ADVOCATES FOR COMMUNITY HEALTH

July 15, 2024

The Honorable Sheldon Whitehouse
United States Senator
530 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, M.D.
United States Senator
455 Dirksen Senate Office Building
Washington, D.C. 20510

RE: The Pay PCPs (Primary Care Providers) Act of 2024 Request for Information
Submitted electronically to physician_payment@cassidy.senate.gov

Dear Senators Whitehouse and Cassidy,

On behalf of our members, we thank you for issuing this Request for Information (RFI) on your newly introduced bipartisan legislation, S. 4338, the Pay PCPs Act, which would create a hybrid primary care payment in Medicare. As the RFI states, this bill would encourage CMS to accelerate its existing efforts and priorities to support value-based primary care and ensure adequate payment to primary care providers (PCPs).

Advocates for Community Health (ACH) is a membership organization focused on advocacy initiatives to affect positive change for community health centers (CHCs), the patients they serve, and the entire nation's health care system. The Health Center Program is the largest network of primary care providers in the country. Community health centers serve over 31 million people in the United States, many from traditionally underserved communities, regardless of ability to pay or insurance status. Our members spearhead forward-thinking federal policies and drive change to advance and achieve health equity through comprehensive, integrated primary care.

Although Medicare is not a large payer for many health centers, our members are among the larger CHC systems and represent those health centers most likely to bill Medicare, especially in large rural service areas. Please see our recommendations below.

Hybrid payments for primary care providers:

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?

We appreciate the ways in which hybrid payments give primary care providers in Medicare steady, upfront, and value-based payments for under-reimbursed services while maintaining traditional fee-for-service payments for certain services. We suggest the following ways to correctly identify PCPs for health center patients:

- Ensure attribution covers an array of PCPs, including Physicians, Physician Assistants (PA), Nurse Practitioners (NP), Certified Nurse Midwives (CNM), Visiting Nurses, Clinical

Psychologists (CP), and Clinical Social Workers (CSW). We also recommend including clinical pharmacists, as they often provide patients with medication therapy management (MTM) and other counseling services.

- Include parity by applying the same primary care regulations and flexibilities to CHCs that are applied to other primary care providers. CHCs are often overlooked in changes to payment policy, and extension of changes to CHCs often lag 2-3 years behind, despite CHCs providing the same primary care services as other sites.

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?

We support considering the plurality of services. However, we recommend removing payment claw backs; payments are prospective and clawbacks add extreme administrative costs and burden to the entire health care system.

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.

Congress could consider categories of primary care and the plurality of such care. For example, family physicians provide routine reproductive health services to patients. In such cases, additional payment towards a per beneficiary per month payment (PBPM) should be considered for services such as behavioral health services or preventive reproductive health services to more than one provider.

We note that CHCs are paid under a Medicare and Medicaid prospective payment system (PPS), which already bundles many primary care services. However, labs, some behavioral health care, and other services are reimbursed separately. We respectfully request that this legislation explicitly allow same-day billing for all CHC providers. Without the ability for providers to be reimbursed for different services on the same day to meet patients' behavioral and medical health care needs, CHCs face extreme challenges to provide person-centered, evidence-based, and integrated care. As currently written in the Medicare Claims Manual 20.1, CHCs and rural health centers are only allowed to bill more than one visit under specific circumstances, and there are no permanent telehealth flexibilities.

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?

We suggest working with MedPAC and the legislation's proposed new technical advisory committee on these issues. These expert entities can provide analysis and context to best understand the wide range of Medicare's services and populations – including medically underserved populations - and the relevant data. We would highlight, however, CMMI's ACO

Flex Model, which considers a county base rate based on the county's average primary care spending before applying risk adjustment. It is important to note that improper benchmarks can lead to significantly inaccurate payments.

What factors should Congress consider when setting risk adjustment criteria?

We recommend risk adjustment criteria include ways to make payments more equitable, including based on individual beneficiaries' conditions. We appreciate that the bill specifically suggests adjusting by clinical factors and social determinants of health. Social risk factors must be incorporated into risk adjustment models for value-based care in Medicare and Medicaid to provide more accurate benchmarks for participants.

Are these quality measures appropriate? Which additional measures should Congress be considering?

We appreciate the bill's language regarding referral efficiencies, which may include services furnished by PCPs. We recommend Person-Centered Medical Home (PCMH) measures, which are aimed toward improving patient experience, lowering health costs, and reducing fragmentation. 78% of CHCs were recognized as a patient-centered medical home (PCMH) in 2022, meaning that the center improves patient-centered coordination of care, better manages chronic conditions, and achieves ongoing quality improvement.

It's important to note that CHCs must submit quality measures to the Uniform Data System (UDS) and according to the most recent data, CHCs have shown improvement in 12 out of 18 clinical quality measures. Health centers improved the percentage of patients with controlled hypertension and uncontrolled diabetes (inverse measures), outperforming the national Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks.

We also recommend that Congress work with CMS to streamline quality measures across Medicare and Medicaid programs in their Universal Foundation, and that health equity be considered as part of the quality measures.

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?

Primary care is comprehensive, and hybrid payments and flexible spending are essential to providing care to address Health-Related Social Needs (HRSNs). A flexible PBPM model can

supply beneficiaries with non-medical interventions, such as refrigerators for food and medicine, socks to prevent foot ulcers, and vacuums to mitigate asthma-related triggers. Flexible spending

can also fund additional support like community health workers who can help beneficiaries navigate the health system and coordinate care. This will significantly improve patient access to quality care.

Specifically, for integration of care, we recommend permitting CHCs to bill Psychiatric Collaborative Care Management service codes (CoCM) (99492, 99493,99494) with Chronic Care Management without additional requirements and burdens. Additionally, we suggest Congress work with CMS to understand the codes included in PBPM payments in their primary care models like ACO Flex and Making Care Primary (MCP) Model. The MCP model is designed around care management, care integration (including with specialty care), community connection, and addressing HRSNs.

Cost-sharing adjustments for certain primary care services:

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?

We recommend the following specifically for CHCs:
Beneficiaries often drop out or disenroll from treatment because of the cost-sharing burden for chronic care management. We recommend permitting CHCs the flexibility to waive co-pays, which matches their usual practice of adjusting and sliding fees based on income, as set by HRSA 330 grants. Any assistance around cost-sharing helps the patients in greatest need of such services.

Besides, or in addition to, cost-sharing reduction, what strategies should Congress consider to make the hybrid payment model attractive for beneficiaries and providers?

CHC workforces must reflect the populations they serve through their cultural and linguistic competency. This kind of representation increases patient trust, health care quality, and health outcomes. Therefore, adequate provider payment for the interdisciplinary teams, in addition to policies that improve provider well-being and focus on cultural and linguistic competency, are critical to our health system's future.

We also recommend instituting flexible funding streams to improve patient access to care. Flexible spending should explicitly include HRSNs such as transportation services and nutritional services as well as general provider and care-setting flexibilities. This includes telehealth policies, including allowing care "outside the four walls," and allowing telehealth and telemonitoring to be furnished in any geographic area and in any originating site setting, including the beneficiary's home. We also recommend allowing certain services to be furnished via audio-only telecommunications systems, adjusting in-person visit requirements, and allowing patients to see providers such as licensed marriage counselors,

bachelor-level social workers, and community health workers.

Technical advisory committee to help CMS more accurately determine Fee Schedule rates:

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

We recommend including members from community health centers, the Centers for Medicaid and Medicare Services office on dual eligibles, and Program of All-Inclusive Care for the Elderly (PACE) programs on the technical advisory committee, as primary care also includes prioritizing the needs of our aging population.

Conclusion

We appreciate the opportunity to provide feedback on hybrid primary care Medicare payments. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org and/or Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org .

Sincerely,

Amanda Pears Kelly
Chief Executive Officer