



July 15, 2024

The Honorable Sheldon Whitehouse
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
United States Senate
Washington, DC 20510

Dear Sen. Whitehouse and Sen. Cassidy:

On behalf of the American College of Physicians (ACP), we greatly appreciate you introducing the Pay PCPs Act, S.4338, on May 15, 2024. We commend you for recognizing the critical role that primary care physicians play in our healthcare system and the need for long-term policy solutions that would strengthen the primary care workforce. Your bill is an important initiative to ensure that physicians are able to work in a health care delivery system that facilitates high quality value-based care for our patients. Our sincere hope is that this important first step will eventually lead to legislative action based on bipartisan solutions that elevates primary care. ACP looks forward to continuing working with you and accordingly provides the feedback below about the Pay PCPs Act as introduced on May 15, 2024. We share your objective of enacting legislation that stabilizes payments to primary care physicians and creates a more affordable, sustainable, and equitable health system that improves patient access to primary care and concomitantly, health outcomes.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

Hybrid payments for primary care providers (from the RFI):

- “How can Congress ensure we are correctly identifying the primary care provider for each beneficiary and excluding providers who are not a beneficiary’s correct primary care provider or usual source of care?”

- How should Congress think about beneficiaries who regularly switch primary care providers? What strategies should CMS use to minimize disruption and administrative burden for these providers?
- How should the legislation address beneficiaries who routinely see two or more providers who could each plausibly be the “primary” care provider? For instance, a beneficiary who routinely visits both a family medicine provider and an OBGYN.”

As outlined in the 2023 ACP position paper, [Principles for the Physician-Led Patient-Centered Medical Home and Other Approaches to Team-Based Care](#), ACP calls on all policymakers, health care professionals, administrators, and other interested parties to refrain from using the term “provider” and instead refer to health care professionals by the title in which they are credentialed and licensed. The generic term “provider” falsely implies that all health care professionals have interchangeable skills and competencies and fails to respect the trust and understanding that is central to the patient-physician relationship. Therefore, throughout our response, ACP will use the term primary care physicians and/or clinicians for greater clarity, rather than the term “provider.”

Hybrid Payment should be voluntary and tested

ACP agrees with and supports efforts to expand and accelerate the adoption of value-based models of care, including hybrid payment models for primary care. Therefore, ACP supports aspects of the Pay PCPs Act, S. 4338, that would expand and accelerate the adoption of a hybrid per member per month (PMPM) payment model, preferably outside of the PFS. We believe this type of model could have the potential to improve the delivery of primary care. **However, we strongly recommend that if this hybrid PMPM payment model is implemented in the Medicare physician fee schedule (PFS), the cost of implementation must be outside the scope of budget neutral payment offsets.** We remain concerned that if payment for the hybrid PMPM payment model is implemented in a budget neutral (BN) manner as currently required by statute, it would only cause a further reduction in payment to all other services in the fee schedule. For example, the increases that were applied to evaluation and management (E/M) services in the 2021 PFS were required to be offset by an arbitrary across-the-board BN reduction to all services paid under the PFS. Fortunately, congressional action in the past two years has helped mitigate a substantial portion of these BN cuts. However, a program-wide hybrid payment model implemented solely within the existing PFS would lead to further pitting of specialties against each other if the PFS is not reformed to accommodate the new model. In brief, the introduction of the proposed new hybrid payment model must allocate resources outside the PFS in order to be a viable option for physicians and their patients.

In conjunction, we also recommend that the bill authors consider collaborating with your colleagues in the House of Representatives to ensure that the Physician Fee Schedule Update and Improvements Act, H.R. 6545, is also enacted into law. This bill would raise the threshold for implementing budget neutral payment cuts from \$20 million to \$53 million and would provide an increased update to the threshold every five years afterward based on the Medicare Economic Index (MEI). While this House bill will not entirely solve the

structural issues with the Medicare PFS, which needs even more significant reforms to address budget neutrality and to provide annual inflationary updates to all services within the PFS, it is a strong step in the right direction.

We also recommend that a hybrid payment model, as proposed in this legislation, should be voluntary and tested prior to any consideration for widespread implementation into the PFS. The Centers for Medicare and Medicaid Services Innovation Center (CMMI) have already conducted several tests of hybrid payment via the Comprehensive Primary Care (CPC) and the Comprehensive Primary Care Plus (CPC plus) models and are currently conducting further tests via the Primary Care First (PCF), Making Care Primary (MCP), and the ACO Primary Care Flex models. ACP recognizes that the earlier models, CPC and CPC plus, were challenged in that they did not meet the statutory requirements for expansion (i.e., improving quality while maintaining cost or decreasing cost while maintaining quality), but this is why CMMI has now initiated newer models based on the learnings of the earlier ones. The College also understands the frustrations by many interested entities that these models are primarily available in limited areas of the country and for limited time windows. **Therefore, we are supportive of a model that builds upon the learnings of these past and current models and that is introduced for nationwide implementation on a voluntary basis. There must also be clear mechanisms included for evolving and improving this hybrid model over time to account for any unintended or adverse consequences.** We encourage you to work with CMS to ensure that any hybrid model that is included in legislation complements and supports these efforts and avoids potentially diluting CMS' ability to generate data that can demonstrate efficacy or opportunities to improve the quality of care being provided at lower costs.

Additionally, attribution, as required in the legislation, presents considerable challenges to administering the hybrid payment in that patients sometimes see multiple primary care physicians, often in in different types of settings. For instance, a primary care physician that is initially identified for the PMPM payment, but who does not continue to see the patient throughout the designated time period may suffer unintended consequences, such as payment claw backs. These consequences for the physician must be accounted for and avoided for the hybrid payment model to be a viable option.

As outlined in ACP's paper 2020 titled, [*Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms*](#), physicians and their clinical care teams are in the best position to optimize patient care and meet performance targets when they know exactly which patients they are responsible for through prospective patient assignment. Voluntary patient attribution, which enables patients to select their primary care physicians, is the patient-centered gold standard. Patient-relationship codes, which allow physicians to identify each patient they are responsible for managing, are another promising form of attribution of patients.

Hybrid payments for primary care providers (continued, from the RFI):

- “What methodology should be used to determine the “actuarially equivalent” FFS amount for the purpose of the hybrid payment?
 - Should hybrid payment rates be based on historic averages across the entire FFS population? If so, are there risks that providers will receive an inappropriate payment rate for certain unusually high- or low- utilizing beneficiaries?”

Appropriately valuing primary care services

The PMPM could manifest in many ways, including salaries, direct contracting, and other variations that are deployed via compensation packages throughout the medical community. The capitation fee must be predictable and sufficient to cover the costs and practice expenses being incurred and appropriately adjusted for patients' health status and social drivers of health. ACP does not support a consideration for actuarial equivalence with current or historic FFS payments based on historic averages across the entire FFS population. Payments for primary care services, even with recent value increases for E/M codes, have historically been undervalued and remain so. With a PMPM payment potentially resulting in lowering FFS values, these services could be undervalued even more. Such payments should not impose additional administrative and reporting burdens on physicians that do not advance quality, value, or equity, nor should they require physicians and their teams to accept an unreasonable and unsustainable degree of financial risk for population-based outcomes.

In addition to the base capitation fee, financial incentives tied to value by using valid, appropriate measures must be sufficient to drive the desired change in care delivery and related investment in staffing, technology, and infrastructure, which existing [research](#) estimates to be 10 to 15 percent of physician compensation. Physicians should be separately paid via FFS for providing additional complex cognitive value-added services that exceed the scope of the capitated arrangement, such as performing social drivers of health assessments, behavioral health service assessments, and connecting patients with other appropriate services and counseling.

As stated in [Reforming Physician Payments to Achieve Greater Equity and Value in Health Care](#), ACP recommends that all payers prioritize the inclusion of underserved patient populations and those who are disadvantaged by health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health in all value-based payment models, including population-based prospective payment approaches.

