Purchaser Business Group on Health

1611 Telegraph Avenue, Suite 210
Oakland, CA 94612
(415) 281-8660

pbgh.org

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P)

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the Centers for Medicare & Medicaid Services' ("CMS") Medicare Physician Fee Schedule ("MPFS") proposed rule for calendar year ("CY") 2025. The Purchaser Business Group on Health ("PBGH") wholeheartedly supports your multi-year effort to further strengthen and invest in primary care while encouraging accountable care relationships.

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 members represent diverse private sector industries as well as public sector purchasers. 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. Our comments focus on CMS's proposed new bundled MPFS payment for a set of advanced primary care management ("APCM") services, CMS's request for information ("RFI") on the proposal, and advanced primary care.

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 system that truly cares for *health*. 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 PBGH has 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] We believe our efforts hold valuable lessons learned and insights for CMS as the agency continues its transition from FFS to value-based payment models.

PBGH first launched its primary care improvement initiative in 2014. From 2014-2019, a CMS-funded multi-stakeholder 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 purchaser members 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.

Additional Background: PBGH's California Advanced Primary Care initiative

PBGH's California Quality Collaborative ("CQC") and the Integrated Healthcare Association ("IHA") 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 2024, PBGH's CQC and the IHA will launch a demonstration project with Aetna, Blue Shield of California, and Health Net to test the model in up to 30 independent primary care practices throughout the state. This demonstration project is unique because commercial

[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**.

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, PBGH 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.

The information gained in the pilot is already being used by purchasers and health plans in both the public and private sectors to better connect patients to practices delivering the best primary care in the market and incentivize improvement for other providers, increasing the availability of advanced primary care. In April 2024, PBGH launched the PBGH Care Excellence Program to identify high quality advanced primary care practices by leveraging learnings from the pilot, clinical guidance, best practice, and employer input. In some cases, we are facilitating employers to easily arrange direct contracts with identified practices to offer their employees and families the highest standard of advanced primary care.

Some of our learnings on the effectiveness of advanced primary care include:

- ***Higher spend leads to better outcomes***: Provider organizations that spent a higher percent of total cost on primary care demonstrated the desired outcomes of higher quality, better patient experience, lower emergency department and inpatient hospital utilization and lower total cost of care

- ***Expansion of clinical data exchange capability***: Better infrastructure for clinical data reporting at the point of care enables providers to represent their true performance, both for their own improvement tracking and for increased visibility across the system for decision making. Part of improving infrastructure involves payers and purchasers acknowledging the daily lived experience of care teams managing many platforms, reporting streams and sets of requirements — and helping align to alleviate that administrative burden.

- ***Comprehensive views of performance***: Comprehensive performance reporting is facilitated by interoperability of systems, standard data specifications and alignment of formats and initiatives across multiple payers, state agencies, purchasers and improvement organizations. Large populations for measure

assessment and improvement tracking also supports stratification across demographic variables and uncovers disparities so they can be reduced.

- ***Support for the delivery system***: The daily reality for physicians and their teams – particularly those working in small practices without the ability to negotiate higher rates – can be both challenging and chaotic. To navigate these challenges successfully and to foster sustained improvement and job satisfaction, physicians in such practices require additional resources. These include shared tools, technical assistance, and team support to facilitate the adoption of new processes and systems necessary for practice transformation.

- ***Equity***: Payment models for advanced primary care should include clinical and social risk adjustment (paying more for vulnerable patient mixes along with incentive payments for improvement). Technical assistance is also critical to help practices improve data collection on patient experience and demographics.

We are excited about the future of advanced primary care and hope to align our work with CMS's advanced primary care initiatives, so learnings from the private sector can inform the public sector and shape future policy discussions.

Comments on CMS Advanced Primary Care proposals and RFI

Advanced Primary Care Management ("APCM") Services

We applaud CMS's recognition of the importance of driving team-based, coordinated primary care and work to import learnings from the CMS Innovation Center's advanced primary care models into the fee-for-service ("FFS") system. The current FFS system undervalues primary care and limits the delivery of flexible, personalized and coordinated care. We also agree with CMS that advanced primary care is a core mechanism for achieving the agency's goal of having 100 percent of traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030.

