



**TO:** Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services  
**FROM:** The Commonwealth Fund  
**DATE:** July 29, 2022  
**RE:** Primary Health Care RFI

Dear OASH Primary Health Care Team:

Thank you for the opportunity to respond to your Request for Information on behalf of the Commonwealth Fund and inform the work of the HHS Initiative to Strengthen Primary Health Care, which is critical to improve quality, advance equity, and lower costs.

The Fund supports independent research on health care issues and makes grants to promote better access, improved quality, and greater efficiency in health care, particularly for underserved communities, including people of color, people with low income, and those who are uninsured.

Below we highlight key recommendations for advancing a high-quality, comprehensive, and equitable primary health care (PHC) system:

1. Increase investment in PHC.
2. Shift to hybrid or capitated payment approaches.
3. Support the integration of PHC with behavioral health, social services, and public health.

### **RECOMMENDATION 1: INCREASE INVESTMENT IN PRIMARY HEALTH CARE**

Primary health care is at a financial disadvantage relative to the rest of the health care system. Primary care providers (PCPs) are [paid less](#) than specialists and spending on PHC has trended downward in the past several decades, from an estimated [6.5 percent](#) of total health care expenditures in 2002 to [4.7 percent in 2019](#) — meaning the U.S. spends about one-third what [other high-income countries do](#) (14%). This undervaluing of PHC services has limited potential to provide high-quality, [accessible](#), comprehensive services and contributed to a [PCP shortage](#) particularly affecting already-underserved populations. Consensus among experts — from the recent National Academies of Sciences, Engineering, and Medicine (NASEM) report on [Strengthening Primary Health Care](#), the [Medicare Payment Advisory Commission](#), and the Commonwealth Fund's [Task Force on Payment and Delivery System Reform](#) (DSR TF) — has called for increased payment for PHC services. Steps to achieve this goal include:

***R.1.1: CMS should develop independent data collection procedures to estimate Relative Value Updates (RVUs).*** CMS currently relies on data from the specialty-dominated RVU Update Committee (RUC) to determine RVUs, which [research](#) has shown to systematically overvalue procedures and undervalue primary care services such as evaluation and management. To improve the accuracy of RVUs and the overall accuracy of the Medicare physician fee schedule,

CMS could collect its own data on practice expenses and work time, for example through surveys. This could improve estimates by making them more timely, objective, and transparent.

***R.1.2: CMS should restore the RVU Update Committee (RUC) to its advisory capacity by forming a Technical Expert Panel to identify incremental improvements that can be made to the Medicare Physician Fee Schedule within current authority.*** Armed with the above data, CMS can [reduce its reliance](#) on the specialty-dominated RUC's RVU estimates by forming an independent committee of experts to review the data and issue recommendations to reduce current payment distortions in the fee schedule.

## **RECOMMENDATION 2: SHIFT TO HYBRID OR CAPITATED APPROACHES**

How we pay for PHC also has created challenges. Fee-for-service (FFS) payments [dominate PHC](#), which has incentivized PCPs to provide more care and see as many patients as they can in a day. These payments also limit PCPs' ability to offer nonmedical, high-value services like care coordination or screening for social determinants of health. For these reasons, the NASEM and Commonwealth Fund DSR TF reports have called for changes to how we pay for PHC, moving to hybrid models that include a mix of FFS and prospective, capitated payment to enable greater flexibility. Steps to achieve this goal include:

***R.2.1: CMS should allow Accountable Care Organizations (ACOs) to implement primary care hybrid payment models through the Medicare Shared Savings Program (MSSP).*** CMS [has the authority](#) to offer ACOs the option of providing partial capitation to PHC in the MSSP program, which could greatly scale capitated payments for PHC. Some newer, smaller, or rural ACOs may not be equipped to manage and administer capitated payments, and therefore such payments could be optional. This approach [was successful](#) in the Center for Medicare and Medicaid Innovation's (CMMI) Next Generation ACO Model; ACOs accepting population-based payments had greater spending reductions than those that did not.

***R.2.2: CMMI should scale and spread multipayer PHC models.*** Building on [evidence from the last decade of PHC payment reform](#) at CMMI through the Comprehensive Primary Care Initiatives and Primary Care First (PCF), CMMI should develop and scale a multipayer PHC payment model that includes a mix of population-based payments as well as FFS payments for high-value, underutilized services like immunizations and home visits.

***R.2.3: CMS, CMMI, and the Bureau of Primary Health Care should collaborate to develop and pilot test alternative payment models (APMs) in Federally Qualified Health Centers (FQHCs).*** Agencies should collaborate to lower barriers and identify opportunities to [engage FQHCs in APMs](#), for example by modifying current models, like PCF, to support their participation or leveraging Section 1115 demonstration authority with states. HHS should engage FQHC leaders in planning and — given that FQHCs serve many patients of color — make advancing health equity an explicit goal of payment models.

***R.2.4: CMS should issue guidance to states to leverage Medicaid managed care contracts to promote population-based payments for PHC.*** CMS can issue guidance to state health officials on best practices for implementing hybrid, population-based payment models through Medicaid

managed care contracts to achieve greater equity, quality, and affordability. Several states [currently use contracts](#) to this end, so there is experience on which to draw.

