August 1, 2022

Admiral Rachel L. Levine, MD, FAAP
Assistant Secretary of Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Judith Steinberg, MD
Senior Advisor, Office of the Assistant Secretary of Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Dear Admiral Levine and Dr. Steinberg:

The American College of Physicians (ACP) commends the administration and the Office of the Assistant Secretary for Health (OASH) for its work to develop innovative approaches to strengthen Primary Health Care and appreciates this opportunity to offer feedback. We underscore the importance of ongoing transparency and stakeholder feedback to successfully transform and strengthen Primary Health Care and look forward to providing more detailed feedback throughout the process.

ACP is pleased to share our comments on OASH's Request for Information on the HHS Initiative to Strengthen Primary Health Care. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 160,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The approach of building a health care system that is smarter about how dollars are spent to make people healthier must shift to one with a clear intention of health equity. The need is urgent for all care partners to collectively change how we approach payment for primary care services and move to prospective, value-based payment models while ensuring that the payments are structured in a way that truly advances and supports high-value primary and comprehensive care and health equity.

In the paper published by ACP, "Reforming Physician Payments to Achieve Greater Equity and Value in Health Care: A Position Paper of the American College of Physicians," ACP makes

several recommendations that focus attention on a system where financial incentives are aligned to achieve better patient outcomes, lower costs and reduce inequities in health care. These recommendations include:

- **That Medicare and other payers progressively adopt population-based, prospective payment models for primary and comprehensive care that are structured and sufficient to ensure access to needed care and address the needs of individuals who are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health.**
- **A call for research in creating a validated way to measure the cost of caring for patients who are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health.**
- **Modifications to the Medicare law to establish a mechanism for savings to be calculated across all aspects of the program—that is, increased investment in relative and absolute payments for primary care and preventive health care services (Part B) results in savings due to reduced emergency department visits and hospitalizations (Part A)—and to allow these savings to be reinvested back into primary and preventive care, as well as into social and public health services. ACP cautions that investment in primary care must not be predicated solely on achieving short-term cost savings, given that primary care has broader societal benefit in improving population health and associated savings will often be longitudinal and take place over many years.**
- **That the Secretary of Health and Human Services be authorized to address the inadequacies within the Quality Payment Program. This includes developing policies and financial approaches to ensure that the Quality Payment Program as a whole begins to address such issues as inequity, health care disparities, and social drivers of health.**
- **The need for delivery and payment systems that fully support physicians, other clinicians, and health care facilities in offering all patients the ability to receive care when and where they need it in the most appropriate manner possible, whether that be via in-person visits, telehealth, audio only, or other means.**
- **That adequate funding be made available to support the development of effective health information technology systems and communication mechanisms, including adequate broadband availability, to ensure that delivery and payment reforms are able to address the needs of all patient populations, including those that are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health.**
- **That federal and state policymakers and payers, health plans, health systems, private-sector investors, and philanthropic institutions develop and implement additional financing mechanisms beyond direct payment to clinicians and practices, such as grants and technical assistance, to support innovative approaches to address inequities, health care disparities, and social drivers of health.**

RFI Topic #1: Successful Models or innovations that help achieve the goal state for Primary Health Care:

Models that hold participating clinicians and entities accountable for quality, utilization, and cost by offering prospective, fixed payments to cover total cost of care offer an important opportunity to remove administrative barriers that add unnecessary system cost and more importantly detract from direct patient care. Keeping with CMS' Patients Over Paperwork Initiative and ACP's own Patients Before Paperwork Initiative, we implore OASH to explore every opportunity to remove unnecessary burdens for participants in any model, including claims-based billing, prior authorization, and payment requirements for certain services. CMS should act on its Meaningful Measures Initiative by utilizing a small set of evidence-based, outcomes-focused measures that capture important, valid, and clinically relevant performance and cost information. Patient safety and program integrity can and should be upheld without requiring clinicians to report on so many measures that they actually spend more time reporting data than delivering care to patients, as is currently the case.

It is vitally important that any model, but particularly capitated payment models, provide ample funding to support primary care, cognitive, and care management services provided by internal medicine specialists, which the Medicare Payment Advisory Commission and others have consistently noted are routinely undervalued in our current fee for service (FFS) reimbursement system.[1] Internists have unique training and skills in providing primary, preventive and comprehensive care to adults, particularly in the diagnosis, treatment, and management of patients with complex conditions. Access to primary care has been associated with higher quality of care,[2],[3] lower system costs,[4],[5],[6],[7] higher patient satisfaction,[8] and lower mortality rates,[9],[10] which are the very outcomes a capitated model aims to accomplish. In a model based on delivering efficiencies through reduced unnecessary services and downstream complications, effective comprehensive, longitudinal, preventive care and care management from internal medicine specialists will be a priority and must be valued as such in the underlying payment structure.

