



August 31, 2022

Meena Seshamani, MD PhD  
Deputy Administrator and Director, Center on Medicare  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
7500 Security Boulevard,  
Baltimore, MD 21244-1850.

**Re: Request for Information on Medicare (CMS-4203-NC)**

Dear Dr. Seshamani,

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (the Campaign), we appreciate this opportunity to respond to the Medicare Advantage Request for Information.

PCC is a nonprofit, nonpartisan multistakeholder coalition of 66 organizational Executive Members ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships, and “upstream” drivers for a better patient experience and better health outcomes. (See the [Shared Principles of Primary Care](#)).

In March 2022, PCC launched the Better Health – NOW campaign to realize bold policy change. This campaign starts from a simple principle: we need strong primary care in all communities, so everyone has access to better health. Primary care is the only component of the U.S. health care system where increased supply is associated with improved population health and more equitable outcomes.<sup>1</sup> Yet today, the U.S. devotes only 5% to 7% of health care dollars to primary care, a proportion that is trending down even as glaring health disparities persist.<sup>2,3</sup> Better Health – NOW advocates for policy changes that reform both how much we invest in primary care as well as how we pay for it – to assure everyone has access to primary care they can trust.

While we provide our comments below, we have heard from multiple primary care stakeholders that the 30-day timeframe does not provide sufficient time to respond to

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<sup>1</sup> McCauley L, Phillips RL, Meisnere M, Robinson SK. Read "Implementing high-quality primary care: Rebuilding the foundation of Health Care" at nap.edu. National Academies Press: OpenBook. <https://nap.nationalacademies.org/read/25983/chapter/1>. Published 2021. Accessed April 15, 2022.

<sup>2</sup> Greiner A, Kempinski A. Primary care spending: High stakes, low investment. Primary Care Collaborative. <https://www.pcpc.org/resource/evidence2020>. Published April 20, 2022. Accessed April 15, 2022.

<sup>3</sup> 2021 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; December 2021. AHRQ Pub. No. 21(22)-0054-EF.

this important RfI, given other pending notice and comment opportunities. **We encourage CMS to extend the timeline for comment for an additional 30 days – to support greater public input.**

### **Summary of Five Recommendations and Comments**

- Recommendation #1: Measure primary care spending and its impact on Medicare Advantage beneficiary outcomes.
- Recommendation #2: Improve CMS capacity to collect, standardize, report, and where practicable and effective, stratify data to facilitate comparisons across all parts of Medicare (traditional fee-for-service, ACOs/MSSP, and Medicare Advantage).
- Recommendation #3: Use plan design and payment reform to encourage proactive care and to remove cost and other barriers to beneficiaries accessing preventive care, integrated behavioral health care and chronic care.
- Recommendation #4: CMS should encourage MA plans to use primary care payment reform and investment to drive practice level innovation, support comprehensive primary care, and reduce administrative burden, as recommended in the 2021 National Academies of Science, Engineering, and Medicine (NASEM) [report](#), *Implementing High-Quality Primary Care*.<sup>4</sup>
- Recommendation #5: CMS should use a small, robust, valid set of quality measures and incentives that reflect the contribution of primary care. Quality measurement should facilitate comparison across all parts of the Medicare program. Performance incentives should reward both high achievement and improvement in beneficiary outcomes and experience of care in all communities with respect to behavioral and physical health.

### **Medicare Advantage (MA) Is Growing and Influencing New Primary Care Models**

According to the [Kaiser Family Foundation](#), over 40% of Medicare beneficiaries—26.4 million of 62.7 million beneficiaries—were enrolled in Medicare Advantage (MA) plans in 2021; this percentage has risen steadily since 2007.<sup>5</sup> The Congressional Budget Office (CBO) projects the share of Medicare beneficiaries enrolled in MA plans will rise to 51% by 2030.<sup>6</sup> Beneficiaries in urban and suburban counties are more likely to be enrolled in MA, with wide variation across and within states. MA enrollment is concentrated in plans organized as health maintenance organizations (HMOs) with a defined network.

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<sup>4</sup> National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing high-quality primary care: Rebuilding the foundation of health care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

<sup>5</sup> Freed, M, Fuglesten Biniek, J, Damico, A, Neuman, T., Kaiser Family Foundation, 2021 <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/> accessed 8/22/2022.