PBGH and its members – especially those who participants in PBGH's Primary Care Payment Reform Workgroup – strive to remove barriers to better health outcomes by shifting away from traditional FFS payment and toward alternative payment models that support the provision of advanced primary care. This includes payment that enables team-based care, integration with mental health, robust access through multiple modalities, and other characteristics of advanced primary care. Among our objectives is facilitating alignment with other primary care transformation efforts and aligning to our shared attributes of Advanced Primary Care:

- ***Person- and family-centered*:** Care is designed around the needs and priorities of patients and families, encourages patient and family participation in improvement efforts and incorporates feedback. Patients share preferences and goals of treatment, engage in shared decision-making with their care team and should be made to feel their choices are respected and integrated into care plans.

- ***Relationship-based*:** Patients choose a primary care provider who best meets their needs. Patients consistently communicate with and receive care from their selected primary care provider and supporting care team members, who work collaboratively with the patient, their family and their extended care team to build trusting relationships.

- ***Accessible:*** Patients get the right care at the right time with a care team that is familiar with their needs. Accessible care includes same-day care for urgent needs through in-person and virtual services with their care team, care provider availability after appointment hours, secure messaging with the team and an online medical record.

- ***Comprehensive***: Patients receive screening and care for behavioral and social needs integrated into their primary care team, as well as common procedures by their primary care team instead of scheduling a separate appointment with a specialist. Patients' care needs are proactively identified by care teams that reach out for anticipated care needs and offer additional support for those patients at high or rising risk.

- ***Team-based:*** Patients know and receive care from a primary care provider who is supported by members of an interdisciplinary care team, such as a medical assistant, nurse, pharmacist, psychiatrist, health coach or community health worker. Under the direction of the primary care provider, care team members communicate and coordinate across the team to address patients' needs and provide care appropriate to their training and expertise.

- ***Integrated:*** Patients' physical, mental and social needs are communicated across their primary care team and with other care providers and settings. Health information and care activities outside of the primary care team are integrated into patients' care plans.

- ***Coordinated*** Patients are guided through care transitions between hospitals, emergency care, specialty care and their primary care teams. Patients can navigate across settings with established referral pathways to high-value specialist providers, with which the primary care team exchanges information and coordinates care.

- ***Equitable:*** Patients receive and experience care services and health outcomes that do not vary in quality or access due to personal characteristics, such as gender, race, ethnicity, language, socioeconomic status or sexual orientation/gender identity. Primary care teams proactively monitor their care to identify, eliminate and prevent care and health disparities.

It is critical to move towards a system that distinguishes and accounts for the resources associated with primary care and other longitudinal care. While we believe the creation of new bundled payment codes for APCM services is a step in the right direction to advance primary care, we are concerned about the potential for overcomplication from adding new billing and documentation requirements.

Specifically, PBGH is concerned that the creation of three separate codes could present an additional burden and barrier to adoption. Instead, **we recommend CMS create a single APCM bundled payment code that providers can adopt**. **We also urge you to consider the wide discrepancy in payment for the three codes and ensure they are sufficient to compensate primary care providers fairly**. It is likely some providers will find that $10 for GPCM1, for example, poses more in billing and administrative costs to code than they would receive in additional payment, which would defeat the purpose.

These two concerns are particularly important if CMS views bundled payments as a stepwise approach towards the eventual creation of a value-based or hybrid primary care payment system. When employers utilize prospective payments for their populations to perform a bundle of services, they seek to reduce the administrative burden associated with introducing new coding and billing requirements.

Further, we thank CMS for its interest in other payers' potential adoption of new APCM bundled payment codes. In the employer-sponsored market, we usually see a two-to-three-year lag in Medicare code adoption. PBGH urges careful consideration around the potential for adoption and future strategy for transition or phase-out, especially given the lack of adoption of other recent, related codes such as those for transitional care management ("TCM") or chronic care management ("CCM").[4] **The best way to reduce that lag time and improve the uptake of codes outside of Medicare is to engage purchasers and employers upfront**. Employers and Medicare use two different coding systems and there is an opportunity for CMS to engage with employers and purchasers early on to bring Medicare and non-Medicare payers into alignment.

Regarding CMS's proposed service descriptions and elements of care management, **we encourage CMS to consider how best to incorporate Behavioral Health Integration ("BHI") and services addressing health-related social needs ("HSRNs"), given their**

[4] Agarwal et al. (Dec 2018) "Adoption of Medicare's Transitional Care Management and Chronic Care Management Codes in Primary Care" *JAMA*, Vol. 320, No. 24 [Link]

critical importance and interrelatedness. We recognize that these services are separately payable and CMS views them as supplemental; however, at minimum we urge you to consider how to encourage the adoption of these types of services alongside APCM to ensure they are conducted. If integrated, it would be important to ensure there is not a financial disincentive when compared to separately billable services – consistent with our earlier recommendations about APCM payments.

As CMS notes, there is a robust, established evidence base for approaches to integrating care for beneficiaries with behavioral health conditions in the primary care setting. Mental health issues and concerns often emerge during primary care visits, yet only 3% of psychiatrists and psychiatric nurse practitioners coordinate care with primary care practitioners. Primary care is a key point of entry to the health care system for many patients and presents an important opportunity to engage patients to address their emotional and mental health needs. Evidence shows that integrating behavioral health services into primary care can enhance mental health care access and coordination, improve outcomes, and reduce costs.[5] PBGH supports both models of behavioral health integration, including the Primary Care Behavioral Health model and the Collaborative Care Model (CoCM), approaches to behavioral health integration that has been shown in multiple studies to improve patient outcomes. CoCM enhances primary care by adding key services to the primary care team: care management, behavioral health support and psychiatric consultation as needed.

PBGH's California Quality Collaborative ("CQC") has a project underway called the Behavioral Health Integration Initiative aimed at accelerating integration efforts by small and independent primary care practices throughout the state of California. The initiative aims to improve screening, diagnosis and treatment of patients' mild-to-moderate behavioral health needs, like depression, anxiety and substance use disorder. We believe that some of our key tenets are similarly applicable to CMS's efforts to drive integrated behavioral health care, such as:

- Direct technical assistance and funding to primary care practices engaged in improvement efforts;

- Better understanding patient perspectives of their behavioral health needs, access to care and treatment through expanded surveying; and

- Development of common standards for patient privacy, consent and data sharing among payers and providers to reduce administrative burden to integrating care.

Lessons from CQC's project demonstrate that providers need to be reimbursed for integrated behavioral health services, which is why we encourage increased

[5] PBGH "Behavioral Health Integration" [Link]

reimbursement for the Collaborative Care codes for advanced practice providers at 100% of the Medicare rate.

PBGH also urges CMS to consider how to encourage the integration of social workers and others on the care team to adequately address HRSNs. Elements of accountable, whole-person care — including clinician knowledge of a person's overall medical history, social needs, preferences, family and cultural beliefs — improves patient self-management for chronic conditions. This is especially important for patients from racial and ethnic minority groups, who are more likely to suffer from complex comorbidities.

Additionally, we believe it is critical to adjust payments to providers caring for patients who experience not only greater *medical* complexity but also greater social-emotional complexity, in addition to tying them to primary care quality measures to ensure outcomes are enhanced and equitable. It is critical that risk adjustment criteria account for HRSNs 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 encouraged upcoding of diagnoses, which amplifies administrative burden on clinicians, and 2) It ignores fundamental drivers of disease. According to the Centers for Disease Control and Prevention, HRSNs have been shown to have a greater influence on health than either genetic factors or access to health care services.[6]

As you note, recent CMS payment models such as ACO REACH and Making Care Primary have incorporated risk adjustment for social risk factors, such as Part D Low Income Subsidy enrollment status and Area Deprivation Index, to better capture factors relevant to care of the patient. **PBGH believes advanced primary care billing and payment policy should adopt these same principles to reduce health disparities and social risk**.

Additionally, ensuring care coordination across clinicians and support systems is vital, however **we are concerned that the proposed APCM payment methodology does not incentivize other clinicians (i.e., those not receiving payment for APCM) to coordinate with primary care providers.** Care coordination is not a one-way street; CMS should consider ways to encourage clinicians to communicate and collaborate with each other to develop shared and coordinated clinical plans so they can support each other. This can occur via case conferences, for example, (similar to how tumor boards function in oncology), which must be supported through payment incentives. Additionally, and interrelatedly, we need more support for non-physician clinicians and their role in care coordination and team-based care models. Additional considerations and learnings from PBGH's members and partners are included in the next RFI section.