Certain codes need to be included in any hybrid payment model as they are in the Medicare physician fee schedule. In [comments](#) regarding the proposed 2024 Medicare Physician Fee Schedule, ACP was supportive of proposals to expand equitable access to care and link underserved communities with critical social services in the community. ACP supported CMS' proposal to create separate coding and payment for Community Health Integration (CHI) services, which closely aligns with ACP policy. CHI services help address unmet

social drivers of health (SDOH) needs that affect a patient’s diagnosis and treatment. To ensure these needs are considered across the continuum of patient care, we recommended these needs be documented in the medical record and should also be included for a hybrid payment model.

ACP was also supportive of the CMS’ proposal to include coding and payment (HCPCS code G0136) for SDOH risk assessments. By providing for separate coding and payment for these services, physicians and other practitioners can better account for the time and resources spent on assessments that ultimately impact patient care. Since SDOH needs undoubtedly impact patient care, the College also fully supported the agency’s recommendation to make the SDOH assessment part of a patient’s annual wellness visit, even if optional, and recommends that any hybrid payment model do the same.

Quality Measures In Hybrid Payments (From the RFI):

- “The legislation proposes to allow the Secretary to define quality measures for hybrid payments and suggests four which may be pursued: (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.
 - Are these quality measures appropriate? Which additional measures should Congress be considering?
 - What strategies should Congress pursue to minimize reporting and administrative burden for primary care providers who participate in the hybrid model?”

Quality measurement needs to be streamlined and practical

Quality is often used interchangeably with *performance*, despite the two terms having important distinctions. Many current quality measures aim to determine the performance of the physician, practice, system, or payer, rather than measuring the true quality of care the patient receives. Additionally, the many required metrics used for current “value-based” reporting and payment programs are a strong contributor to care team burden and can monopolize limited practice resources. Therefore, ACP has consistently called for an appropriate mix of measures to be used by the physicians and practices to drive value-based improvements, with only a subset of the most valid, meaningful (to both the patient and physician), and evidence-based measures used for public reporting and determining payment. The College also believes that value must be defined around the patient, including the processes of care they receive, their clinical outcomes, their own health and health care goals, their safety, and their experience and engagement with their care. Given this, we appreciate that the draft legislation intends to have a focused set of measures across the four categories which we discuss below.

The first of these categories is patient experience. As noted earlier, ACP is supportive of using appropriate and evidence-based measures to assess patient experience and

engagement; however, there are still challenges with the existing measures in this space. In a recent [paper](#) published by the ACP Performance Measurement Committee (PMC), the College states that while patient-reported outcome–based performance measures (PRO-PMs) that are methodologically sound and evidence based have the potential to assess, promote, and reward patient-centered care, it is critically important that we proceed with caution when incorporating them into payment models.

The second category is clinical quality measures. Our current approach to measuring quality is focused on measuring performance based on a mixed bag of measures that vary in myriad ways, including but not limited to whether they are patient-centered, evidence-based, clinically relevant, applicable across practice settings, and feasible. Even measures attempting to capture the same insights often have differences in methods of measurement. Consequently, physicians are confused and lack confidence in the measures' ability to accurately capture the quality of care. Given these issues, ACP strongly recommends that this model use a limited set of accurate, meaningful measures that are consistent with those used in other CMS programs. The ACP PMC has assessed numerous measures using a set of appropriateness criteria to determine whether they are evidence-based, methodologically sound, and clinically meaningful. These recommended measures can be found on [ACP's website](#), along with additional details regarding the methodology used by the committee.

The third category is service utilization. While this can certainly be a useful set of metrics to determine the overall quality of care for a patient, ACP strongly recommends **against** attributing these measures as the individual clinician level, particularly at the level of the individual primary care physician. For example, in the case of readmissions, there is [no evidence](#) that primary care clinicians who deliver the plurality of services in the year leading up to a patient's initial admission have sufficient control over readmissions. All measures, especially those tied to payment, must be evidence-based and attributed to the appropriate unit of analysis e.g. where the measure addresses an outcome that is under the influence of the clinician being assessed. While certainly primary care physicians may have some influence over hospital admissions or readmissions, there is little evidence to substantiate the claim that the primary care services that a patient received in the year leading up to an initial admission has a statistically significant influence on readmission.

Finally, the fourth category is efficiency in referrals. ACP believes that this category is important and therefore encourages the legislation authors to review our [Medical Neighborhood Alternative Payment Model](#) that was recommended for testing by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Components of this model are now being included in the new CMMI Making Care Primary model via their [specialty integration strategy](#), as well as the use of the [ambulatory co-management code](#). It would be ideal for this hybrid model to align with other efforts of CMMI, such as these.

Regarding the administrative burden of reporting on measures, physicians need some level of flexibility to choose measures that are most beneficial to their practice and patients. Doing so would allow participants to focus on key strategic areas for meaningful

improvement in care delivery while reducing reporting burden. Along these lines, certain artificial intelligence (AI) technologies have the capability to enhance the clinical documentation process to reduce documentation burden on physicians and other clinicians; capture and increase the accuracy of coded data; and support other uses of the clinical documentation such as for research, performance measurement, and public health. In a recent [position paper](#), ACP recommends that “in all stages of development and use, AI tools should be designed to reduce physician and other clinician burden in support of patient care.” Additionally, the College states that new payment initiatives, especially those for value-based care, must support the use of AI technology as a mechanism to reduce burden and ideally improve quality.

Types of Services (From the RFI):

- “The legislation allows the Secretary to include four types of service in hybrid payments: (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management visits, regardless of modality, for new and established patients.
 - Is this list of services appropriate?
 - Are there additional services which should be included?
 - Are there any services which should be excluded?
 - Will including these services in a hybrid payment negatively impact patient access to service or quality of care?”

Behavioral Health Integration services should be excluded

ACP appreciates and supports including a robust range of services in the hybrid payments, but we strongly caution against including behavioral health integration services and believe they should be excluded from hybrid payments. While the College generally supports behavioral health integration efforts overall, including it in the hybrid payment would have an adverse impact on access since these services are already undervalued and would be even more so with a hybrid payment.

Cost-sharing adjustments for certain primary care services (From the RFI):

- “What is the appropriate amount of cost-sharing to make the hybrid payment model attractive for beneficiaries and providers while constraining negative impacts on the federal budget?
- Besides, or in addition to, cost-sharing reduction, what strategies should Congress consider to make the hybrid payment model attractive for beneficiaries and providers?”

Cost-sharing should be studied further

ACP appreciates the effort to lower barriers to primary care access for Medicare beneficiaries. ACP supports completely waiving beneficiary cost sharing for primary care

services in programs such as Medicaid and furnishing chronic care services within Medicare. We believe that high cost-sharing can create barriers to evidence-based, high value, and essential care and should be eliminated entirely, particularly for low-income patients and patients with certain defined chronic illnesses. [Evidence](#) clearly shows that even very low Medicaid copayments are associated with decreased use of necessary care. High deductibles may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis. ACP commends the Pay PCPs Act for reducing Medicare co-insurance by up to 50 percent. However, ACP also supports funding for research and the development of appropriate copayments and deductibles so that patients are also stakeholders in their delivery of care. While the 50 percent of Pay PCPs Act is a significant reduction in cost sharing, more information is needed to determine what would be appropriate to both eliminate a barrier to care and contain overutilization at the same time.

Technical advisory committee to help CMS more accurately determine Fee Schedule rates (From the RFI):

- “Will the structure and makeup of the Advisory Committee meet the need outlined above?”
- How else can CMS take a more active role in FFS payment rate setting?”

Remove the Technical Advisory Commission from the Pay PCPs Act

ACP opposes a provision in the Pay PCPs Act that would establish a new Technical Advisory Committee on Relative Value Updates and Revisions as it is divisive in medicine and will only strengthen opposition to the final passage of this legislation.

We also have strong concerns with the scope of authority provided to the technical advisory committee in the legislation. Specifically, we are deeply concerned by the committee’s proposed duties including the authority to evaluate and determine whether payment codes should be collapsed and whether certain services should be bundled or unbundled. Because of the complexity of issues involving the valuation of medical services, we strongly recommend that the proposed technical advisory committee should be excluded from the Pay PCPs Act of 2024.

Issues Remain with the RVS Update Committee (RUC) Appropriately Valuing Primary Care

We do strongly believe it is essential to maintain integrity in the Medicare PFS, ensure patients receive high-quality care, and determine accurate payment rates for physicians’ services. ACP believes that part of this objective is to make sure we utilize and refine the most appropriate and adequate processes for doing so.

Despite the positive changes for internal medicine physicians as a result of the work of the RVS Update Committee (RUC), we remain concerned that it has a tendency to value codes primarily on the basis of physical skill involved which leads to the undervaluing of cognitive services (i.e., critical thinking involved in data gathering and analysis, planning, management, decision making, and exercising judgment in ambiguous or uncertain

situations) are routinely [undervalued](#). In fact, one study [found](#) that Medicare reimburses physicians 3 to 5 times more for common procedural care than for cognitive care. In that study, the authors demonstrated that two common specialty procedures, cataract extraction and screening colonoscopy, can generate more revenue in one to two hours of total time than a primary care physician receives for an entire day's work. Though cognitive services are not procedure-intensive (e.g., spinal tap), with technological innovations, mass amounts of data to review, and the role of team-based care, internal medicine physicians and primary care physicians' services (e.g., care coordination for a high-risk patient) are increasingly labor-intensive. The College understands that physicians who primarily provide procedural services also provide a degree of cognitive care, but those physicians who almost exclusively provide cognitive care are deprived of an appropriate accounting due to the RUC's reliance on the metrics of time, intensity, and practice expense alone.

Importantly, these fundamental biases are averse to the critical role that primary care plays in health care and necessary reform to support the provision of continuous, patient-centered, relationship-based care. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels.

As the National Academy of Science Engineering and Medicine (NASEM) [report](#) points out, the nation's health is directly linked to the strength of its primary care delivery system and workforce. As the current payment system drives down the value of primary care, there has been a resulting shortage of primary care physicians. This shortage will, and has had, a profound impact on the quality of care and patient health outcomes, particularly for our most vulnerable populations. Accordingly, the systemic undervaluing of cognitive, including primary care, services is problematic and widespread.

How to Improve the RVS Update Committee (RUC) Process

Rethinking how Medicare determines payment amounts for physicians' services is a longstanding debate with significant and far-reaching impact. The RUC provides relative value recommendations to CMS annually. Along with several other medical societies, ACP is an active participant in the RUC process. ACP regularly provides robust input in Current Procedural Terminology (CPT) and RUC processes, including engagement in the CPT/RUC E/M workgroup to study the issue of documentation requirements in the O/O E/M (office and outpatient/ evaluation and management) code set and develop recommendations for improvement. The College is most appreciative of these opportunities and the incredible work that has resulted in positive changes for physicians and patients across the country. To support the RUC's work, ACP has also published numerous educational materials to discuss the importance of internal medicine physicians' participation in the RUC process and determining fair values.

However, these processes are not without their flaws. While ACP supported the RUC's decision in 2011 to expand its membership to include greater representation of primary

care and geriatric specialties, we acknowledged more needs to be done to ensure the RUC has the necessary expertise from physicians with the training, skills, and experience in comprehensive and longitudinal care of patients, especially those with complex illnesses. To that end, ACP provided recommendations in response to the Request for Comment About Evaluating E/M Services More Regularly and Comprehensively that the Centers for Medicare and Medicaid Services (CMS) included in the proposed 2024 Medicare Part B Physician Fee Schedule (PFS) rule.

In ACP’s [comments](#) about the CY24 PFS rule, we state that “a supplement or complement to the RUC is necessary, as a one-size-fits-all approach to assign value to physicians’ services is unworkable and fails to serve subsets of physicians’ services, particularly E/M. The College recommends that the RUC’s valuation process is supported by an independent, wholly separate entity that can inform aspects of care and the provision of physicians’ services that are not captured in the traditional process.” This independent, separate entity should not reside within CMS as currently envisioned by the Pay PCPs Act. Though the RUC process has its deficiencies, ACP believes that statutory budget neutrality requirements for the PFS are pitting specialties against one another. However, patients in need of primary care services and those providing the nation’s primary care should not pay the price.

The College does not believe that the RUC is not effective or should be replaced in its entirety; we value the RUC’s ability to convene medical specialty societies and inform the valuation of physicians’ services from the physician perspective. The RUC’s history demonstrates that its methodologies serve the other subset of physicians’ services well, but there are notable deficiencies in the valuation of cognitive services. To inform aspects of care that are not captured by the RUC’s traditional methodologies, it is imperative that the physician community and medical specialty societies are involved in this process, and that supplementary or complementary approaches are poised to fill the gaps in traditional methods of valuation.

ACP strongly believes there are refinements needed to the RUC process and methodology (i.e., how cognitive services are evaluated), but we would be remiss to not also acknowledge the challenges presented by a supplementary or complementary approach. Creation of an alternative panel could be labor and resource intensive and may ultimately result in the same pitfalls that currently exist. An alternative panel may also obfuscate methods and metrics informing the valuation of physicians’ services. As a launching point, ACP recommends that CMS instead explore the possibility of the Medicare Payment Advisory Committee (MedPAC) providing such advisory responsibilities. MedPAC provides information on access to care, quality of care, and other issues affecting Medicare. Since the RUC advises on only the relative resources to furnish a service, without consideration for the tertiary impacts, the College believes the MedPAC is uniquely situated to enhance the RUC’s work.

Accordingly, ACP has also offered recommendations to modernize the RUC’s processes by implementing several principles, including:

1. **Data-Driven Decision Making:** Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively;
2. **Collaboration and Transparency:** Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies;
3. **Continuous Review and Adaptation:** Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies;
4. **Equity and Access:** Work with the Current Procedural Terminology Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians;
5. **Broader Engagement:** Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values;
6. **Education and Training:** Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization;
7. **Timely Implementation:** Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessments and adjustments as needed.

The Centers for Medicare and Medicaid Services (CMS) Should Restore the Refinement Panel

Accordingly, to address the issues with the RUC process and valuing appropriate payment for cognitive care as identified above, the Centers for Medicare and Medicaid Services (CMS) should also [restore](#) the Refinement Panel. The panel would serve, as it was before 2011, as the entity for the relative value appeals process. ACP supports CMS facilitating an unbiased, open, and a reliably functional administered appeals process. A reconstituted Refinement Panel could examine public and stakeholder feedback, accept testimony from physicians, and take action by recommending refinements to relative values. Since 2011, CMS significantly reduced the majority of reviews by limiting appeals only to those which contain “new clinical information.” With only 36 percent of appeals accepted, CMS limited the ability of external stakeholders to recommend changes. Then in 2016, CMS essentially ended the Refinement Panel altogether by making codes no longer eligible for review because the panel would be restricted to interim final values for existing services, which CMS no longer issued. A reestablished Refinement Panel could work with the RUC to furnish the most effective process to take into consideration the experience from physicians to make recommendations for code changes.

Conclusion

ACP sincerely thanks Sen. Whitehouse and Sen. Cassidy for their ongoing leadership to address the issue of elevating primary care within the Medicare program. We greatly appreciate your inviting input from the health-care community and our hope is that the information we shared will provide you with a physician perspective. We stand ready to continue to serve as a resource and welcome the opportunity to continue to work with you in developing policy on health care and primary care payment in the 118th Congress. Please contact Jared Frost, Manager, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Issac Opole". The signature is written in a cursive, flowing style with some overlapping letters.

Issac Opole, MBChB, PhD, MACP
President