AMGA
Advancing High Performance Health

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Rachel L. Levine, M.D., Assistant Secretary for Health
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Dr. Levine:

AMGA would like to thank the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH) for the opportunity to submit comments to support HHS' efforts to strengthen primary health care.

Founded in 1950, AMGA is a professional society, representing more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, and patient-centered medical care.

We remain concerned that the current workforce shortage and inflationary pressures will exacerbate financial difficulties that primary care providers are experiencing, which, if unaddressed, will create significant obstacles that impair efforts to promote primary care access and advance health equity. We believe that with certain modifications, the Initiative to Strengthen Primary Care could help primary healthcare providers address some of these challenges.

AMGA is pleased to offer the following recommendations to improve primary health care for patients and providers.

- **Support Efforts to Increase the Medicare Physician Fee Schedule (MPFS) Conversion Factor to Promote Patient Access and Improve Health Equity**: AMGA recommends that HHS support efforts to increase provider reimbursement through the MPFS conversion factor and use the extent of its authority to provide sufficient reimbursement in recognition of rising care costs. This will help to ensure continued primary care access.
- **Support Efforts to Eliminate Beneficiary Cost-Sharing for Chronic Care Management:** AMGA recommends that HHS support efforts to eliminate beneficiary cost-sharing for care management and remote monitoring codes. Requiring cost-sharing creates a barrier for access to these services.
- **Maintain Telehealth Flexibilities:** AMGA recommends that HHS uses the extent of its authority to maintain telehealth flexibilities.

- **Promote Value-Based Care:** AMGA recommends that HHS support remove barriers to wider adoption of value-based care models. Regulatory flexibilities in value-based waivers should not be seen as an incentive to participate, but rather the foundation of any successful value-based model.

These recommendations are detailed further below.

1. **RFI Question 4: Identify specific actions that HHS may take to advance the health of individuals, families, and communities through strengthened primary health care.**

A. Support Efforts to Increase the MPFS Conversion Factor

Recommendation: In response to *Question 4* of the RFI, we urge HHS to address impacts associated with the decreased MPFS conversion factor on primary care providers' ability to continue providing high-quality care for their patient communities. Investments to advance health equity are also needed to promote beneficiary care access.

AMGA members are facing significant financial pressures due to the ongoing COVID-19 pandemic and increased operating expenses. For example, the Bureau of Labor Statistics recently reported that consumer prices increased by 9.1%, a new 40-year high.[1] These financial pressures on primary care will worsen with the proposed reduction in the MPFS conversion factor. As proposed by the Centers for Medicare & Medicaid Services (CMS), the MPFS conversion factor will be reduced by 4.4% next year. This proposed conversion factor is a consequence of the Medicare Access and CHIP Reauthorization Act of 2015, which requires a 0% update for clinicians in 2023, but this cut, along with Medicare sequestration and pending PAYGO cuts, will undermine primary care providers' ability to deliver care by significantly straining their finances. If finalized, the proposed conversion factor will again decrease reimbursements, while provider expenses are increasing.

Specific Barrier: This payment freeze dangerously exacerbates the existing physician workforce crisis and impairs primary care access in our vulnerable communities. Providers are facing a tight labor market and have reported significant staffing shortages. According to a report from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), about 1.5 million employees left the healthcare industry between March and April 2020.[2] Insufficient staff will lead to lags in preventive care services for patients and diminish gains in health outcomes. We therefore urge HHS to utilize the full extent of its authority to pay providers adequately, taking into consideration rising care costs and support legislative efforts to increase the MPFS conversion factor.

Timeline for Implementation: We believe this could be implemented in less than two years.

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[1] https://www.bls.gov/opub/ted/2022/consumer-prices-up-9-1-percent-over-the-year-ended-june-2022-largest-increase-in-40-years.htm.
[2] https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.

B. Support Efforts to Eliminate Cost-Sharing for Chronic Care and Remote Monitoring Services

Recommendation: We urge HHS to support efforts to eliminate Medicare beneficiary cost-sharing requirements for Chronic Care Management (CCM) and remote monitoring services and use the extent of the Department's authority to minimize cost-sharing burdens for vulnerable beneficiary populations.

CCM is a critical part of coordinated care, and as a result, CMS established a separate code under the MPFS to reimburse providers for non-face-to-face care management services. Currently, beneficiaries have a cost-sharing obligation for CCM (or PCM), Collaborative Care Management (CoCM), Remote Patient Monitoring (RPM), and Transitional Care Management (TCM) services.

Specific Barrier: AMGA is concerned that this cost-sharing requirement has a disparate impact on primary care access. Patients often decline these services solely due to the cost-sharing requirement, which defeats the larger goal of these codes to prevent and reduce more costly and extensive care. Beneficiaries least able to afford cost-sharing obligations are likely to forgo care, raising health equity concerns. We therefore urge HHS to support efforts to eliminate these cost-sharing requirements and to use the extent of its authority to eliminate and minimize cost-sharing burdens for these services.

Timeline for Implementation: We believe this could be implemented in less than two years.

C. Maintain Telehealth Flexibilities and Support Legislative Efforts to Enhance Telehealth Access

Recommendation: We urge HHS to use the extent of its authority to maintain telehealth flexibilities that were implemented in response to the COVID-19 Public Health Emergency (PHE) and support legislative efforts to further promote telehealth access.

AMGA member multispecialty medical groups and integrated systems of care took unprecedented steps to meet the care needs of their patients during the COVID-19 PHE through expanding telehealth services, often increasing from 10 telehealth visits per month to an average of 2,000 telehealth visits per week, which helped to ensure continued high-quality care access for patient communities.

AMGA members have made significant investments in telehealth modalities and platforms to ensure that their patients have access to care. After more than two years of the pandemic, Medicare beneficiaries have increasingly relied upon telehealth services to receive care from their providers. We encourage HHS to leverage the investments made by providers and the increased access telehealth provides Medicare beneficiaries to inform legislative efforts to promote telehealth access.

Specific Barrier: Primary care access remains a concern. We urge CMS to continue maintain telehealth payment flexibility, including separate payments under the Medicare program for audio-only (telephone) services. CMS should reimburse these services equal to video telehealth and in-person care, as the resources needed to deliver this care are similar. Audio-only visits should also satisfy the face-to-face requirement for collecting diagnoses for risk-adjustment and care coordination purposes. Telehealth services help to ensure all patients have access to critical

care that they need. As stated above, AMGA members ensured high-quality care for patient communities through telehealth modalities that ensure continuity of service.

Timeline for Implementation: We believe this can be implemented in less than two years.

2. **RFI Question 2: Describe current barriers to implementing innovations or improvements that would strengthen primary health care to improve the health of individuals, families, and communities.**

Barrier: There is a barrier for participants in value-based models to take on greater risk as a result of regulatory requirements and varying waivers.

Proposed Solution: In response to *Question 2* of the RFI, we urge HHS to develop a common set of regulatory requirements and flexibilities for value-based models that do not vary based on the level of risk. We believe a value-based care model would help to improve patients' primary healthcare outcomes. Importantly, our members support efforts to reduce primary care regulatory burdens while transitioning to value-based care. We urge HHS to ensure providers are adequately reimbursed so they can invest in the infrastructure needed to deliver care in a value-based model.

In addition, flexibilities regarding telehealth, skilled nursing care, and beneficiary incentives should not be based on the level of risk because these tools form the basis of any value-based reimbursement structure. Otherwise, providers will need to adjust how they deliver care, which not only makes it difficult to apply any lessons learned in value-based models, but also serves as a disincentive to participate in a model. AMGA is concerned that fee-for-service regulations do not account for the significant investment required to engage in these population health models, including those that, for the time being, are in a shared-savings-only arrangement. Limiting waivers and beneficiary incentive opportunities to only models with downside risk undermines efforts to promote value-based care under the Medicare program.

Further, we believe the Merit-Based Incentive Payment System (MIPs) has not reimbursed providers adequately despite the considerable resource investments required. These payment adjustments are well below what Congress authorized. HHS should eliminate the low-volume threshold in the MIPS program so more providers participate and the resulting payment adjustments are closer to what Congress envisioned.

We appreciate your consideration of our comments. If you have any questions or would like additional information, please feel free to contact me at 707.838.0033 ext. 339 or ddrevna@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA