Labor on capitated payment arrangements in self-funded plans in California, in order to move forward with the promise of value.

Likewise, we strongly encourage Congress to remove existing restrictions on first dollar coverage for primary and preventive care. We have seen firsthand how increased access to primary care improves the health and wellness of patient populations and existing policies can present barriers to this necessary care.

In addition, we believe Medicare and Congress should work together to authorize payment models and increase payment rates for advanced primary care models that achieve high quality outcomes and reduce total cost of care. MedPAC and other experts have observed that certain procedures and specialty services are overpriced, based on the relative value units (RVUs) used to calculate payment rates to physicians. Congress and HHS should consider structural and process changes to correct this imbalance.

2. Improve and build on price transparency efforts to include actionable and streamlined quality metrics and data standards. To truly achieve value-based care, we need robust and aligned quality data – not just cost – across all payers. PBGH is a national leader in redesigning how quality is measured and reported as the basis of a transformed, patient-centered health care system.

But to fully achieve this vision, full transparency on prices, quality and equity is needed across providers for purchasers to ensure value for their employees, as well as standardized measures of quality, patient experience, appropriateness, and total cost of care. These data sets are invaluable to assess the potential impact of proposed transactions. As such, we support many of the transparency policies contained within the "Lower Costs, More Transparency Act" (H.R. 5378) passed out of the House on December 11, 2023. This includes codifying and expanding federal price transparency rules; ensuring that health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan; [8] and language aimed at increasing transparency into hospital outpatient billing practices and correcting Medicare payment

[8] On this vital point, specifically, PBGH strongly supports language in the Health Care PRICE Transparency Act 2.0 (S. 3548). While the Senate bill is narrower in scope than the Lower Costs, More Transparency Act, its provisions for employer data access are stronger and contain more specific requirements that would greatly enhance the ability of employers to drive value in their health care purchasing practices. For these reasons, PBGH supports the Senate bill's language on data access and price transparency be adopted in (reconciled with) the House bill.

discrepancies. Similarly, we strongly support policies that require transparent PBM reporting to plan sponsors but believe spread pricing prohibitions should be extended into the commercial market and take up other efforts to lift the veil on PBMs and other service providers to ensure compensation practices are fully exposed, so plans fiduciaries can ensure full line of sight into contracts and spending to better drive value for our members.

PBGH is supporting our members in their adoption of alternative payment models (in primary care especially) that depart from traditional fee-for-service and appropriately align incentives between providers and purchasers and disincentivize low-value care. In relation to price transparency data specifically, PBGH has launched a novel transparency data demonstration project, which will home in on key regional markets around the country (where our members have sufficient headcount). The project will combine the newly transparent data sets with employers' respective claims price and quality data, to provide each employer with insights into how their networks and plan design stack up against the potential within their market. Employers will be able to use this information to identify high-quality, low-cost providers and form strategies for steering their patients to these providers. Informed referrals from advanced primary care providers will play a key role in these strategies, as research has demonstrated that the recommendations of a trusted physician are far more powerful than price for explaining where patients choose to receive follow-up care.[9]

3. Reduce anti-competitive negotiation and contracting practices. Finally, we urge Congress to take action to address anti-competitive negotiation and contracting practices that can limit purchasers and employers' options in their pursuit of value-based models that will achieve lower cost, high-quality care.

We strongly support legislation at the federal and state levels that would remove gag clauses on the sharing of price and quality information by providers; ban anti-competitive contracting practices including "anti-tiering" or "anti-steering" clauses; ban "all-or-nothing" contracting which demands higher payment rates for the entire system; and other anti-competitive clauses such as most-favored nation (MFN) clauses, leveraged by dominant insurers to ensure they receive the lowest prices, often to the detriment of smaller purchasers. PBGH President and CEO Elizabeth Mitchell has testified before the Senate Committee on Health, Education, Labor and Pensions on the importance of advancing these provisions. In addition to such anti-competitive behavior being used to gain market power and raise prices, it also hinders purchasers' ability to create innovative, high-value programs such as high-performance networks, which incentivize patients to use specific providers and facilities with higher quality and lower prices.

[9] Chernew et al. (Jul. 2018) "Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans" *National Bureau of Economic Research* [Link]

States have also moved to restrict the anticompetitive contracting practices at the heart of California's complaint against Sutter. Although state attorneys general may be able to prosecute anticompetitive behavior – such as the use of anticompetitive contracting provisions by dominant systems – legislation prohibiting these contract clauses is necessary to improve state enforcement authority and disrupt the distorted bargaining dynamic. For example, Michigan and North Carolina ban specific anti-competitive practices, while Massachusetts has empowered an agency to publicly review contracts for monopolistic terms on an ongoing basis. Rhode Island and Colorado have capped rate increases exceeding specified growth targets to impede unequal bargaining power that can lead to market failures.[10] While Sutter removed many of these anti-competitive terms from its contracts, they are still being used as a tactic in private provider-insurer negotiations. Thus, any state or federal legislation must aim to address not just anti-competitive language in contracts but also underlying anti-competitive behavior throughout the negotiations process. More recent state legislation – such as that in Washington state (HB 2066) – has aimed to enable states to regulate what health plans do through contracts as well as other anti-competitive behavior.

Thank you again for the opportunity to comment, and we look forward to working with you on these important issues. If you have any questions or wish to collaborate further, please contact Raymond Tsai, Vice President of Advanced Primary Care at rtsai@pbgh.org.

Sincerely,

The Purchaser Business Group on Health

[10] King (Nov. 17, 2020) "Addressing Health Care Consolidation: Policy Solutions" *Assembly Health Committee* [Link]