<sup>6</sup> Congressional Budget Office. Medicare—COB's Baseline as of March 6, 2020.

A larger share of Black and Hispanic beneficiaries, compared to White beneficiaries, are now enrolled in MA<sup>7</sup>; they are also more likely to report having difficulty affording and getting care.<sup>8</sup> Beneficiaries enrolled in MA plans also offering Part D drug benefits often pay no supplemental premium (beyond Part B) and enjoy supplemental benefits not available in traditional Medicare. In contrast to beneficiaries in traditional Medicare, however, almost all MA plan enrollees are in plans that have prior authorization requirements on at least some covered benefits.

Enrollment in Medicare Advantage “special needs plans” (SNPs) is also growing. Enrollees in MA SNPs have complex health and social needs, are more likely to be Medicaid eligible (“duals”), and more likely to be enrolled in Medicare due to disability. According to the Commonwealth Fund, 60% of Medicare beneficiaries under age 65 have mild/moderate (26%) or serious mental illness (34%), and 30% of dual-eligible beneficiaries have serious mental illness.<sup>9</sup> All MA plans, and particularly SNPs, have the potential to address health inequities and develop innovative care models that include BHI under the right payment models and program oversight mechanisms.

Medicare Advantage plans are eligible for MA quality “stars” bonus payments. The MA quality “stars” is a composite summary measure of over 40 quality measures (including Part D measures). The amount of bonus funding given to qualifying plans has quadrupled from \$3 billion in 2015 to almost \$12 billion in 2022, and 80% of MA enrollees are now in MA plans that receive quality star bonuses, according to Kaiser Family Foundation.<sup>10</sup>

## **Medicare Advantage Can Facilitate Primary Care Investment and Innovation**

While primary care is the foundation and front door of health care, the sector has eroded in recent years across the health care system,<sup>11</sup> and stresses of the COVID-19 pandemic have weakened it further.<sup>12</sup> Yet some elements of primary care are experiencing new

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<sup>7</sup> Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy, Medicare Beneficiary Enrollment Trends and Demographic Characteristics, March 2022 <https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf> accessed 8/18/2022.

<sup>8</sup> Cubanski, J, Neuman, T. Kaiser Family Foundation, <https://www.kff.org/coronavirus-covid-19/issue-brief/problems-getting-care-due-to-cost-or-paying-medical-bills-among-medicare-beneficiaries/> accessed 8/18/2022.

<sup>9</sup> McGinty, B., Medicare’s Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement, Commonwealth Fund, <https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities> accessed 8/28/22.

<sup>10</sup> Fuglesten Biniek, J, Freed, M, Damico, A, Neuman, T. Kaiser Family Foundation 2021. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-star-ratings-and-bonuses/> accessed 8/18/2022.

<sup>11</sup> Kempfski, A., Greiner, A., Primary Care Investment: High Stakes, Low Investment, Primary Care Collaborative, December 2020. <https://www.pcpcc.org/2020/11/24/pccs-new-report-sounds-alarm-low-and-declining-us-primary-care-spending> accessed 8/18/2022.

<sup>12</sup> Larry A. Green Center, Primary Care Collaborative, <https://www.pcpcc.org/2022/04/19/recent-survey-shows-primary-care-practices-are-overwhelmed-1-4-clinicians-planning-leave> April 2022, accessed 8/18/2022.

[investment](#) and delivering improvements in care and innovation.<sup>13</sup> Some of the new investment appears consistent with the NASEM [recommendations](#) to increase overall primary care spending and to shift primary care payment toward hybrid (part fee-for-service, part capitated) and population-based models.<sup>14</sup> According to the Health Care Payment and Learning Action Network (“the LAN”), more health care payments in 2020 reflected shared risk [arrangements](#) in Medicare Advantage than in any other payer category used by the LAN.<sup>15</sup>

A recent [description](#) and typology of new primary care models highlights Medicare Advantage as a market “segment” for investment in new primary care models and innovation:

“Usually, these organizations partner with an insurance carrier in order to participate in MA, though some insurance carriers are also rolling out their own models. Some entities also are expanding into the Medicare fee-for-service (FFS) population through accountable care organizations (ACOs) and direct contracting entities. . . . These organizations are characterized by a focus on intensive primary care that include team-based care, enhanced access and support, and navigation and referral services. They frequently include important additional nonmedical services such as transportation to ensure that patients make it to their appointments. These organizations are supported by a robust and often novel technology infrastructure that undergirds their care model, but also provides enhanced capabilities for population health management regarding both quality and cost outcomes. These Medicare ‘segmenters’ generally take on full risk under MA and stand to earn returns if they are able to provide high-value care within the confines of a capitated budget.”<sup>16</sup>

These and other emerging primary care models designed for Medicare beneficiaries enrolled in MA plans and Medicare ACOs have the capacity to provide comprehensive whole-person primary care services (inclusive of behavioral health), address unmet health and social needs, reduce inequities, and provide beneficiaries ongoing care in the home and community to manage chronic conditions. They also may prove to be more satisfying, sustainable workplaces for primary care clinicians because of a focus on longitudinal care relationships supported by high-functioning, tech-enabled teams. To the extent these emerging primary care models succeed, CMS’ approach to the Medicare Advantage program will be crucial to supporting and sustaining them and ensuring their successes are broadly available across Medicare’s geographically, racially, ethnically, and economically diverse beneficiaries

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Ravindranath, M., Ramsey Pflanzner, L. Nine primary care companies that are upending how we go to the doctor and building a new future for medicine, <https://www.businessinsider.com/the-companies-reimagining-doctors-visits-with-virtual-in-person-care-2021-6> accessed 8/18/22.

<sup>14</sup> NASEM, Implementing high-quality primary care: Rebuilding the Foundation of Health Care, 2021, Policy Brief: Payment Reform <https://www.nap.edu/resource/25983/High%20Quality%20Primary%20Care%20Policy%20Brief%201%20Payment.pdf> accessed 8/18/2022.

<sup>15</sup> Health Care Payment Learning & Action Network, APM Measurement Effort, 2020 Results. <https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/> accessed 8/18/2022.

<sup>16</sup> Landon, B, Weinreb, G., Bitton, A., Making Sense of New Approaches to Primary Care Delivery. <https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0032> accessed 8/18/2022.

**Recommendation #1: Measure and track primary care spending and its impact on Medicare Advantage beneficiary outcomes.**

Promising models of primary care in Medicare Advantage should be well-studied and monitored by researchers, CMS, and MedPAC to determine their impact on beneficiary access, experience of care, and health outcomes. Because of differences in both quality measures and payment methodologies, it can be challenging to assess the relative performance and contribution of primary care to health outcomes across traditional fee-for-service, Medicare Advantage, Medicare ACOs and other value-based arrangements.

However, one recent [study](#) of primary care spending in traditional Medicare found that primary care accounted for less than 5% of total Medicare spending (including Part D drugs) - even when using a broad definition of primary care.<sup>17</sup> **Medicare should follow the lead of more than fourteen states and measure primary care spending as a share of total spending, and target and track increases in primary care spending (as recommended by NASEM) to evaluate the impact of primary care.** For example, Oregon collects and reports the amount and share of total spending on primary care, inclusive of claims and non-claims-based payments, by insurance carriers participating in commercial markets and public programs, including Medicare Advantage. In 2019, Oregon [found](#) significant variation in primary care spending across MA carriers, from a high of 17.1% to a low of 2.9%. The variation across MA carriers in the share of primary care spending that was in non-claims spending was even greater. Overall, Oregon found the share of total primary care spending in non-claims (i.e., predominantly value-based arrangements) payments was higher among carriers in Medicare Advantage than in other commercial markets and Medicaid.<sup>18</sup> . In 2019, Oregon [found](#) significant variation in primary care spending across MA carriers, from a high of 17.1% to a low of 2.9%. The variation across MA carriers in the share of primary care spending that was in non-claims spending was even greater. Overall, Oregon found the share of total primary care spending in non-claims (i.e., predominantly value-based arrangements) payments was higher among carriers in Medicare Advantage than in other commercial markets and Medicaid.<sup>19</sup>

CMS already has established a reporting framework whereby it could track primary care investment in Medicare Advantage while limiting additional reporting burden. In 2017, CMS began requiring Medicare Advantage plans, through annual reporting [requirements](#), to provide information on the amount of money paid via alternative payment models (APMs) and the number of entities reimbursed under these APM arrangements, using the categories of payment defined by the LAN.<sup>20</sup> **CMS should use this reporting process to require MA plans to break out and report separately primary care spending as a share of all payments (Parts A and B) made to contracted entities, and the breakdown of this spend in fee-for-**

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<sup>17</sup> Reid, R., Damberg, C., Friedberg, M., Primary Care Spending in the Fee-for-Service Medicare Population, JAMA Intern Med. 2019; 179(7):977-980 doi:10.1001/jamainternmed.2018.8747

<sup>19</sup> Oregon Health Authority, Primary Care Spending in Oregon, 2019. <https://visual-data.dhsoha.state.or.us/t/OHA/views/PrimaryCareSpendinginOregon2019/Aboutthisreport?%3Aembed=y&%3AisGuestRedirectFromVizportal=y> accessed 8/18/2022.

<sup>20</sup> CMS, CY 2022 Part C Reporting Requirements <https://www.cms.gov/files/document/cy-2022-part-c-reporting-requirements.pdf> , p.15, accessed 8/18/2022.

**service and value-based payments using the LAN definitions and categories.**

With appropriate safeguards, this data should be made available for researchers and stakeholders. CMS should use the data to gain insights into the factors that drive plan performance on measures of access, quality, cost, equity, and member experience. In addition to measuring and tracking primary care spending, CMS should consider measuring and tracking primary care utilization as it collects more encounter level data from MA plans.

Tracking primary care spending in Medicare Advantage is consistent with data collection underway elsewhere in the federal government. Medicare can already measure primary care spending in traditional Medicare and Medicare ACOs because it has access to Medicare claims data. Additionally, the federal government is now collecting primary care spending data among commercially insured populations. Section 204 of Title II of Division BB of the of the Consolidated Appropriations Act of 2021 ([Pub. L. 116-260](#)) requires group health plans, issuers, and Federal Employee Health Benefits (FEHB) carriers to report primary care spending to the Departments of Labor, Health & Human Services, and Treasury as part of a broader transparency effort to track prescription drug and other categories of health care spending.

Alongside the data from traditional Medicare and the commercially insured, tracking primary care spending and overall spending in Medicare Advantage will provide powerful insights for federal policymakers and stakeholders and support federal efforts to implement NASEM’s recommendations for strengthening primary care.

**A. Medicare Advantage Has Powerful Potential to Advance Health Equity**

**Recommendation #2: Improve CMS capacity to collect, report, and, where practicable and effective, stratify data to facilitate comparisons within and across all parts of Medicare (traditional fee-for-service, ACOs/MSSP, and Medicare Advantage.)**

The 2021 landmark NASEM [report](#), *Implementing High-Quality Primary Care*, notes that “primary care is the only health care component where an increased supply is associated with better population health and *more equitable outcomes*.”<sup>21</sup> When beneficiaries become eligible for Medicare, their health status reflects inequities that often begin early in life and reflect structural factors rooted in years of systemic racism, economic hardships and other circumstances. For many beneficiaries, gaining Medicare eligibility helps them establish and maintain a regular source of care because their source of coverage stabilizes, yet disparities across race in the percentage of beneficiaries reporting a usual source of care persist in Medicare .<sup>22</sup>

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<sup>21</sup> <https://doi.org/10.17226/25983> National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

<sup>22</sup> Fuglesten Biniek, J., Ochieng, N., Cubanski, J., Neuman, T. Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage, 2021. <https://www.kff.org/medicare/issue-brief/cost-related-problems-are-less-common-among-beneficiaries-in-traditional-medicare-than-in-medicare-advantage-mainly-due-to-supplemental-coverage/> access 8/26/22.

In 2021, Black, Hispanic, American Indian and Alaska Native (AI/AN), Asian-American, Native Hawaiian, and other Pacific Islander (AA and NHPI), and Multiracial Medicare beneficiaries were more likely to be enrolled in MA plans than in traditional Medicare; White beneficiaries were less likely to be enrolled in MA than in traditional Medicare, according to data from the CMS Office of Minority Health.<sup>23</sup> Access to comprehensive primary care grounded in and responsive to communities is foundational to a strategy to reduce health inequities. Unfortunately, Medicare’s physician fee schedule undervalues the prevention, chronic care management, and care coordination activities that can mitigate health inequities compounded over the lives of many individuals and exhibited in many marginalized communities.<sup>24</sup> Medicare Advantage plans, however, are not constrained by the misvalued Medicare physician fee schedule in the level and types of payments they make to primary care or providers.

A systematic review of studies comparing Medicare Advantage and traditional Medicare on key metrics showed that Medicare Advantage was associated with more preventive care visits, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facilities lengths- of- stay, and lower health care spending.<sup>25</sup> However, evidence on patient experience, readmission rates, mortality, and racial/ethnic disparities did not show a trend of better performance in MA compared to traditional Medicare. The authors noted that these analyses were observational and might not fully account for selection bias and risk adjustment challenges.

The HHS Office of Minority Health has been tracking a set of clinical and beneficiary of care measures collected for Medicare Advantage enrollees, and has reported these measures in grouping by race/ethnicity, sex, and rural/urban geographic location over several years.<sup>26</sup> While gaps have narrowed across groups in many of the clinical measures over the 2009-2018 period, particularly for Black and Hispanic beneficiaries compared to Whites, gaps remain and have even widened in some measures. Improvements were also measured for rural beneficiaries compared to urban beneficiaries on several clinical and experience of care measures over the same period.

The PCC applauds the data and reporting effort by the Office of Minority Health. It is a solid foundation to build on. To advance equity in Medicare, it is important to focus on prevention and outcomes measures in chronic diseases (including physical, mental health and substance use disorders) where we know there are persistent gaps in outcomes across different beneficiary populations and communities, particularly across

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<sup>23</sup> Centers for Medicare and Medicaid Services (CMS), Office of Minority Health, 2021 Racial, Ethnic & Gender Disparities in Health Care in Medicare Advantage, table 1 <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting> accessed 8/18/22.

<sup>24</sup> Podulka, J., Narayan, Y, Holmes, L., Increasing Medicare’s INvestment in Primary Care, Commonwealth Fund, March 7, 2022. <https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/increasing-medicares-investment-primary-care#4> accessed 8/26/22.

<sup>25</sup> DuGoff, E., Tabak, R., Diduch, T., Garth, V., Quality, Health, and Spending in Medicare Advantage and Traditional Medicare *Am J Manag Care.* 2021;27(9):395-400. <https://doi.org/10.37765/ajmc.2021.88641>

<sup>26</sup> CMS, Office of Minority Health, Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Health Care in Medicare Advantage: 2009-2018, <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting> accessed 8/18/2022.

race/ethnicity. **The PCC encourages CMS and the Office of Minority Health to look at the variation across MA plans and geographies to identify plans and geographies where gaps are closing or closed to gain insights about the interventions and care models associated with these improving outcomes.**

**Equally important, CMS should continue to refine quality measurement and stratification across populations in traditional Medicare.** This effort is more urgent considering the 2020- 2021 disparate health effects of COVID 19 on Black, Brown, and rural Americans.

At present, however, stratification of measures is limited and generally only available for dually-eligible and low-income subsidy populations. A more broadly implemented approach to stratification will require better quality data and robust, well-funded efforts to support plan sponsors, primary care practices and health care providers in collecting self-reported data. We encourage CMS to work proactively and collaboratively with stakeholders toward broader implementation across Medicare

## **B. Expand Access: Coverage and Care**

**Recommendation #3: Use plan design and payment reform to encourage proactive care and to remove cost and other barriers to beneficiaries accessing preventive care, integrated behavioral health, and chronic care..**

Cost sharing requirements can be a barrier to patients in need of preventive care and chronic care and contribute to health inequities. Lack of access to transportation and technology such as a smartphone can also limit beneficiaries' ability to access available services and supports. Medicare Advantage plans have the flexibility to modify cost sharing for most services and can reduce cost-sharing as a mandatory supplemental benefit. Almost half of rebate dollars (funds available to plans that bid below their area cost benchmark) were used to lower cost-sharing, according to MedPAC.<sup>27</sup>

**To improve health outcomes and equity, CMS should ensure that MA enrollees have access to plan designs that remove barriers to ongoing preventive and chronic care, including medications – care often delivered in primary care settings.** Supplemental benefits offered by MA plans have grown with the size of Part C rebates and plans now have more flexibility to tailor supplemental benefits and to address social determinants of health. Research suggests the number of plans offering non-primarily health-related supplemental benefits remains quite small, but is growing.<sup>28</sup> In addition, CMMI is using its demonstration authority to permit MA plans to test “value-based insurance designs” (VBID).<sup>29</sup> Despite these opportunities and flexibility for MA plans to address equity and improve health outcomes, there is little

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<sup>27</sup>Medpac, The Medicare Advantage program: Status report, Chapter 12, March 2021 [https://www.medpac.gov/wp-content/uploads/2021/10/mar21\\_medpac\\_report\\_ch12\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf), accessed 8/18/2022.

<sup>28</sup> Rizer, A., Benzing, L., Filling the Gaps: The Role and Value of Supplemental Benefits in Medicare Advantage, Health Affairs Forefront, August 5, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220804.34406> accessed 8/18/2022.

<sup>29</sup> CMS Findings at a Glance, Medicare Advantage Value-Based Insurance Design Model, Evaluation of Model Year 1 2017, <https://innovation.cms.gov/files/reports/vbid-yr1-evalrpt-fg.pdf> accessed 8/18/2022



peer-reviewed evidence yet for the effectiveness and relative effectiveness of various interventions, according to MedPAC.<sup>30</sup> It is difficult to isolate the impact of interventions, and such interventions may not show an immediate impact on cost and health outcomes.

The level of a payer’s investment in primary care and the payment models through which those investments flow are also crucial to the capacity of primary care to strengthen population health. When primary care practices receive sufficient financing and support, they can build robust, multi-disciplinary community-based primary care teams. **With more robust payment levels and flexibility, these practices can serve as one-stop resources for beneficiaries to be screened for social risk factors and referred for services and supports, address behavioral health needs, and manage chronic conditions.** Collaborations and data sharing between MA plans and primary care can leverage the trust beneficiaries often develop in primary care teams. Phone support, remote monitoring, and home visits by primary care teams have the potential to deliver care where and when it is needed and preferred, while optimizing the use of technology and the strengths of interdisciplinary teams during a time of workforce shortages. When they support local, community-based systems built around strong, integrated primary care teams and practices, MA plans not only support the delivery of better care; they invest in stronger communities.

**To realize the potential to improve outcomes for beneficiaries in all communities, CMS should encourage all MA plans to invest in and leverage primary care – particularly robust, multi-disciplinary community-based primary care teams described above.** Unless CMS sets high and consistent expectations and shares data publicly, some MA plans, when faced with pressure to deliver short-term financial returns, will be reluctant to make and sustain these investments in robust community-based services and whole-person health, including behavioral health

### **C. Medicare Advantage Can Be a Powerful Driver of Innovation to Promote Person-Centered Care**

#### **Recommendation #4: Use payment reform to drive practice level innovation and reduce administrative burden**

While data on the adoption of alternative payment models (APMs) in MA suggests that, in the aggregate, MA is moving faster in adoption of APMs than other payer categories, there is little public data available on the details and distribution of these models across geographic areas. Members of the PCC who have the opportunity to participate in these APM models in MA, particularly clinicians and practice leaders, express strong satisfaction, and enthusiasm for the resources and flexibility they have to innovate, tailor care to beneficiary needs, “practice at the top of their license”, and reduce some of the administrative burdens on their practice.

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<sup>30</sup> Medpac, Leveraging Medicare policies to address social determinant of health, April 7, 2022 (slide presentation), <https://www.medpac.gov/meeting/april-7-8-2022/> accessed 8/18/2022

**As mentioned previously, the PCC urges CMS to collect more data on the risk-sharing models between MA plans and primary care (and multi-specialty) practices and ACOs.** We also hear reports from PCC stakeholders that incentives and working conditions for front-line clinicians and teams may not reflect the intent of the payment model to move away from volume driven, face-to-face visits valued with misvalued “relative value units” (RVUs). A [study](#) published early in 2022 of physician groups affiliated with health systems found that volume-based compensation was the most common base compensation incentive component for primary care physicians, and increasing volume was the most commonly cited action for physicians to increase compensation.<sup>31</sup> We were especially alarmed to see [research](#) suggesting that volume-based compensation schemes such as those based on Medicare RVUs or RVU like “productivity” measures, have a discriminatory impact on female primary care physicians.<sup>32</sup>

To the extent these findings hold true across the delivery system, it runs directly counter to APMs’ potential to shift health care from payment-centered service delivery to person-centered whole-person care.

The 2021 NASEM report, *Implementing High-Quality Primary Care*, calls for integrated primary care delivery (p. 141.) as a “foundational strategy for health care organizations to support a culture of high-quality, person-and family-centered primary care built on trusted, accessible, and continuous relationships.” For NASEM, integration can mean “integrating primary care with behavioral health, pharmacy, and oral health services and with public health and services to address social determinants of health.”<sup>33</sup> Leading Federally-Qualified Health Centers (FQHCs) and PCC Executive Members like Oak Street Health and Catalyst Health Network, are among the innovators for this kind of integrated primary care.

There are several facilitators needed to implement integrated primary care, with the most successful models likely to have payment systems, an intermediate entity or aggregator to manage financial risk and support IT and data systems, and a leadership structure that promotes a strong culture of functional integration, measurement, and accountability for high-quality outcomes. To achieve integration, NASEM notes that

payment systems will need to move away from fee-for-service and toward mandatory hybrid models or other alternative models., including ACO models, in which organizations can reap the financial benefits of improving health and well-being, and provide incentives to invest in start-up costs associated with planning, specifying, and designing the infrastructure of an effective integrated delivery system that thrives on interprofessional teams for high-quality care. These

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<sup>31</sup> Reid, R., Tom, A., Ross, R., Physician Compensation Arrangements and Financial Performance Incentives in U.S. Health Systems, *JAMA Health Forum*, 2022;3(1):e214634 doi:10.1001/jamahealthforum.2021.4634

<sup>32</sup> Horstman, C., Male Physicians Earn More Than Women in Primary and Specialty Care, Commonwealth Fund blog, <https://bit.ly/3dNxZet> accessed 8/18/2022

<sup>33</sup> McCauley L, Phillips RL, Meisnere M, Robinson SK. Read "Implementing high-quality primary care: Rebuilding the foundation of Health Care" at [nap.edu](http://nap.edu). National Academies Press: OpenBook. <https://nap.nationalacademies.org/read/25983/chapter/1>. Published 2021. Accessed April 15, 2022.

payment models must also consider the long-term savings in investments in prevention, health promotion, coordinated and whole-person and family centered chronic care management, and early diagnostic and treatment services, which may impact sectors outside of health care, including education, social services, and the justice system. Thus, new payment models, including value-based payment, must account for and incentivize these additional outcomes.

Data analytics, interoperability, and data at the point of care are all necessary to drive person-centered care innovation. **CMS must continue to use its regulatory authority to foster data sharing and lower the friction practices face in obtaining actionable and timely data, such as from hospitalizations and ED visits.** Data feeds from MA plans should be timely and in a form that enables practices to ingest them in their own analytics and population health tools.

#### **D. Medicare Advantage Can Support Affordability and Sustainability**

**Recommendation #5: CMS should use a small, robust, valid set of quality measures and incentives that reflect the contribution of primary care. Quality measurement should facilitate comparison across all parts of the Medicare program, traditional Medicare, ACOs, and MA. Performance incentives should reward both high achievement and improvement in beneficiary outcomes and experience of care across all communities. CMS should test the incorporation of measures of social risk to stratify quality measures with respect to behavioral and physical health.**

The share of Medicare spending devoted to primary care is low, with most studies finding Medicare primary care spending between 3- 5% level overall.<sup>34</sup> Primary care visits also appear to be declining in traditional Medicare.<sup>35</sup> As CMS and other policymakers consider strategies to improve affordability and sustainability of the Medicare program, they should not consider primary care a cost center or category to find savings. Primary care is the one lever that can drive both better, equitable health outcomes and more efficient utilization of health care resources.<sup>36,37</sup> Primary care is crucial to preventing and managing chronic conditions and avoiding “downstream” utilization of hospital, specialty care, and post-acute care.

As policymakers consider policies to lower the Medicare per beneficiary cost trend<sup>38</sup>, the imperative to build more efficient and effective care models will grow. It is critical for

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<sup>34</sup> Reid, R., Damberg, C., Friedberg, M., Primary Care Spending in the Fee-for-Service Medicare Population, *JAMA Intern Med.* 2019;179(7):977-980. doi:10.1001/jamainternmed.2018.8747

<sup>35</sup> Ganguli, I., Lee, T., Mehrotra, A., Evidence and implications Behind a National Decline in Primary Care Visits, 2019. <https://link.springer.com/article/10.1007/s11606-019-05104-5> accessed 8/18/22.

<sup>36</sup> Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med.* 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624

<sup>37</sup> Shi L. The impact of primary care: a focused review. *Scientifica (Cairo)*. 2012;2012:432892. doi:10.6064/2012/432892

<sup>38</sup> Chernew, M., Getting the Most From Payments to Medicare Advantage Health Plans-Thoughts on the Controversy, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795749> accessed 8/27/22.

Medicare to be able to identify high-performing care models and ensure they are not undermined by short-term savings goals. It will also be important to maintain and strengthen quality incentives such as the MA quality stars bonus program to reward and differentiate plans that improve health outcomes, equity, and beneficiary experience. **The MA quality star measures and scores should encourage, not disadvantage, practices, plans and providers serving populations at high social risk. Consistent with recommendations from MedPAC, the PCC supports stratifying practices, providers and plans into peer groups for purposes of evaluating and adjusting quality-based payment.**

Because Medicare Advantage plans are at risk for the total cost-of-care, eligible to earn quality bonuses, and tend to have stable enrollee populations across plan years, they have some incentive to invest in expanded primary care capacity. When plans support comprehensive, community-based services and take accountability for certain population health goals, they can reap downstream efficiencies. [Research](#) conducted using 2014 CMS data which linked MA encounter data with MA star ratings and individual measures found that MA plans with higher quality star ratings were more likely to contract with physicians with Medicare patient “panels” comprised disproportionately of Medicare Advantage enrollees. The analysis also showed that physicians that cared for MA enrollees provided over half of that care to enrollees in a single insurer. Physicians who cared for a share of MA enrollees at least one standard deviation above the average MA physician panel penetration were more likely to care for enrollees in a plan with a higher quality star rating. In addition, the quality difference was larger when physicians were caring for disabled beneficiaries enrolled in MA contracts with a high proportion of disabled enrollees.<sup>39</sup> **The results suggest it can be a win-win strategy for MA plans to collaborate with primary care practices and for those practices to focus on care models that support high performance on care captured by stars quality measures. More research exploring these plan-practice relationships is needed to gain more insights into what form this collaboration takes, what level and type of payment arrangements are made between the plan and the practice, and how health and cost outcomes are affected.**

**In addition to promoting risk-sharing primary care payment models in Medicare Advantage, the PCC supports expansion of primary care-oriented total cost-of-care models in traditional Medicare. Specifically, we encourage CMS to strengthen the Medicare Shared Savings Program (MSSP) to support hybrid and population-based primary care payment, and to evaluate the impact of the new ACO REACH model as it is rolled out.** When primary care hybrid or capitation models are included as part of total cost-of-care models and evaluated across enrolled or attributed populations, primary care’s leadership and contribution to better health outcomes and sustainable health care resource use becomes apparent.

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David Blumenthal, MD, president of the Commonwealth Fund has observed that the strategy of insurers assuming financial risk for the cost of care via capitation “creates a

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clear business case to use primary care as a technique for reducing cost and increasing quality by maximizing preventive care, effectively managing chronic conditions to avoid unnecessary hospitalizations and emergency room visits and to minimize expensive specialty care for conditions that can be treated effectively by PCPs.”<sup>40</sup>If realized, the win-win Blumenthal describes would result in more competitive premiums for purchasers and consumers while insurers also earn margins that support increased spending to support comprehensive, whole-person primary care.

Medicare Advantage shows promise as a lever to increase investment in primary care and pivot incentives to better health for beneficiaries. MA’s market incentives must be paired with market oversight, payment design that rewards value and encourages plans to serve all communities, strong transparency mechanisms to foster competition based on value, and measured both on an annual basis and over a time horizon that supports investment in better health outcomes and equity for all communities.

PCC and our Better Health-NOW campaign participants stand ready to work with you to expand more robust primary care within a stronger Medicare program. Please contact PCC’s Director of Policy, Larry McNeely ([lmcneely@thepcc.org](mailto:lmcneely@thepcc.org)) with any questions.

Sincerely,



Ann Greiner  
President & CEO  
Primary Care Collaborative