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Adm. Rachel Levine, MD
Assistant Secretary for Health
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to: OASHPrimaryHealthCare@hhs.gov

RE: Request for Information: HHS Initiative to Strengthen Primary Health Care

Dear Admiral Levine:

The Purchaser Business Group on Health (PBGH) is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families. On behalf of PBGH and its members, I write to respond to the request for information regarding the Department of Health and Human Service's (HHS's) new initiative to strengthen primary health care. PBGH has more than three decades' experience working directly in communities with provider organizations, purchasers, and payers to improve access to and quality of primary care. More information about PBGH's extensive work in payment reform and quality improvement, behavioral and maternal/child health integration, and primary care measures development are available online.[1]

Our response to the RFI does not seek to answer all the questions posed in the inquiry; rather, we will focus on five key areas of recommendations:

- Payer Alignment
- Increased Investment in Primary Care
- Care Redesign and Service Integration
- Measurement
- Health Equity

Payer Alignment

[1] https://www.pbgh.org/initiative/primary-care/

To date, most of HHS's efforts to improve access to and quality of primary care focused on providers that are federal grantees (such as Federally Qualified Health Centers or FQHCs) and through public payers including Medicare and Medicaid. While this emphasis is important and critical to patient access and quality of care to those served by these programs, the lack of alignment with private payers and independent providers has hampered efforts to improve primary care.

PBGH members have been at the forefront of direct contracting and other strategies with provider organizations that align with various iterations of the Medicare Shared Savings Program. Employers have entered into contracts with accountable care organizations with specific targets for quality improvement, cost savings and total cost of care management. Some employers have collaborated with primary care networks to build primary care medical neighborhoods with high quality specialty referral networks. PBGH members have also piloted intensive outpatient care models that provide outreach and care coordination for high-risk individuals, as well as copay waivers for primary care visits. Covered California, CalPERS, and other PBGH members also encourage their PPO members to designate a primary care physician at enrollment. Some of our members and other purchasers have even invested in primary care through onsite clinics and expanded telehealth access.

HHS should ensure primary care improvement efforts include multi-payer alignment around common objectives. One successful example is the California Advanced Primary Care Initiative. Under the initiative, PBGH's California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA) convened a coalition of six large commercial health care payers to work together to enable primary care practices to transform to a high-performing, value-based care model that reduces costs and improves quality and equity. Through 2025, CQC, IHA, and several commercial payers will work together to advance four objectives:

1. Transparency: Report primary care investment, adoption of value-based payment models that support the delivery of advanced primary care and performance on the Advanced Primary Care measure set jointly developed by CQC and IHA.

2. Payment: Adopt an agreed upon value-based payment model for primary care providers that offers flexibility, supports team-based care delivery and incentivizes the right care at the right time.

3. Investment: Collaboratively set increased primary care investment quantitative goals without increasing the total cost of care.

4. Practice Transformation: Provide technical assistance to primary care practices working to implement clinical and business models for success in value-based payment models, integration of behavioral health and reduction of disparities.

HHS should support locally-led multi-payer efforts. Last year, the Health Care Payment – Learning Action Network (LAN) launched State Transformation Collaboratives in four states: Arkansas, California, Colorado, and North Carolina.[2] We had hoped more progress would have been made over the course of 2022 in California for example; but it appears clear that while the collaboratives are operating at the state level, they continue to be led by federally-designated contractors, rather than state leaders.

In the face of slow progress by federally administered efforts in California, state-based collaboratives, state and local payers, purchasers, and providers have taken the initiative to advance delivery and payment reforms on their own. As health care delivery is local, HHS should leverage existing partnerships like these among state and local payers, purchasers, and providers – which allow state leaders to take the lead rather than relying on slower-moving federal contractors.

Increased Investment in Primary Care

We were pleased to see the improvement in payment for care management service codes which is a step in the right direction. However, among commercial payers' payment for the Collaborative Care Model CPT codes remains limited. More actions are needed.

HHS should adequately incentivize primary care physicians and the system in order to promote quality, accessibility and equity. Existing examples include the Medicare Comprehensive Primary Care Plus (CPC+) program which uses care management fees to fund the salaries of care managers, behavioral health care providers and other staff to improve care delivery and coordination. Under a Centers for Medicare and Medicaid Innovation Award, PBGH's Intensive Outpatient Care Program piloted a similar care management fee structure among 23 provider organizations in five states.

Additional payment strategies CMS could undertake include 1) hybrid payment (capitation + fee-for-service) for direct services, 2) population health management per member per month (PMPM) payment for provision of services by provider organizations, ACOs and/or sub-contractors, and 3) increasing performance-based payments based on the Advanced Primary Care Measure Set, rewarding both

[2] https://hcp-lan.org/state-transformation-collaborative/

attainment and improvement. CMS can also increase payment for timely follow-up screening with standardized instruments when patients screen positive for depression and anxiety, which would support care coordination as well as outcomes measurement.

HHS should advance minimum primary care spending thresholds. We know that high quality, accessible, and equitable primary care is the foundation of a high value health care system. Yet despite accounting for 55 percent of health care office visits, primary care spending represents less than five percent of total health care expenditures, a figure that is actually declining.[3] At least 17 states are advancing primary care spending thresholds.[4] These thresholds represent a commonsense way to increase investment in primary care without increasing the total cost of care.

HHS and the Administration should protect competition in health care markets across the country. The Administration should support private physician practices in a manner that enhances their resources and improves their efficiencies so they can better focus on providing the best care for their patients. In many areas across the country, health care markets have become increasingly concentrated. These consolidated markets have generated higher prices and lower quality of care, all adversely impacting employers and other healthcare purchasers and American workers. The Administration should establish frameworks and key elements needed to monitor and weigh the impact of these transactions, especially the consolidation of provider organizations and the acquisition of primary care practices by hospital-owned foundations and integrated practices, health plans, and associated entities.

Care Redesign and Service Integration

We know primary care is most effective when it is integrated and coordinated with mental and behavioral health, maternal and child health and chronic disease management.

HHS should support care redesign that improves care coordination and service integration Advanced Primary Care that places patients at the center of every interaction and prioritizes access to high-quality primary care to prevent higher acuity and costlier care, making for a healthier nation. Building off a statewide practice transformation initiative funded by the Centers for Medicare and Medicaid (CMS), PBGH's California Quality Collaborative (CQC) crafted definitions for 'exemplar' primary care practices with the goal of identifying, celebrating and learning from high-performing organizations within the program's network. This led to a consensus

[3] https://www.pcpcc.org/sites/default/files/resources/PCC_Primary_Care_Spending_2020.pdf
[4] https://www.chcf.org/wp-content/uploads/2022/03/InvestingPCLessonsStateBasedEfforts.pdf

definition of "Advanced Primary Care." CQC defined Advanced Primary Care by high-performance attributes and a set of results-oriented measures that focus on how the care process is, or should be, experienced from the patient perspective. This set of measures is based on existing outcome measures widely in use by California and national payers that if collectively applied would enable medical practices to deliver Advanced Primary Care. More information on these advanced primary care attributes and measures is available online.[5]

HHS can support the broader adoption of Advanced Primary Care by adopting a federal definition of advanced primary care using CQC definitions. Further HHS should use federal funds to provide technical assistance to providers that adopt advanced primary care models. In support of multi-payer collaboration, CQC has also worked to transfer lessons learned in the CMS Transforming Clinical Practice Initiative to Medicaid managed care plans and other payers.

HHS should support Advanced Primary Care Models focused on service integration. Beyond supporting the Collaborative Care Model to advance behavioral health integration in primary care, the advanced primary care delivery model places patients at the center of every health care interaction. At the core of the advanced primary care model are attributes that ensure primary care is well integrated with other aspects of the health care systems. This includes ensuring patients receive comprehensive care that includes the screening and management of behavioral, financial and other social needs; the coordination of care between primary care teams and other care providers; and the use of tools that support population-based care and the provision of care management for patients with chronic conditions. Many of PBGH employers directly contracted ACOs highlight the value of service integration, with demonstrated improvements in quality of care and reductions in emergency department visits and avoidable admissions.

Other PBGH member strategies to support service integration and longitudinal episode management include a pilot for bundled maternity payment that aligns incentives across hospital care, OB-GYNs, primary care, including pediatrics – beyond well-baby care, the latter can serve as a critical entry point for identifying and addressing post-partum depression. To create a more seamless experience for employees and their families while also optimizing savings through site of care management, two employers are investing in on-site infusion clinics as well.

Measurement

[5] https://www.pbgh.org/initiative/advanced-primary-care/

Advanced Primary Care Models can be supported through an aligned measure set that reinforces clinical quality outcomes and patient-centered measures. Using measures that have longitudinal specifications requires practices to prioritize infrastructure investments to coordinate care, monitor preventive care adherence, and reduce adverse risk from poor management of chronic conditions.

HHS should support the use of a concise and meaningful measure set for all payers, focused on patient outcomes. As a starting point, we recommend the Department support uniform cross-payer reporting of measures, like those endorsed by the CQC's Advanced Primary Care model and identified in Table I. These 12 measures were selected by CQC with consensus support from health plans, provider organizations, and purchasers, both due to a rich body of literature demonstrating that high-performing primary care practices employ these measures and because they are nationally recognized and widely adopted.

HHS should consider opportunities over time to build on the Advanced Primary Care models by incorporating additional measures across the health system-- while avoiding measurement overload for providers. Ensuring accurate and meaningful measurements of quality, access, and patient outcomes is essential to a high functioning primary care system. To advance patient-centered care and whole-person health, HHS should also encourage use of composite measures for quality of life and patient experience. A meaningful and parsimonious set of outcomes measures should be publicly-reported by all providers; this does not preclude the use of existing clinical process measures internally for immediate feedback and benchmarking to reduce variation and improve quality. However, small and independent primary care practices can be overwhelmed by the proliferation of well-intended but often unnecessary measures. Finding the proper balance is key.

Health Equity

Next to patients and their families, the organizations that purchase health care — employers, government agencies, labor union health plans — have the strongest interest in ensuring that health care services lead to not only improved well-being, but also better overall functioning and worker productivity. With the growing diversity of the United States population, employers are challenged to ensure that every employee gets the health and healthcare care services they need in ways that recognize and respond to variations in language, gender, culture, and community structure. As employers increasingly prioritize diversity, equity and inclusion as central tenets to their human resource strategies, they expect the same from their health care partners.

Employers want to see quality reporting that addresses provider efforts to reduce variations in outcomes.

HHS should provide direct support for the "hidden safety net" in parity with other safety net providers. While policymakers have made commendable efforts to support access to care for low-income families at FQHCs and other federal grantee providers, in California more than 60 percent of primary care visits for Medicaid beneficiaries take place at non-federally supported providers.[6] These often minority-owned small practices represent a "hidden safety net" for millions of Medicaid beneficiaries and other low-income individuals and families. Disproportionately owned by racial and ethnic minorities, these practices receive very little direct support from the federal government and are increasingly joining larger practices to keep their doors open.

These practices serve a mixed panel of Medicaid and Medicare beneficiaries, as well as commercial-insured patients. Beyond resources, they need alignment across purchasers and payers in expectations and payment to succeed. When Medicaid is not aligned with commercial payers and the broader industry, providers are challenged to fully participate in Medicaid programs requiring substantial business and clinical model with only a proportion of their patients enrolled in Medicaid and the proportion of practice revenue being even smaller with low payment rates. The lack of federal models designed in recognition that majority of primary care practices have mixed panels, is an example of structural racism and it exacerbates inequities in health outcomes and resources to communities of color.

HHS should invest in testing and scaling innovations for Race, Ethnicity and Language (REaL) data exchange between providers, payers and purchasers, and community-based organizations. REaL data is increasingly required by public and private payers, but providers lack systems to exchange data collected across the delivery system, leading to further fragmentation and variation in data sets.[7] The lack of ability to exchange this vital data also requires patients to furnish REaL data every time they engage with the delivery system, leading to redundant, wasteful efforts within the delivery system to collect, report and analyze data by every provider.

HHS and the Office of Management and Budget should work with the private sector in updating racial and ethnicity classifications. States, employers, and other health care stakeholders increasingly find current classifications – which were developed in 1997 –

[6] California Quality Collaborative (CQC). Weaving Together Mental and Physical Health Care Outside the Safety Net. 2020.
[7] https://www.commonwealthfund.org/blog/2021/modernizing-race-and-ethnicity-data-our-federal-health-programs

no longer useful in reflecting current understanding of racial and ethnic diversity within their populations. Moreover, we understand that current federal data collection standards and certain federal enrollment data on race and ethnicity are inconsistent.

Race and ethnicity data are foundational for understanding and addressing health disparities, and such inconsistencies hinder the work needed to address these important issues. We are pleased that the White House announced an effort to update these classifications.[8] We support this effort and would encourage the Administration to take the lead in raising awareness and helping educate all stakeholders. Given past discrimination, it is important that any broad effort undertaken must also not marginalize and include community input and collaboration to make sure that the results reflect the community.

Thank you for considering our comments and suggestions. We would welcome the opportunity to discuss these comments and partner with the Department to strengthen primary care to improve access and quality. Please feel free to contact me (agilbert@pbgh.org) to further discuss these issues or any other matter of mutual concern.

Sincerely,

Alan Gilbert, Esq.
Vice President, Health Policy

[8] https://www.whitehouse.gov/omb/briefing-room/2022/06/15/reviewing-and-revising-standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity/

TABLE I: ADVANCED PRIMARY CARE ENDORSED MEASURES

Exhibit 1: Advanced Primary Care Core Measure Set

			Attributes of Advanced Primary Care				
Quality Domain	Measure	NQF ID	Person & Family Centered	High-Value	Team-Based & Collaborative	Accessible	Coordinated & Integrated
Health Outcomes & Prevention	Asthma Medication Ratio	1800			●		●
	Childhood immunization Status (Combo 10)	0038	●		●		●
	Colorectal Cancer Screening	0034	●		●		●
	Controlling High Blood Pressure	0018			●		●
	Diabetes HbAlc Poor Control (>9%)	0059			●		●
	Immunizations for Adolescents	1407	●		●		●
Patient-Reported Outcomes	Depression Remission at 6 Months	0711	●	●	●	●	●
	Consider using a phased implementation approach over a specified time to build capacity to move from screening to outcomes. Preventive Care and Screening: Screening for Depression and Follow-up Plan	0418	●	●	●	●	●
Patient Safety	Concurrent Use of Opioids and Benzodiazepines	3389			●		●
Patient Experience	Patient Experience (CG-CARPS)	0005	●		●	●	●
High-Value Care	Emergency Department Visits	-		●		●	●
	Inpatient Utilization/ Acute Hospital Utilization	-		●		●	●
	Total Cost of Care	1604		●			