### **RECOMMENDATION 3: SUPPORT THE INTEGRATION OF PHC WITH BEHAVIORAL HEALTH, SOCIAL SERVICES, AND PUBLIC HEALTH**

Integrating PHC with other systems — such as behavioral health, public health, and social services — is essential to promoting whole-person care and advancing more equitable access and outcomes for patients. The subsequent recommendations are important for achieving the goal of high-quality PHC, but they rely on adequate payment reform and data-sharing so that providers are sufficiently resourced and prepared to take on these changes in care delivery.

#### **Behavioral Health Integration**

In a recent [testimony](#) to the U.S. Senate Finance Committee on behavioral health (BH), The Commonwealth Fund’s Reginald Williams recommended integration to strengthen PHC and address our nation’s BH crisis. PCPs often encounter patients with BH needs but are ill-equipped to treat them, [due to](#) lack of resources, staffing shortages, and unclear billing practices. In addition to [implementing innovative payment models](#), integration requires upfront investments to support capacity building, including implementing new care models and hiring additional staff. HHS could support upfront investments in the following ways:

***R.3.1: CMS should provide financing and guidance to ensure successful and sustainable integration.*** The Collaborative Care Model (CoCM), an evidence-based integration model, has been supported by CMS through [Medicare reimbursement codes](#) and a [State Medicaid Directors](#) letter, yet the [Bipartisan Policy Center](#) reports that current reimbursements are not enough to cover the upfront costs of integration or to cover the full cost of providing this model of care. CMS should reevaluate payment rates for CoCM codes to ensure they sufficiently cover the costs of care and offer additional implementation and reimbursement guidance to State Medicaid Directors regarding evidence-based integration models.

***R.3.2: HHS should incentivize, finance, and support initiatives to expand and diversify the behavioral health workforce.*** Engaging a wide BH workforce, including community health workers and paraprofessionals, in integrated care [can](#) mitigate staffing shortages, engage patients with limited access, and expand the capabilities of care teams. Medicare currently covers only a limited set of BH practitioners, although a recent [proposal](#) would allow for payment of certain types of providers as part of PHC teams. Medicaid managed care plans have more flexibility to cover paraprofessionals. CMS should continue to expand the types of providers covered by Medicare and Medicaid to include paraprofessionals. HRSA should [expand the types of health care professionals eligible](#) for their [scholarship](#) and [loan repayment](#) programs to include BH providers and increase funding for the program; not only would this diversify and expand the workforce, but it would expand access to BH services in Health Professional Shortage Areas.

#### **Social Service Integration**

The COVID-19 pandemic has led to a renewed commitment to advance health equity and address the drivers of health (DOH) that account for 80 percent of health outcomes and have a disproportionate impact on communities of color. This will require changing how and what we measure. Measurement matters because it equips providers with data to identify and address

unmet needs, and it allows policymakers and payers to account for DOH in payment models and resource allocation. Data collection, screening tools, and measurement must be standardized, consistent, and embedded throughout the health care system’s regulatory frameworks.

***R.3.3: CMS should embed DOH into PHC models through standardized screening, process, and outcomes measurement and reporting.*** CMS has proposed the first-ever DOH measures for the [Hospital Inpatient Quality Reporting Program](#) and the [Merit-based Incentive Payment System](#), drawing from the Accountable Health Communities model. Enacting these measures in the final rules — and applying them to other CMS programs and models — would lay the foundation for patient-level data collection on DOH needs. CMS should build upon it in future rulemaking with DOH “action” measures across Medicare and Medicaid to ensure that patients who screen positive are connected with the resources they need to be healthy. CMS should also align these measures within the agency and across payers to avoid fragmentation in how data are collected, for example by [leveraging standard-setting bodies](#) like the National Committee for Quality Assurance and the National Quality Forum to promote measure alignment.

***R.3.4: HHS should leverage population-level DOH data to steer investment in provider and community capacity to improve health.*** This could include expanding [Medicaid “in lieu of” services](#) as well as making advance investment payments that practices can flexibly use for staffing, direct services, or technology infrastructure.

### **Public Health Integration**

The COVID-19 pandemic affirmed that [primary care providers are the most trusted source of information](#) on vaccinations for patients. They are well positioned to build upon this community trust and [contribute to routine public health activities](#). The Commonwealth Fund’s [vision for a robust, sustainable public health system](#) includes a health care system — laid with a strong PHC foundation — that works closely with public health agencies in normal times and during emergencies. To that end, HHS is well positioned under existing statutory authority to spearhead data-sharing efforts and promulgate standards for meaningful collaboration at the state and local levels. The below steps could be taken, which align with recommendations from the [Fund’s Public Health Commission](#) and [NASEM consensus study on PHC](#):

***R.3.5: HHS should promote cross-sector training and collaboration between public health departments and health care organizations.*** Embedding leadership roles into organizations — [as New York City has done with its health department’s new chief medical officer](#) — and holding them accountable to sustained partnership will facilitate routine collaboration between the two sectors. HHS could achieve this by providing upfront funding for the needed infrastructure, including data systems and staffing, and by establishing core competencies to which health departments and health care organizations can be held accountable.

***R.3.6: HHS should financially incentivize community health centers to contribute to public health activities in normal times and during emergencies.*** As a condition of receiving funds from HRSA or SAMHSA, community health centers should conduct health needs assessments and emergency preparedness planning. These needs assessments should be done in coordination with their local public health departments and nonprofit hospitals to ensure a holistic view of a community’s needs.