RFI Topic #3: Successful Strategies to engage communities:

Policy leaders and the clinical community must work together to make progress toward equity using value-based payment. Appropriate funding is required to cover the cost of value-based

[1] http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0
[2] Influence of primary care on breast cancer outcomes among Medicare beneficiaries. Ann Fam Med. 2012.
[3] Contribution of primary care to health systems and health. Milbank Quarterly. 2005.
[4] National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries. Ann Emerg Med. 2012
[5] Health care utilization and the proportion of primary care physicians. Am J Med. 2008.
[6] Can PC visits reduce hospital utilization among Medicare beneficiaries at the end of life? J Gen Intern Med.
[7] Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff. 2004.
[8] Linking primary care performance to outcomes of care. J Fam Pract. 1998.
[9] Primary care attributes and mortality: A national person-level study. Ann Fam Med. 2012.
[10] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393

initiatives that address the needs and well-being of the whole patient, including social drivers of health. According to the NASEM report, "High-quality primary care complements specialist expertise by starting with a focus on the whole person and their family, within the context of their community, and then iteratively identifying and working on the most important concern in that moment, while keeping the whole in view …". Funding such programs will require an infusion of resources, monies, and time into value-based initiatives. Several programs provide funding, but all operate within their own silos. The Social Impact Partnerships to Pay for Results Act was signed into law on 9 February 2018. Congress appropriated $100 million for the program under this Act to implement "Social Impact Partnership Demonstration Projects" and feasibility studies to prepare for those projects. There is also the Social Determinants Accelerator Act, which was designed to help states and communities formulate strategies to better leverage existing programs and authorities to improve the health and well-being of those participating in Medicaid. Rather than funding siloed programs and creating additional councils, funders should make investments available from central funding resources shared across all care partners and stakeholders.

RFI Topic #4: Proposed HHS Actions:

The COVID-19 pandemic has underscored the importance of a strong, stable primary care system for patients and the health system in general. In the years where primary care practices have faced endless challenges, practices have maintained a high level of resiliency due to the alternative payment mechanisms provided by participating in Comprehensive Primary Care Plus (CPC+). Due to the prospective care management fees from CPC+, practices were able to more rapidly deploy innovative actions to provide continuous, high quality primary care to patients and advance public health in communities amid the pandemic, such as scheduling telehealth visits for patients with chronic conditions; setting up drive-through COVID-19 testing centers; and helping patients safely access the appropriate level of care based on their symptoms. New models based on the successful aspects of predecessor models such as the CPC+ model must be implemented. Investment in primary care must not be predicated solely on achieving short-term cost savings, given that primary care has broader societal benefit in improving population health and associated savings will often be longitudinal and take place over many years.

Such programs as the Comprehensive Primary Care Plus (CPC+) which offers a hybrid payment approach utilizing partial primary care capitation should be offered as an option by CMS within the Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs). Allowing this type of an option would help more practices move away from dependence on a fee-for-service (FFS) system that consistently under resources primary care and stymies transformation.

For MIPS to achieve the goal of helping physicians transition to value-based models, policymakers could consider adjusting financial rewards and penalties under MIPS in several

ways to create incentives to lower spending, improve quality, and strengthen protections against favorable selection.

Restructuring MIPS offers the opportunity to incorporate policies and financial approaches that actively address such issues as discrimination, health care disparities, and social drivers of health. Although some of this can be done via improved risk adjustment methods within the metrics, more direct financing of entities that provide critical and evidence-based social, community, and public health services must be prioritized. Underserved patient populations need to be included when value-based payment models are developed and improved on.

We welcome the opportunity to discuss our comments in greater detail. Please contact Brian Outland, Director, Regulatory Affairs at 202-261-4544 or boutland@acponline.org for questions and potential times for a meeting. We believe the OASH's approach is directionally appropriate, and we stand ready to work with you and the OASH team to make all these critical and necessary improvements needed to ensure the success in strengthening primary health care.

Sincerely,

William Fox, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians