July 15, 2024

The Honorable Bill Cassidy
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

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

Subject: Pay PCPs Act of 2024

Dear Senators Cassidy and Whitehouse:

On behalf of the California Public Employees' Retirement System (CalPERS) and Covered California, we are writing in response to your request for information (RFI) accompanying the Pay PCPs Act of 2024. We appreciate your bipartisan leadership to address primary care challenges, promote value-based payment models in Medicare, and improve care for Medicare beneficiaries, particularly individuals with chronic diseases.

CalPERS is the largest commercial health benefits purchaser in California and the second largest commercial purchaser in the nation. We secure health benefits for approximately 1.5 million active and retired state, local government and school employees, and their family members. In 2022, CalPERS enrolled 150,427 members in Medicare Supplement plans and 166,429 in Medicare Advantage (MA) plans.[1] We contract with numerous large health insurance companies to provide our members with a variety of health plan offerings, including health maintenance, preferred provider, and exclusive provider organization (HMO, PPO, and EPO) products.

Covered California is the state's health insurance marketplace under the Affordable Care Act working to reduce the number of uninsured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace. Covered California is an active purchaser, ensuring access to equitable, high-quality care for nearly 1.8 million Californians, facilitating enrollment in 15 Qualified Health Plans including HMO, PPO, and EPO products across 12 issuers.

By working together, CalPERS and Covered California strive to align our health benefit offerings, improve the efficiency of healthcare delivery, and leverage our purchasing

[1] *See* CalPERS 2022 Health Benefits Program Annual Report, *available at* https://www.calpers.ca.gov/docs/forms-publications/health-benefits-program-annual-report-2023.pdf

power to negotiate better rates and services for individuals. This partnership aims to enhance the overall health coverage landscape in California, making it more accessible, affordable, and beneficial for all residents across the state. Drawing from our experience in California, we are responding to the RFI's questions on hybrid payments for primary care providers and cost-sharing adjustments for certain primary care services to help the Centers for Medicare and Medicaid Services (CMS) more accurately determine Fee Schedule rates.

I. HYBRID PAYMENTS FOR PRIMARY CARE PROVIDERS

Access to high-quality primary care is critical for improving population health outcomes, reducing disparities, and slowing health care cost growth. CalPERS and Covered California believe that payment for primary care should be sufficient to support the adoption and maintenance of advanced primary care (APC) attributes, including the ability to assess and address patients' behavioral health and social needs. Payment for primary care should also shift away from volume (fee-for-service [FFS]) and toward value (prospective, outcome-based, population-based). Multi-payer alignment on primary care investment, measurement, and value-based payment is essential to strengthening primary care.

CalPERS and Covered California believe there are significant merits to the exploration of establishing a hybrid per beneficiary, per month (PBPM) payment model in FFS Medicare to promote access to primary care. Moving away from FFS payment and toward capitation better aligns payment incentives and supports investments, such as population health management, with the potential to improve clinical quality, patient experience, and health outcomes. We suggest providing transparency regarding primary care payment structure and methods for attributing services to providers so that incentives are clear and there is adequate oversight of that care. We also encourage CMS to establish a mechanism for the regular review and adjustment of payment rates to reflect changes in health care costs, practice patterns, and patient needs. This could include annual or biennial reviews based on inflation, health care market changes, and feedback from primary care providers and patients.

A. Beneficiary Attribution

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

CalPERS and Covered California are committed to ensuring that our enrollees are linked to high-quality primary care clinicians to create stable primary care relationships. To this end, we have been national leaders in ensuring that all our enrollees are connected to a primary care provider, serving as a precedent for universal primary care linkage. We recommend a two-pronged approach to beneficiary attribution – enrollee choice attribution and visit-based attribution.

1. Member Choice Attribution: First, beneficiaries should be given the option to choose their primary care provider by a specified deadline. Prioritizing a beneficiary's personal choice in this manner not only serves to engage patients more deeply in their health care decisions but also establishes a foundation of trust, and promotes continuity of care. This continuity is crucial, as it reduces the likelihood of beneficiaries frequently switching their primary care providers.
2. Visit-Based Attribution: For beneficiaries who do not select their own primary care provider by a specified deadline, Medicare should attribute patients based on claims data related to primary care visits.

We also recommend aligning the patient attribution methodology used with commercial, Medicare, and Medicaid populations when possible and adjust if needed. It is also equally important to ensure providers have clear, actionable information about patients attributed to them, regardless of whether prospective or concurrent attribution is used.

Additionally, it is critical to avoid overreliance on the notion of an assigned primary care provider as a driver of health behavior. Covered California has investigated the association between the use of a member's assigned/plan-designated primary care provider with actual primary care utilization rates. Despite the widespread practice of requiring enrollee assignment to a primary care provider, little is known about the relationship between primary care assignment and health care utilization in commercial health insurance, especially in PPO and EPO plans where the primary care provider does not serve as a critical access point to specialty services.

Covered California used 2022 data in its all-plan claims database to investigate the association of primary care selection or assignment with actual primary care and other health care service utilization patterns. Of the 2.3 million enrollees evaluated, we found that 22 percent had visits with their assigned primary care provider, 22 percent had visits with a primary care provider who was not their assigned primary care provider, 28 percent had only non-primary care utilization (medical or pharmacy), and the remaining 27 percent had no utilization of any type in the evaluation period.

We investigated whether plan type (HMO, PPO/EPO) was associated with differences in use of the assigned or other plan-designated primary care provider. We found that enrollees in HMO plans were about 24.5 percent more likely to have a claim with their assigned primary care provider. Enrollees in HMO plans on average have 0.51 more claims with their assigned primary care provider in a given year as compared to enrollees in EPO/PPO plans.

However, when we expanded our view to include any plan-designated primary care provider and did not limit to only an enrollee's assigned primary care provider, we found the inverse to be true. Enrollees in PPO/EPO plans were 8.3 percent more likely to have a claim with any primary care provider. Enrollees in PPO/EPO had 0.57 more claims with any primary care provider in a given year as compared with enrollees in HMO plans. Consistent with the inherent design of HMO plans where care is funneled through an assigned primary care provider, a significantly higher portion of enrollees in HMO

plans use their assigned primary care provider as compared to enrollees in EPO/PPO plans. However, a significantly higher portion of enrollees in PPO/EPO plans use plan-designated primary care providers overall.

While efforts to assign enrollees to a primary care provider are well-intentioned and intended to encourage people to establish relationships with a primary care provider, we should consider shifting the focus of our policies and processes to encourage continuity of care with a single, known, trusted provider. Whether that provider is the primary care provider on paper, assigned by a health plan or denoted on a health insurance card, it's the relationship with and the continuity of care that has been shown to reduce emergency room utilization,[2] improve overall health care costs,[3] and lead to equitable outcomes.[4]

How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?

As noted above, utilizing a two-pronged approach to attribution and prioritizing a beneficiary's personal choice will help engage patients in health care decision-making and build trust. If a beneficiary can choose their clinician, they may be more likely to stay with that clinician over time.

Additionally, it is critical to develop systems that support and incentivize continuity of care with a trusted provider. There is strong evidence that highly continuous primary care relationships improve outcomes and decrease overall health care expenditures in the Medicare population.[5] Given the current state of the primary care system, we recommend that Congress address the proliferation of retail-based and virtual point solutions offering access to "primary care-like" services and their impact on the health care system. While these types of offerings can improve access in the short term, they do not support continuous primary care relationships and can be detrimental to health care outcomes. These offerings may also increase unnecessary utilization, or emergency room visits.[5] These types of service offerings are often fragmented, do not connect back with the beneficiary's designated primary care provider, and may enable enrollees to more easily and frequently switch between providers.

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[2] *See* Lapointe-Shaw L, Salahub C, Austin PC, et al. Virtual Visits With Own Family Physician vs Outside Family Physician and Emergency Department Use *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813291

[3] *See* Sonmez D, Weyer G, Adelman D. Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savingshttps://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808555

[4] *See* Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

[5] *See* Lapointe-Shaw L, Salahub C, Austin PC, et al. Virtual Visits With Own Family Physician vs Outside Family Physician and Emergency Department Use *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813291

B. Hybrid Payment

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

The methodology for setting hybrid payment rates should strike a balance among incentivizing primary care providers to participate in the hybrid model, improving beneficiary access to primary care services, and managing Medicare spending. Moreover, the methodology should be informed by similar primary care models tested by the CMS Innovation Center, including Making Care Primary (MCP) and Comprehensive Primary Care Plus (CPC+).[6,7]

CalPERS is committed to expanding participation in alternative payment models (APMs), with a focus on APC and integration of physical and behavioral health care. CalPERS and Covered California actively participate in the foundational work of the California Department of Health Care Access and Information's Office of Health Care Affordability (OHCA), which is tasked with setting statewide targets for cost growth, adoption of APMs, and primary care spending. We also actively participate in statewide workgroups with our purchaser partners in California to achieve alignment in purchaser and regulator goals around the adoption of APMs and primary care spending targets.

Together, we have made significant changes to our health plan contracts to promote APC and APM adoption. We require our HMO and PPO health plans to expand the adoption of primary care payment models to increase the percent of primary care providers paid through an APM and to align with OHCA's targets. The contract language also includes APM-related reporting requirements using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP-LAN APM) categories and sub-categories for "service with no link to quality and value," "fee for service with a link to quality and value," and "alternative payment models built on a fee for service structure such as shared savings and population management." The plans must also report on behavioral health care spending and total health care spending, as well as how they are promoting and expanding the integration of physical and behavioral health care.

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[6] *See* Making Care Primary: Payment and Attribution Methodologies, *available at* https://www.cms.gov/files/document/mcp-pymt-att-methodologies.pdf

[7] *See* Comprehensive Primary Care Plus Payment and Attribution Methodologies for Program Year 2021, *available at* https://www.cms.gov/priorities/innovation/media/document/cpc-plus-payment-methodology-cy2021

C. Risk Adjustment

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

We encourage you to explore a hybrid-specific risk adjustor for primary care. A risk adjustment model that accurately reflects what it costs to care for beneficiaries could help ensure adequate provider payments. We recognize that a concurrent risk adjustment model – one that uses conditions diagnosed in the prediction year to predict costs in the same year – may be appealing for a hybrid model, but there are concerns that such a model may incentivize upcoding.[8] The Committee should strive to accurately adjust for health risks and social complexity of patients while limiting gaming as much as possible.

Furthermore, as the primary care workforce is in crisis and insufficient to serve the aging population across the country[9], the pressure on physicians to adjust their coding to meet administrative requirements that have no impact on their clinical decisions or plans should be considered. While many actions may be taken to improve Hierarchical Condition Category coding accuracy by linking diagnoses or considering the order/priority in which diagnosis codes are arranged in a medical record, these types of administrative practices have minimal bearing on care delivery and clinical decision making. And, while some practices may provide their practitioners with additional support or feedback geared at these type of coding practices, we are not aware of evidence that these types of practices result in improved outcomes or better clinical decision making. Indeed, there is evidence that these types of practices have an outsized benefit on insurance companies with unclear benefit being passed along to enrollees.[10]

D. Quality Measurement

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

We support the types of quality measures proposed in the legislation. The hybrid model should require participating providers to report a set of primary care-specific quality measures. Using the same quality measures would allow for comparison across

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[8] *See* Berenson RA, Shartzer A, Pham HH. Beyond demonstrations: implementing a primary care hybrid payment model in Medicare, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10986246/

[9] *See* Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now. *available at* https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[10] *See* Jacobs PD, Kronick R. The effects of coding intensity in Medicare Advantage on plan benefits and finances available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7969203/..

providers, reduce the administrative burden associated with reporting, and align with existing measure sets, such as those utilized by the Purchaser Business Group on Health's Advanced Primary Care initiative, or the California Department of Managed Health Care's Quality and Equity measure set. Both measure sets utilize National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures in wide use across regulators, purchasers, and health plans. These measure sets also focus on measures with high impact on primary care and population health.

