July 15, 2024

Re: Response to Request for Information related to S. 4338, the Pay PCPs Act, introduced by Senators Sheldon Whitehouse and Bill Cassidy.

Dear Senators Sheldon Whitehouse and Bill Cassidy:

Arnold Ventures welcomes the opportunity to respond to your recent Request for Information (RFI) related to your introduced legislation S. 4338, the Pay PCPs Act, posted on May 15, 2024.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work on provider payment reform aims to re-orient the health care system toward delivering higher quality, less costly care that improves health outcomes. A primary focus is accelerating the adoption of population-based payment models such as accountable care organizations (ACOs) and capitated payments for primary care, which give providers greater flexibility to deliver the care their patients need while holding them accountable for quality and total cost of care. These models are a promising alternative to fee-for-service (FFS) payment, which often results in inefficient and inequitable care.

We also recognize the importance of improving the physician fee schedule both for its accuracy and because it is the platform for alternative payment models like ACOs. This includes addressing the longstanding misvaluation of certain services, which has resulted in underinvesting in cognitive services and primary care and overpaying for certain procedural services over time.

We appreciate the Senators’ interest in strengthening primary care through payment reform and improving valuation in the fee schedule given your many competing priorities, and for the opportunity to provide input. In what follows, we offer our support for proposals in the Pay PCPs Act including introducing hybrid capitated payments for primary care and creating a technical advisory committee on the fee schedule, respond to RFI questions concerning the design and implementation of these proposals, and outline opportunities for additional congressional action to strengthen primary care and create a more efficient health care system that better serves patients.
Hybrid Payments for Primary Care

Our current FFS payment system, which often results in unaffordable, low-quality care for patients, is particularly hostile to primary care. Because FFS reimburses providers based on the number and type of services they provide, it incentivizes primary care clinicians to focus on patient visit volume. This system also fails to adequately reimburse primary care clinicians for other kinds of services such as coordinating with other providers and providing ongoing chronic disease management. A reliance on FFS codes for payment limits the delivery of flexible, personalized care and highlights the need for a long-term solution that moves primary care away from FFS. Robust primary care is vital for creating a more efficient and high-performing health care system that better serves patients by providing more continuity, which is associated with reduced mortality, health care expenditures, and hospitalizations.\(^1\)\(^2\) Arnold Ventures encourages Congress to shift primary care payment in the Medicare fee schedule away from FFS and instead make hybrid capitated payments the default payment model for primary care, consistent with the proposal in the *Pay PCPs Act.*

In a landmark 2021 report on implementing high-quality primary care, the National Academy for Science Engineering and Medicine highlighted the shortcomings of FFS and recommended that a hybrid capitated, per-patient per-month payment, rather than FFS, be the default for primary care.\(^3\) In a hybrid capitated payment model, providers receive two kinds of payments: (1) a per-member per-month population-based payment for a core set of services and care management and (2) FFS payments for select additional services provided at visits. This payment structure can result in more patient-centered care, greater use of technology like telehealth when appropriate and cost-effective, and stronger team-based staffing that enables high-quality primary care.\(^4\) Hybrid capitated payments’ flexibility and focus on outcomes can also better position primary care providers to deliver more comprehensive, personalized, and equitable care.\(^5\)

In addition, evaluations of CMMI models that tested different forms of prospective payments report positive physician experiences.\(^6\) Past CMMI models have played an important role in generating evidence on the benefits of hybrid capitated payments. Practices that received hybrid capitated payments in prior CMMI models highlighted that reliable, predictable funding allowed for better budgeting, resources and staffing dedicated to care coordination, and integration of other health care professionals like behavioral

---

4 Ibid.
health providers. Practices with prospective payment models also highlighted the value of consistent revenue during shocks like the COVID-19 pandemic.

**Services included and payment rate for population-based payments**

Hybrid capitated payments for primary care have been widely studied by health services researchers and tested by CMMI and select private payers. Tested models vary in design but provide some insights on how to best structure a hybrid capitated payment within the Medicare physician fee schedule. However, iteration and updates over time will likely be needed, meaning Congress should give some flexibility to CMS to design and implement hybrid payment for primary care most effectively.

One of the key questions is determining which services should be included in the capitated portion of the payment and which services should continue to be paid on a FFS basis. FFS payment drives higher utilization while population-based payment is well-suited for wrap-around services that may not be associated with a specific visit and are not as easily reimbursable in FFS. Population-based payments are most appropriate to cover the following types of services:

- **High-volume, low-cost services** like minor office procedures. With these services, capitated payments would reduce volume-based incentives and give clinicians greater flexibility to deliver services in the time and format that’s most efficient and appropriate.

