AMA
AMERICAN MEDICAL ASSOCIATION

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July 29, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW, Hubert H. Humphrey Building
Washington, DC 20201

Re: Document Number: 2022-13632: Request for Information (RFI): HHS Initiative To Strengthen Primary Health Care

Dear Secretary Becerra:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to provide information regarding the Department of Health and Human Services' (HHS) Initiative To Strengthen Primary Health Care.

Payment

The AMA/Specialty Society RVS Update Committee (RUC) has a long history of improving payment for primary care services. We wish to raise awareness of these improvements, including:

- **Improved Payment for Evaluation and Management (E/M) Services**–The RUC has recommended increases in E/M services each time that the primary care organizations and/or the Centers for Medicare & Medicaid Services (CMS) have requested review. The most recent improvements in 2021 were implemented and led to more than $5 billion in redistribution from other services to E/M. Since the inception of the Resource Based Relative Value Scale (RBRVS), Medicare payment for a mid-level office visit (99213) has increased from $31 in 1992 to $92 in 2022. In comparison, payments for cataract surgery (66984) have decreased from $941 to $545 and payments for MRI of the lumbar spine (72148) have decreased from $485 to $208.
- **Improved Payment for Preventive Services**–The RUC review of many preventive services has led to increased Medicare payments for preventive medicine.
- **Transitional and Chronic Care Management**–The Current Procedural Terminology® (CPT®) Editorial Panel developed new codes to describe Transitional Care Management (TCM) and Chronic Care Management (CCM) services to be reported for care coordination provided over a 30-day period. After development of these codes in May 2012, the RUC reviewed the physician work and practice costs components associated with the provision of these services and submitted its recommendations to CMS in October 2012. On January 1, 2013, Medicare implemented the RUC recommendations and began payment for CPT codes 99495 and 99496 for the care of transitioning patients from a hospital or skilled nursing facility to the home. CMS began Medicare payment for monthly CCM, describing a medical home model of care for the chronically ill, on January 1, 2015. The RUC reviewed the TCM services again in 2018 and recommended an increase to reflect a change in physician work required to perform these services due to a diffusion of technology in which physicians now have the infrastructure and workflow established to provide these services. The increase was implemented on January 1, 2020. Furthermore, for 2021, CMS increased the TCM services again to reflect the increases to the E/M office visits based on their analogous relationship. The AMA is hopeful that these payments will allow

physicians to invest in personnel (e.g., nurses) and other infrastructure, which will help reduce emergency room visits and readmission rates.

The implementation of such RUC-recommended improvements has been overshadowed by several factors, particularly budget neutrality constraints within the Medicare Physician Fee Schedule (MPFS). The AMA has consistently supported policies enacted by CMS that overhauled E/M office visit policies and guidelines. However, the budget neutrality offsets that resulted from incorporating the improved E/M documentation and payment policies into the MPFS, combined with a statutory payment freeze during this period of high inflation, is disruptive and threatens access to care for Medicare patients. The AMA deeply appreciates your comments earlier this year concerning the potential for physicians to leave the practice of medicine due to insecurity in Medicare payments making their practice unsustainable.

We are grateful for the President's budget including a $3.5 billion proposal to address the incentive payments for both physicians participating in alternative payment models and those who do not.

Alternative Payment Models for Primary Care

The AMA encourages the Administration to support alternative payment models (APMs) for primary care. The current payment system can penalize primary care practices financially for keeping patients healthy, for example, because payments are tied to office visits and other services patients need, but healthy patients may need fewer services. Since the passage of the Affordable Care Act, a number of APMs to provide better support for comprehensive primary care have been initiated, but none have been available nationwide, and some that were popular with primary care practices were terminated, such as Medicare's Comprehensive Primary Care Plus model. Although the Primary Care First model is still available in Medicare, this model is available in about half the states and is only for primary care practices that are ready to participate in an advanced APM with downside financial risk and other requirements.

The AMA and the medical societies representing primary care physicians have provided input into the recent strategic refresh by the Center for Medicare and Medicaid Innovation. We are encouraged by the direction outlined in the new strategy, including the emphasis on addressing both patients' medical needs and their health-related social needs, such as lack of stable access to transportation, food, and housing.

Strengthening the Primary Care Workforce

Nearly 75 percent of medical school graduates have outstanding medical school debt, with the median amount being $200,000.[1,2] The debt burden that medical students must undertake has caused fewer students to choose lower-paying specialties such as primary care.[3] According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[4] Additional surveys by the Association of American Medical Colleges (AAMC) support this conclusion and found that underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school.[5] Since minority students are more likely to enter primary care than their white counterparts, the immense debt burden of medical school has not only precluded diversity among physicians, but also has limited the potential number of primary care physicians

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[1] https://www.aamc.org/system/files/2020-07/2020%20GQ%20All%20Schools%20Summary.pdf.
[2] https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports/.
[3] https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage.
[4] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760863/.

and thus diminished improvement in patient care in underserved communities.[6] As such, an increase in scholarships, funding for programs like the PSLF program, the National Health Service Corps, the HRSA scholarships such as the Rural Residency Planning and Development (RRPD) programs, increased funding for the Title VII Primary Care Loans (PCL) program, and other loan forgiveness programs are needed. Additionally, it is important to increase funding not only for the National Health Service Corps loan forgiveness program, but for their scholarship program as well. Scholarships help to diminish the financial burden of medical school from the outset, which promotes greater diversity in applicants, and ultimately a greater diversity in the physician workforce.