CalPERS and Covered California, in alignment with the California Department of Health Care Services, which operates Medicaid in California, adopted a subset of measures on both lists and tied significant financial accountability to performance on these measures for our health plans because of their impact on population health outcomes. These measures and related financial incentives focus on improving care for clinically important conditions for which there are major opportunities for improvement and evidence-based measures in current use.

The measure set consists of four measures (noting that CalPERS has one additional measure unique to its measure set focused on maternity health), all of which are nationally endorsed, evidence-based NCQA HEDIS measures:

- Childhood Immunizations
- Controlling High Blood Pressure
- Comprehensive Diabetes Care – Poor Control (HgbA1c >9 percent)
- Colorectal Cancer Screening

In addition to the measures above, all CalPERS and Covered California plans are required to report on the following NCQA HEDIS measures for each of its products:

- Depression Screening and Follow-Up for Adolescents and Adults (DSF), and
- Pharmacotherapy for Opioid Use Disorder (POD)

CalPERS and Covered California are utilizing the same measures and the same benchmark – the NCQA-derived national 66th percentile – for its HMO and its PPO plans, with similar incentive structures. Specifically, for each measure with a result below the benchmark (66th percentile), the plans must each make a payment as outlined below:

- Below 25th percentile: full payment for each measure result
- At or above the 25th to the 65th percentile: payment per measure is assessed proportional to position in that range (sliding scale – meaning, the amount increases the closer it is to the 25th percentile)
- At or above 66th percentile: no measure payment

We recommend you consider incorporating these quality measures, as appropriate, into the hybrid PBPM payment model.

What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?

We recommend standardized quality reporting requirements and aligning with existing measure sets, as outlined above, as much as possible. Congress should direct CMS to develop templates for information and collection reporting. By providing clear guidance, standardized reporting would reduce complexity and errors, streamline data collection and reporting, and improve consistency in trend reporting and comparison to benchmarks.

E. Primary Care Services

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

We agree with the approach proposed in the legislation allowing the Secretary of the Health and Human Services Agency to create categories of different services that may receive the prospective PMPM payment. The proposed list of services is appropriate but could be expanded to explicitly support payments for team-based care.

Will including these services in a hybrid payment negatively impact patient access to service or quality of care?

While we do not foresee a hybrid payment negatively impacting patient access to services or quality of care, we encourage you to require CMS to regularly monitor and assess the impact of hybrid payments on Medicare beneficiaries' access to care and quality of care. We suggest that the report to Congress proposed in Section 4 of the Act also assess the impact of hybrid payments on beneficiaries, providers, and the Medicare program, and incorporate capitation or other financial models to support team-based care activities to incentive coordinated, comprehensive care.

II. Cost-Sharing Adjustment for Certain Primary Care Services

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?

Like the methodology for setting hybrid payment rates, the amount of cost-sharing should strike a balance among improving beneficiary access to primary care services through greater affordability and removing barriers to primary care access, incentivizing primary care providers to participate in the hybrid model, and managing Medicare spending.

III. Technical Advisory Committee to Help CMS More Accurately Determine Fee Schedule Rates

Recruiting a primary care physician onto the advisory committee would be beneficial. Primary care providers have firsthand experience and understanding of the complexities involved in delivering primary care. They are well-positioned to highlight the challenges and opportunities within the current system, ensuring that the council's decisions are informed by practical, on-the-ground knowledge of primary care delivery. In particular, we recommend the inclusion of a primary care provider from a small independent practice given their different experience and perspectives on payment models as compared with large physician groups.

In conclusion, Covered California and CalPERS are committed to addressing primary care challenges through value-based payment models, streamlined reporting, and multi-payer alignment. We welcome the opportunity to continue to collaborate with CMS and other stakeholders to develop and promote hybrid payment models. Our collective goal is to enhance health care quality and efficiency, ultimately benefiting patients and the health care system at large.

We thank you for your consideration and we look forward to continuing to work with you on our shared goal to improve health care affordability. Please do not hesitate to contact Donald Moulds, CalPERS' Chief Health Director, at (916) 795-0404, if we can be of any assistance.

Sincerely,

Marcie Frost
Chief Executive Officer, CalPERS

Jessica Altman
Executive Director, Covered California