- **Care management and coordination** as these types of services are not often linked to a specific visit between a patient and a clinician. Capitated payment can provide more flexible resources for clinicians to offer care coordination without burdensome coding and documentation.

- **Telehealth** services because population-based payments can reduce restrictions or burdensome documentation requirements often placed on clinicians with use of telehealth while creating incentives to avoid duplicative or unnecessary telehealth use. For example, providers could elect to offer audio-only or video-based telehealth services based on what is most effective for patients and efficient for clinicians.

In contrast, high-value, high-cost services like immunizations should be reimbursed through FFS. These types of services are important to deliver to patients and may include high delivery costs so incentivizing greater utilization is appropriate. Additionally, evaluation and management services, which are the platform for most diagnoses and counseling in primary care, could be paid partially by capitated payments, and partially by FFS. Blending FFS and capitated payment for evaluation and management services will offer providers more flexibility while still ensuring strong access to care for patients.

---

7 Ibid.
8 Berenson RA, Shartzer A, Pham HH. Beyond Demonstrations: Implementing A Primary Care Hybrid Payment Model in Medicare. Health Affairs Scholar. August 1, 2023.
9 Ibid.
10 United States Senate Committee on the Budget Hearing on “Achieving Health Efficiency through Primary Care.” March 6, 2024. Testimony of Amol Navathe.
Based on these recommendations, **60 to 70 percent of payment for most primary care clinicians would be covered by a new population-based payment while the remaining 30 to 40 percent would be reimbursed through FFS payments.** This suggested structure is supported by simulations of capitated payments for primary care which find that practice transformation, specifically shifting to more team-based and non-visit-based care, would be incentivized when 63 percent of a practice’s patients had capitated payments in place.\(^\text{11}\) The *Pay PCPs Act* gives HHS the authority to establish prospective, population-based payments that represent 40 to 70 percent of expected charges and may cover care management, patient communication, behavioral health integration, and office-based evaluation and management visits.\(^\text{12}\) Evidence suggests that for most clinicians, the population-based payment can be higher than 40 percent; however Congress should stipulate a range for the population-based payment proportion and include a sufficient floor so that CMS can design and fine tune the payment structure, with adjustments over time depending on practice behavior. The exact level of population-based payment will vary and will be determined by the mix of services that each clinician provides.

**Risk Adjustment**

Risk adjustment, which can be used to adjust the level of payment to providers based on their patients’ health status and expected utilization, plays an important role in population-based payment models. For hybrid capitated payments for primary care, risk adjustment helps ensure that population-based payments match the expected intensity of primary care that is likely needed, which varies based on the makeup of clinicians’ patient panels. In addition, risk-adjusted payments help ensure providers have sufficient resources to invest in practice transformations to enable high-quality, equitable care.

A reasonable starting place for risk adjustment for a hybrid capitated model is to base the payment on historic utilization while considering moving to an approach that bases payment on population needs over time. This approach would enable a smooth transition from FFS by minimizing the potential for financial shocks to practices and enable them to ease into care delivery changes (i.e., decreasing visit volume and increasing use of other resources over time). While historic utilization is a reasonable starting place for risk adjustment in a hybrid capitated payment model, the longer-term goal should be to adjust for risk using an approach that moves payments away from utilization patterns observed in FFS. Historic utilization does not capture the care delivery patterns that hybrid capitated payments aim to incentivize, and an alternative risk adjustment approach would better align financial incentives under a value-based framework.

Developing an alternative risk adjustment approach is also important for advancing equity. A model based on historic utilization may not provide sufficient resources for clinicians to care for patient populations

---


\(^{12}\) *Pay PCPs Act*, S.4338, 118th Congress. Introduced May 15, 2024.
who have been historically underserved such as racial and ethnic minorities. Correcting for this issue (i.e., redistributing payments to enable higher payments for the care of historically underserved groups) is important for allocating resources in population-based payment models in a way that advances health equity. Social risk adjustment—that is, including social risk adjusters that incorporate observed spending—has been proposed as an option for using risk adjustment to enhance equity. However, it is important to note that if the goal of this approach is to increase payments to disadvantaged populations, it may have the opposite effect, further entrenching disadvantage.\(^\text{13}\) For example, patients living in low-income ZIP codes tend to have lower health care spending relative to those in high-income ZIP codes; therefore, including ZIP-code level income in a risk adjustment model would tend to lower risk scores for patients residing in low-income areas, resulting in a lower risk-adjusted payment.\(^\text{14}\) A variety of alternative approaches could be used to enhance risk adjustment as a tool for equity.\(^\text{15,16}\)

Because the hybrid capitated payments cover beneficiaries in FFS, it is appropriate for risk adjustment to only include this population. In other words, Medicare Advantage (MA) enrollees should be excluded from the risk adjustment calculation for hybrid capitated payments in FFS Medicare. A question that has been raised is whether excluding MA beneficiaries from risk adjustment will cause primary care clinicians to steer less healthy patients to MA, and this may be a greater concern for physician practices owned by MA insurers. If the level of risk adjustment is appropriate, however, incentives to avoid sicker patients should be sufficiently mitigated. In addition, many primary care clinicians have sub-capitated arrangements with MA plans that create similar incentives as the hybrid capitated payment model intends to create for clinicians’ FFS patients.

The risk adjustment system for hybrid capitated payments for primary care physicians must be constructed with appropriate guardrails that prevent intensive risk score coding to increase risk-adjusted payments, a major problem in MA that drives significant overpayments to plans. In the context of ACOs, CMS caps risk score growth, which has helped limit the impact of payment increases due to coding incentives. A similar approach could be incorporated into a risk adjustment system for hybrid capitated payments in primary care to protect against greater coding intensity and unwarranted spending increases.

**Congress should require risk adjustment for hybrid capitated payments to primary care physicians and give CMS the authority to design and implement a risk adjustment approach for hybrid capitated payments in primary care.** CMS has extensive experience with risk-adjusted prospective payments in primary care from several CMMI models including Comprehensive Primary Care, Comprehensive Primary


\(^\text{14}\) Ibid.

\(^\text{15}\) Ibid

Care Plus, Primary Care First, Making Care Primary, and, most recently, ACO Primary Care Flex. They also have authority over risk adjustment in MA and experience making changes to improve the CMS-Hierarchical Condition Category (CMS-HCC) model over time. CMS is well-positioned to develop a risk adjustment approach for hybrid capitated payments for primary care that is informed by the evidence from CMMI’s models and that gradually moves away from historic utilization.

**Ensuring High Quality Care**

One of the key goals of hybrid capitated payments for primary care is to incentivize high-quality, patient-centered care. Hybrid capitated payments create incentives for clinicians to change their behavior and transform care delivery. It is critical that the hybrid capitated payment model is designed to ensure that clinicians have appropriate incentives to provide necessary care. This can be accomplished by managing which services are included in the population-based payment, risk adjusting payments (as discussed above), and, to the extent necessary, incorporating outcome-based quality measures. Moving specific services in or out of the population-based payment, can have significant effects on utilization rates for those services. This highlights how a hybrid payment approach can drive more appropriate utilization and ensure that necessary care is provided (i.e., it can incentivize higher utilization of high-value services and lower utilization of low-value care). **We recommend placing a greater focus on the design of the hybrid payment structure itself (i.e., the inclusion and exclusion of certain services and risk adjustment), rather than the use of quality measures, to drive improved patient outcomes.** That said, to the extent there is interest, any new quality measurement effort should minimize physician reporting burden and focus on a small set of patient outcomes rather than process measures.

**Technical Advisory Committee on the Fee Schedule**

The valuation of services in the fee schedule is based on recommendations to CMS from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC), an expert panel with substantial influence on value determinations, the rate-setting process, and, subsequently, physician payment. Structural flaws with the RUC, including inherent conflicts of interest and a reliance on survey data from medical societies, undermine the accuracy of its recommendations and point to an urgent need for reforms. As a result, payment in FFS is not always well aligned with the value of services, meaning reimbursement levels do not always reflect the actual time and resources needed to deliver a service, and the fee schedule overvalues procedural services and undervalues cognitive services.

---


19 Centers for Medicare & Medicaid Services. [ACO Primary Care Flex Model](https://www.cms.gov), CMS.gov.
The RUC relies on surveys of specialty medical society members to assess the time and intensity of providing a specific service and to produce a recommendation for the service’s total work relative value unit (RVU), a measure of the provider’s work when performing a service or procedure, which informs the value determination. The surveys tend to lead to inaccurate, distorted RVUs because they are subjective and may not accurately account for the time and effort of most physicians performing the service. Physician respondents also have an inherent conflict of interest to inflate work values. One study comparing data from operative logs with RUC survey data found that the RUC survey data overestimated procedural times by an average of 31 minutes across 60 procedures. In addition, specialties other than primary care have greater representation on the RUC.

In most cases, CMS accepts the RUC’s recommended RVUs given that other data sources for CMS to validate RUC recommendations often do not exist. As a result, value determinations, and therefore payment rates, are based on flawed data. Given the baseline issues with the data that the RUC uses to determine valuation, congressional action is urgently needed. Arnold Ventures strongly supports the establishment of an advisory body within CMS (e.g., a technical advisory committee like what is proposed in the Pay PCPs Act) to balance the RUC process and sees this as a critical, initial step toward improving valuation in the fee schedule. Ultimately, Congress must do much more to address misvaluation in the fee schedule and equip CMS to take a more active role in FFS payment rate setting (discussed further below), which will likely require additional data and financial resources.

**Structure & Makeup of the Advisory Committee**

Congress should establish an advisory body within CMS (e.g., a technical advisory committee) to balance the RUC process, which aligns with the proposal in the Pay PCPs Act and recommendations from experts. The committee should be made up of individuals with no conflicts of interest and should supplement the RUC by engaging in the following:

- Advising CMS on data collection priorities including additional information that could be collected to supplement the current survey-based approach and reviewing empirical data;
- Advising on new and alternative approaches to determining relative values;
- Considering updates to nonprocedural codes;
- Examining opportunities for bundling services; and
- Recommending additional changes to payment amounts.

---

23 Pay PCPs Act, S.4338, 118th Congress. Introduced May 15, 2024.
In the short-term, creating a technical advisory committee within CMS is a necessary first step for providing crucial advice on improving valuation processes and creating more independence and transparency.\textsuperscript{25} By providing CMS with qualitative assessments from independent experts, the committee can inform CMS on whether to further modify payment in particular situations and supplement the recommendations provided by the RUC. To ensure transparency, advisory panel proceedings should be public. The technical advisory committee is a key initial step that Congress can take now to enable CMS to improve accuracy. However, there remains the need for CMS to establish the infrastructure for accurate and ongoing empirical data collection to validate RVUs and position CMS to take a more active role in the valuation process. This will take time to establish and will likely require new data collection methodologies and a permanent technical advisory committee.

**CMS’ Role in FFS Payment Rate Setting**

Congress should require CMS to implement accurate and ongoing data collection so that CMS has information to independently validate relative value units (RVUs) and supplement the existing survey information with empirical information on time and intensity associated with services.\textsuperscript{26} Data could include code-specific time data from practices and reflect differences in cost structures in various practice environments.\textsuperscript{27} This would reduce reliance on self-reported specialty estimates of code-specific work that clinicians perform.

At a minimum, Congress should direct CMS to improve transparency and better facilitate information around how the RUC reaches its valuation decisions. The secrecy around voting within the RUC may contribute to the RUC’s recommendations being biased in favor of certain specialty societies, which highlights the need for greater transparency.\textsuperscript{28} CMS should make a public, central repository of guidelines and standards, including information on physician work data and methods, that the RUC follows to generate recommendations.\textsuperscript{29}

There is a need to address currently misvalued services including the overvaluation of global surgical codes, which provide a single payment for all services associated with a surgical procedure. The global surgical codes – which include a 0-day, 10-day, and 90-day code – reimburse for the procedure as well as pre- and post-operative care. While the services included in the global surgical codes reflected clinical practice at the time of their introduction decades ago, it is now common for providers other than the surgeon to provide follow-up care. As a result, surgeons may receive payments for post-operative care.

\textsuperscript{25} Ibid.
\textsuperscript{26} Calsyn M, Twomey M. *Rethinking the RUC: Reforming How Medicare Pays for Doctors’ Services*. Center for American Progress. July 2018.
\textsuperscript{27} Bob Berenson. 2022. *Comment Letter on CY 2023 Medicare Physician Fee Schedule Proposed Rule*.
that they do not provide.\textsuperscript{30} To address this pricing distortion, Congress should direct CMS to unbundle the global surgical codes, which would better reflect clinical practice and generate savings to the Medicare program.

There are a number of other pricing distortions in the fee schedule that have been described in the literature and that should be addressed to improve valuation in the fee schedule and drive efficiency.\textsuperscript{31,32} CMS initially led the misvalued services agenda by analyzing data and providing the RUC with lists of codes to review but has recently deferred this review to the RUC.\textsuperscript{33} Congress should direct CMS to again lead the misvalued code review and set expectations for changes they would like to see as a result of review.\textsuperscript{34} Congress should direct CMS to identify services with notable growth in allowed charges, which can flag high expenditure services that need more timely reviews and ensure reviews are done on a rolling basis.\textsuperscript{35}

**Conclusion**

We appreciate Senators Whitehouse and Cassidy’s interest in the important issues of improving Medicare payment for primary care physicians and valuation in the fee schedule. Thank you for the opportunity to provide input. Please contact Erica Socker at esocker@arnoldventures.org or Mark Miller, Ph.D., Arnold Ventures’ Executive Vice President of Health Care, at mmiller@arnoldventures.org with any questions.

Erica Socker, Ph.D.
Vice President, Health Care
Arnold Ventures


\textsuperscript{35} Ibid.