Additionally, students need to be recruited earlier in life. Programs should be created and must involve identification very early of students in high schools who want to commit to practice medicine, education of communities that need health professionals about medical education, and encouragement of communities to help groom and assist local students with getting into medical school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) is necessary. Finally, once individuals choose residencies in primary care support systems are needed. The creation of groups and communities will help to make residents invest in the specialty and the community in which they are serving long term.

When Congress passed the Balanced Budget Act of 1997 (P.L. 105-33), the number of positions Medicare supported in each hospital in 1996 was established as the upper limit in terms of the number of positions or slots that Medicare would fund in those institutions thereafter. Though, for the first time since 1996, 1,000 new Medicare-supported GME positions were provided in the Consolidated Appropriations Act, 2021,[7] that increase will not come close to fixing the expected physician shortage of about 124,000 physicians by 2034, including a projected shortage of primary care physicians of between 17,800 and 48,000.[8] As such, HHS should create additional funded residency slots whether it be through providing additional funding to existing programs like the National Health Service Corps or creating new residency programs. Until the cap is significantly raised, the shortage of primary care physicians will never be truly resolved.

Primary Health Care Integration with Treatment for Substance Use Disorder and Mental Health Conditions

With up to 70 percent of all visits including a behavioral health component (including both substance use disorder and mental health conditions), primary care practices stand at the front line of ensuring the highest possible level of physical and behavioral health for people throughout their lifetime.[9,10, 11] Behavioral health integration (BHI), an evidence-based approach within primary care settings that focuses on the well-being of the whole person through all developmental stages, can help individuals receive treatment earlier and at the right level of care. Successful integration of behavioral health care can occur along a spectrum from coordinated to fully integrated care, with the Collaborative Care Model (CoCM) being one of the most studied and validated models of integration.[12] Other models—such as the Primary Care Behavioral Health Model, or telehealth consultation to primary care physicians

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[6] .https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[7] https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[8] https://www.aamc.org/media/54681/download.
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3037136/.
[10] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm?s_cid=mm6932a1_w.
[11] https://www.commonwealthfund.org/blog/2021/drug-overdose-toll-2020-and-near-term-actions-addressing-it.
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/.

and non-physician clinicians by a behavioral health team—can help expand access to behavioral health services for patients and increase clinician capacity.[13,14,15]

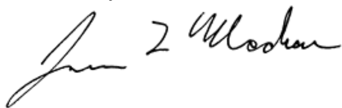
However, financial sustainability continues to be a pervasive concern for practices—both in fee-for-service (FFS) and APMs. Commercial heath plan products, along with Medicare and Medicaid coverage programs, frequently lack sufficient coverage and fair payment with adequate margin for primary care practices to provide integrated services. To make matters worse, many primary care physicians do not have the necessary upfront capital, among other required training and resources, to adopt and sustain BHI within their practices. Also, complex and burdensome billing requirements, particularly in FFS products, and narrow/carveout networks create unnecessary impediments to patients' accessing care. Out-of-pocket patient costs associated with integrated services also deter patients from utilizing such support.[16] Overly restrictive interpretations of federal and state regulations have also made it challenging to share patient information across integrated care team members, an essential component for integrated care. Furthermore, physician practices struggle to find and retain requisite workforce trained in integrated and trauma-informed care particularly given the estimated shortage of behavioral health providers.[17]

HHS can play a key role in accelerating the integration of behavioral health services into primary care settings and close the unmet need for mental health services and substance use disorder treatment by:

- Providing long-term sustainable funding opportunities for primary care practices (similar to funding provided for Meaningful Use and patient centered medical home adoption) to support training and education on implementation of BHI services;
- Raising payment levels for BHI services with a margin for all stakeholders in federal coverage programs such that they can be sustained by practices on an ongoing basis. This should include CoCM, care management/coordination, psychotherapy, dyadic therapy, and other relevant in-person and telehealth services utilized by primary care practices that have adopted BHI;
- Working with health plans and coverage programs to limit utilization management review practices, enforce state and federal mental health and substance use disorder parity laws, and strengthen and enforce network adequacy requirements; and
- Increasing federal funding with the aim of growing the behavioral health workforce, especially psychiatrists, addiction medicine physicians, developmental-behavioral pediatricians and other behavioral health specialists who practice in underserved areas. These should include loan forgiveness programs, new and expanded residency, and training programs.

The AMA appreciates the opportunity to provide information and urge HHS to consider a holistic approach to strengthening primary health care. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org, or by calling 202-789-7409.

Sincerely,



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[13] https://pubmed.ncbi.nlm.nih.gov/29480434/.
[14] https://www.frontiersin.org/articles/10.3389/fpsyt.2012.00007/full.
[15] https://www.acpjournals.org/doi/10.7326/m20-0132.
[16] https://www.ama-assn.org/system/files/bhi-return-on-health-report.pdf.
[17] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf.