118TH CONGRESS
2D SESSION

S. _____

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

_____

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To provide for the establishment of hybrid primary care payments under the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "_____ Act of _____".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Transformation of primary care practices serves as an essential foundation for improving health and life outcomes for Medicare beneficiaries,

particularly for those with multiple chronic conditions and complex needs, mental health challenges, or living in rural and other socioeconomically challenged communities.

(2) Research has shown that 25 percent or more of primary care activities are not recognized for payment under most fee schedules, including the Medicare physician fee schedule, largely because these activities reflect a wide range of high frequency, brief activities that cannot efficiently be paid fee-for-service and because the billing costs for submitting claims for such services would usually exceed the value of payment.

(3) Fee-for-service is ill-suited to support many elements of practice transformation to produce effective primary care, such as developing and maintaining multi-disciplinary team-based care strategies that leverage clinicians such as nurse practitioners, physician assistants, nutritionists, and pharmacists, and coordinating care with other clinicians and social service providers.

(4) Research has shown that primary care represents a much smaller percentage of total health care spending by payers, regardless of type of insurance coverage, in the United States than in other

wealthy nations, and that higher percentage of total spending that is devoted to primary care services is associated with lower overall health care spending, and in the Medicare Shared Savings Program, with higher savings performance by accountable care organizations led by physician groups.

(5) A composite, prospective payment would provide primary care practices with more predictable and flexible revenues to support such elements of effective primary care and help appropriately value services and activities performed by primary care providers and critical services not currently paid for.

(6) Payments for some physician services under the Medicare program, including many that produce substantial spending under the Medicare program, have major distortions.

(7) Determination of payments for physician services under the Medicare program currently begins with subjective survey-based estimates of clinician time and effort per discrete service. This approach to valuing physician services is inconsistent with the comprehensive and continuous nature of primary care.

(8) Studies have found that payment levels in the Medicare physician fee schedule reflect estimates

of clinician time per service for a variety of services that are particularly inaccurate.

(9) The extreme complexity of having more than 8,000 billing codes in the Medicare physician fee schedule risks inaccuracy in estimations of relative values for closely related procedures and obscures distortions in pricing that grow over time for specific services.

SEC. 3. ESTABLISHING HYBRID PRIMARY CARE PAYMENT IN MEDICARE.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may establish within the Medicare physician fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)), hybrid payments only to be available to primary care providers, as defined in the shared savings program under section 1899 of such Act (42 U.S.C. 1395jjj).

(b) HYBRID PAYMENTS.—

(1) IN GENERAL.—Such hybrid payments may be comprised of the sum of—

(A) prospective, per-member-per-month payments; and

(B) fee-for-service payments.

(2) DETERMINATION OF AMOUNT OF PROSPECTIVE, PER-MEMBER-PER-MONTH PAYMENT.—

(A) IN GENERAL.—Subject to the preceding provisions of this subsection, the total prospective, per-member-per-month payment—

(i) may represent between 40 and 70 percent of expected annual total allowed charges derived from the Medicare physician fee schedule for primary care providers of services and suppliers;

(ii) should be at least actuarially equivalent to the applicable physician fee schedule amounts for the services included within the total prospective, per-member-per-month payment; and

(iii) should be calculated based on historic Medicare payments for those services which would included as part of the prospective, per-member-per-month payment.

(B) APPLICATION OF CERTAIN FACTORS.—The Secretary may consider applying percentages different from those specified in subparagraph (A) for different types of primary care providers based on factors such as historical

fee-for-service revenue patterns or quality performance of the provider.

(C) RISK ADJUSTMENT.—The Secretary may assess the need to risk adjust the prospective, per-member-per-month payment and develop appropriate risk adjustment methodologies, taking into consideration only those factors that predict levels of primary care service utilization. Risk adjustment methodologies may incorporate clinical diagnoses, demographic factors, and other relevant information such as social determinants of health.

(c) CATEGORIZATION OF SERVICES.—

(1) IN GENERAL.—For such hybrid payments, the Secretary may create categories of different services that are wholly reimbursed under the Medicare physician fee schedule, but may not include services for which reimbursement occurs partly through other payment schedules under the Medicare program.

(2) SERVICES INCLUDED IN PROSPECTIVE, PER-MEMBER-PER-MONTH PAYMENT.—The Secretary may include the following types of services in the prospective, per-member-per-month payment under this section:

(A) Care management services.

(B) Communications such as emails, phone calls, and patient portals with patients and their caregivers.

(C) Behavioral health integration services.

(D) Office-based evaluation and management visits, regardless of modality, for new and established patients.

(3) CLARIFICATION REGARDING FEE-FOR-SERVICE PAYMENT FOR OTHER SERVICES .—For such hybrid payments, the Secretary may continue to pay through reduced fee-for-service payments for all other services not specified in paragraph (2) under the Medicare physician fee schedule, including screenings, preventive services, annual wellness visits (as defined in section 1861(hhh) of the Social Security Act (42 U.S.C. 1395x(hhh))), vaccinations, and initial preventive physical examinations (as defined in section 1861(ww) of such Act (42 U.S.C. 1395x(ww))).

(d) IDENTIFICATION OF QUALITY MEASURES.—The Secretary may identify quality measures with respect to primary care providers that receive hybrid payment under this section to safeguard health outcomes for Medicare beneficiaries, and reward high quality performance

through mechanisms such as annual bonus payments. Quality measures may be identified using existing mechanisms such as those approved for use in the Accountable Care Organization/Patient-Centered Medical Home/Primary Care Core Set agreed to by members of the Core Quality Measure Collaborative. Measurement may address areas such as—

(1) patient experience;

(2) clinical quality measures;

(3) service utilization, including measures of rates of emergency department visits and hospitalizations; and

(4) efficiency in referrals, which may include measures of the comprehensiveness of services that the primary care provider furnishes.

(e) ATTRIBUTION.—The Secretary shall establish procedures under which a beneficiary is attributed to a primary care provider using historical claims data and the beneficiary affirms that the provider is their primary care provider.

(f) EXCLUSION FROM MIPS.—Section 1848(q)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(q)(1)(c)(ii)) is amended—

(1) in subclause (II), by striking ''or'' at the end;

(2) in subclause (III), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new subclause:

''(IV) is a primary care provider that receives hybrid payments pursuant to section 3 of the [insert short title].''.

SEC. 4. WAIVING BENEFICIARY COST SHARING FOR PRIMARY CARE SERVICES.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may waive any beneficiary cost sharing otherwise applicable under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for primary care services that may be reimbursed through the newly established prospective, per-member-per-month payment established under section 3, provided that the beneficiary designates a primary care provider as their usual source of care and informs the Secretary of who that provider is [pursuant to the procedures established under section 3(e)].

(b) REPORT TO CONGRESS.—Not later than 180 days after the date on which subsection (a) is first imple-

mented, and annually thereafter, the Secretary shall submit to Congress a report on the implementation of such subsection, including an analysis of—

(1) whether the waiver of beneficiary cost-sharing under such subsection has impacted beneficiary utilization of primary care services that may be reimbursed through the newly established per-member-per-month payment; and

(2) whether the Secretary has observed any instances of fraud or abuse associated with the waiver of such cost-sharing, and whether the Secretary has taken steps to minimize any such fraud or abuse.

SEC. 5. ESTABLISHING A NEW TECHNICAL ADVISORY COMMITTEE ON RELATIVE VALUE UPDATES AND REVISIONS.

Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(P) ESTABLISHMENT OF TECHNICAL ADVISORY COMMITTEE ON RELATIVE VALUE UPDATES AND REVISIONS.—

"(i) IN GENERAL.—The Secretary shall establish a technical advisory committee (in this section referred to as the 'committee') within the Centers for Medi-

care & Medicaid Services to provide the Secretary with technical input regarding the accurate determination of relative value units under this paragraph.

"(ii) MEMBERSHIP.—

"(I) IN GENERAL.—The committee shall be composed of 13 members appointed by the Secretary from among individuals—

"(aa) reflecting diverse experiences in provider payment, including providers billing the Medicare program under this title, providers providing care under the laws administered by the Secretary of Veterans Affairs or the Secretary of Defense, and providers in primary care or family medicine (as defined for purposes of the shared savings program under section 1899); and

"(bb) with technical expertise in Medicare payment policies.

"(II) CHAIR.—1 of the members appointed under subclause (I) shall be

a representative of personnel of the Centers for Medicare & Medicaid Services, and that member shall serve as chair of the committee.

''(iii) STAFF.—The committee shall be staffed by personnel of the Centers for Medicare & Medicaid Services.

''(iv) DUTIES.—The committee shall advise the Secretary on an ongoing basis regarding the determination of relative value units under the physician fee schedule through duties such as the following:

''(I) Designing new valuation methodologies the Secretary may use to determine the time and resource use by health professionals associated with furnishing services or other new approaches to determining relative resources for each HCPCS code. The committee may prioritize furnished services that are most common or represent the services with the highest allowed charges.

''(II) Advising on research and development relevant to the deter-

mination of relative value units for individual HCPCS codes.

''(III) Providing recommendations with respect to changes in valuations of current HCPCS codes based upon any newly developed valuation methodologies.

''(IV) Evaluating whether existing HCPCS codes within the same family of services should be collapsed to result in fewer payment codes.

''(V) Identifying opportunities for bundling or unbundling services for payment purposes.

''(VI) Assessing the operational burden of new approaches on physicians and other suppliers and beneficiaries while also considering the vulnerabilities of new approaches on overt fraud and abuse.

''(VII) Assessing the impacts of these new approaches and potential adoption on beneficiary access, financial liabilities, quality of care, and health disparities.

"(v) FUNDING.—

"(I) IMPLEMENTATION.—The Secretary may provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out this subsection (other than research and development under clause (iv)(II)) (not to exceed $5,000,000) for each of fiscal years 2025 through 2029. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended

"(II) RESEARCH AND DEVELOPMENT.—The Secretary may provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out research and development under clause (iv)(II) (not to exceed $10,000,000) for each of fiscal years 2025 through 2029. Any amounts transferred under the preceding sen-

tence for a fiscal year shall remain available until expended.

''(vi) DURATION.—The Commission shall terminate not later than the expiration of the 5-year period beginning on the date of its establishment.''.