[6] CDC (Jan. 14, 2024) "Social Determinants of Health (SDOH)" *CDC Priorities* [Link]

Finally, regarding the beneficiary consent and documentation requirements, we acknowledge that other care management services have similar requirements, including informing patients of the potential for increased Medicare cost-sharing, which we agree is critical. However, in addition to the potential increased documentation burden, **we are concerned this requirement represents a barrier to adoption of these codes and advancement of best practices**. We wholeheartedly believe patients should have autonomy and should retain the option to deny care after receiving sufficient information about benefits, risks and cost to make informed decisions. However, CMS's proposed requirement has the potential to undermine the provision of APCM services and could increase disparities, especially among certain populations with lower health care literacy who may be more inclined to opt-out. Some of the outlined services – such as "medication reconciliation" or "ensure receipt of preventive services" – should be considered minimum necessary services for high-quality primary care, and CMS should consider ways to remove the financial and operational burdens for both providers and patients to ensure they are the standard of care.

Advanced Primary Care RFI

We thank CMS for its RFI on advanced primary care and request for feedback specifically on furthering our shared goal of promoting comprehensive, high-quality, accountable and person-centered primary care that is team-based and integrated across care settings. PBGH greatly supports CMS's goal to advance value-based care, moving away from encounter-based payment as the dominant method and toward payments that are better tied to provision of population-based, longitudinal care. Find below PBGH's responses to the questions posed by the RFI:

Value-based care, payment and billing: PBGH fundamentally believes that payers should focus on paying for *quality* and *outcomes* of patients and communities – not for the *number* or *type* of visits or services. Any future, comprehensive advanced primary care payment should be focused on reducing the coding and paperwork burden and shift to paying for results rather than services. Care delivery innovation requires payment innovation. As proven in the employer market, capitated payment – with some flexible incentives – enables practices to meet clinical and health goals. A model predominantly based on fee-for-service or volume-based payment is antithetical to the core tenants of advanced primary care.

PBGH has collaborated with several companies that have incorporated an "actuarial equivalent" FFS amount into their practices and we would welcome the opportunity to collaborate with CMS on these programs' specifics. Still, relying on historical 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 know that a

critical 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 low-value care. We should not replicate a broken system by building value-based payment models on the back of FFS infrastructure.

Finally, as CMS discusses, sustainability is key. The problem with value-based models and pilots is that once they end, practices are left without the funding that they once received to continue supporting advanced primary care services. Furthermore, many value-based models include incentive payments that are received after a lag time, making upfront investments difficult and leading to financial uncertainty and, consequently, aversion to adopting such models. CMS should consider a stable or permanent approach to support and incentivize providers to invest upfront in these capabilities and ensure financial rewards are realized and are tied to outcomes, not services provided.

***Person-centered care*:** When considering how to structure advanced primary care payments to improve patient experience and outcomes, PBGH's California Quality Collaborative has defined a shared standard of care upon which to draw to ensure care is defined by, and centered around, the patient receiving care and how it is experienced. Among the defined advanced primary care practice attributes and requirements that CMS may choose to adopt and advance through its payment methodology include:

- *Comprehensive, coordinated care*: Managing episodes of care from beginning to end is important for advanced primary care to be comprehensive and coordinated. When patients require care from a specialist, the primary care practice should act as a hub for care coordination across episodes of care, including referrals to specialists and ensuring closed loop communication about the care provided. The practice should also have established referral pathways and completed care coordination agreements with high-volume specialty referrals. Notifications for hospital admissions and ED visits are also crucial for managing patient transitions. Other care team members besides the provider (such as a medical assistant, pharmacist, health educator, community health worker or health coach) should be able to perform care-related tasks such as refilling medications, pre-visit planning, educating patients on condition/diagnosis, and coaching patients on goals for managing chronic conditions. A key tenet of these models must be shared accountability to achieve shared goals. Some employers have started using third-party organizations to facilitate communication and coordination between primary care providers and specialists, as well as various strategies to facilitate patients engaging more with certain clinicians and institutions that provide higher value.

- *Appropriate access to telehealth and messaging*: Advanced primary care patients should have the option to receive care and information through a variety of modalities and communicate with the care team in a non-visit setting. This

capability is patient-centered and improves access to care. Practices should also provide patients with adequate access to same-day appointments for urgent, office appropriate matters in addition to virtual care. Members of the care team should be available to speak after hours and patients should be able to message their provider or care team through a secure email or online portal. Ideally, patients will also be contacted proactively to remind them of screenings or tests that must be done in advance of upcoming appointments, and practices should proactively reach out to high-risk patients when necessary.

- *Reduced administrative burden*: Transitioning away from FFS toward value-based care models (like prospective, capitated payments) presents the opportunity to reduce the administrative burden experienced by primary care practices. Additionally, payment models that encourage team-based care can facilitate practices ensuring that each care team member is performing tasks that are befitting of their training and certification (i.e., working at the top of their licensure with the focus being on the health of patients).

Health Equity, Social and Clinical Risk: We applaud CMS for considering how to incorporate social and clinical risk into payment for advanced primary care. Elements of accountable, whole-person care — including clinician knowledge of a person's overall medical history, social needs, preferences, family and cultural beliefs — improves patient self-management for chronic conditions. This is especially important for patients from racial and ethnic minority groups, who are more likely to suffer from complex comorbidities. According to a California Health Care Foundation report, the key components of advanced primary care are particularly well-suited for reversing systemic health care inequities. Some key considerations based on the RFI questions:

- *Screening and referrals***:** Advanced primary care should ensure patients are screened for social needs and referred to community-based services, ideally with a closed loop feedback system. Practices should also screen for behavioral health concerns (as discussed above), manage and/ or treat conditions in the office as appropriate and refer to external providers as needed. For referrals, the practice should share information with behavioral health providers based on patient consent and have a similar closed loop feedback system to track patient outcomes over time.

- *Data collection and stratification***:** The ability to risk stratify patients and perform in-reach and outreach are fundamental to primary care that is population based and effectively manages chronic care needs. Advanced primary care should ensure practices carry out standardized data collection on self-identified race, ethnicity and language (REaL) and sexual orientation and gender identity (SOGI) data, and should identify how they're working to address health care inequities. This data can be used to identify gaps in health equity through stratification. An easy place

for some payers to start, as evidenced in the employer market, is stratifying primary care spend and use of a primary care clinician by REaL and SOGI data to identify gaps to address. This work is difficult, so practices may need technical assistance to develop and apply a shared structural understanding of racial inequities to ensure g accurate, helpful and actionable insights are generated from data analysis.

- *Quality measures:* As discussed in the next section, integrating health equity into clinical quality measures that tend to have greater disparities, as opposed to having separate, equity-focused measures, is another consideration CMS could adopt as part of its data collection, equity and quality strategies.

***Quality improvement and accountability*:** To help identify practices that have implemented our shared attributes of advanced primary care that result in high-quality, high-value primary care with patients at the center of every interaction, PBGH's CQC, the Integrated Healthcare Association and partner stakeholders defined an Advanced Primary Care Measure Set of pediatric and adult quality measures categorized into five quality domains: (1) health outcomes and prevention, (2) patient reported outcomes, (3) patient safety, (4) patient experience, and (5) high value care. This concise measure set reflects both purchaser and patient priorities and is being leveraged within the PBGH Care Excellence Program to help purchasers identify high quality advanced primary care. Of note is the incorporation of an equity focus into each clinical measure category (rather than breaking it out separately) by including special consideration and – for some purchasers – an incentive payment for strong performance on four measures that tend to exhibit greater disparities.

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 the diminishment of the business case for provider participation.[7] A new, innovative and simplified approach to collect and use patient experience data should be a national priority.

Finally, we strongly encourage CMS to align with purchasers and other commercial payers and purchasers in your efforts, to ensure we are all rowing in the same direction and learning from each other's efforts. PBGH and our partners believe that collective action is one of the most effective strategies to improve patient outcomes and experience. As mentioned above, this alignment must take place at the onset as opposed to after

[7] See PBGH's recent announcement of the sunset of the Patient Assessment Survey ("PAS") program. PBGH produced a "Legacy Impact Report" of the program in August 2024, which is available here.

models or payment mechanisms are planned. We appreciate your intention in reaching out to all stakeholders on these initiatives as well as future advanced primary care and value-based care proposals.

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

Sincerely,

Raymond Tsai, MD, M.S.
Vice President of Advanced Primary Care, PBGH