National Rural Health Association

July 15, 2024

Ranking Member Bill Cassidy
U.S. Senate Committee on Health, Education, Labor, and Pensions
455 Dirksen Senate Office Building
Washington, D.C. 20510

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

Dear Ranking Member Cassidy and Senator Whitehouse,

The National Rural Health Association (NRHA) appreciates the opportunity to provide feedback on S. 4338, the *Pay PCPs Act*. We thank the Senators for their efforts to address primary care challenges and reform physician payment models to improve access and health outcomes.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Rural residents are generally older, sicker, and poorer than their urban counterparts.[1] As such, it is critical to focus on ensuring that rural Medicare beneficiaries, who often have multiple chronic conditions, can access preventive primary care. With the correct assistance for rural providers, NRHA supports transitioning from the current fee-for-service model to a population-based prospective payment hybrid payment model. This type of model should provide payment to practices each month to deliver primary care coupled with FFS payment for other services. A hybrid model must include upfront and ongoing investments to participants and guardrails to protect quality and access in rural communities. A hybrid model should invest in primary care capacity and pay for services that are tailored to the needs of the patients and community. This would help to move away from the incentives to maximize billing that exist in the FFS environment.

NRHA supports the creation and implementation of a hybrid payment model in the Medicare Shared Savings Program (MSSP) and is encouraged by the Senators' introduction of the *Pay PCPs Act*. A hybrid payment model for primary care is one step towards improving rural beneficiaries' health outcomes and reducing spending on healthcare. A blend of per beneficiary per month (PBPM) and fee-for-service payments could help rural providers make the move toward value-based care.

NRHA offers the following recommendations and principles for a hybrid payment model:

General recommendations.
A hybrid payment option **should not be subject to budget neutrality**. Imposing budget neutrality would result in reductions to primary care payment elsewhere in the Medicare Physician Fee Schedule (MPFS) and disadvantage providers and patients that are not equipped to choose the hybrid option.

[1] Randy Randolph, et al., *Rural Population Health in the United States: A Chartbook*, North Carolina Rural Health Research Program, University of North Carolina at Chapel Hill, 1 (2023), https://www.shepscenter.unc.edu/product/rural-population-health-in-the-united-states-a-chartbook/.

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Relatedly, the MPFS is constrained by the budget neutrality mandate. Any increase of over $20 million must be offset by cuts elsewhere in the MPFS. This threshold has not been updated for inflation since inception of the fee schedule. In contrast, payment systems for hospital, skilled nursing facilities, and others attempt to account for inflation in annual payment updates. Further, when CMS overestimates utilization it is not invested back into the MPFS, which can effectively result in a payment cut. **We urge you to work alongside the Senate Finance Committee to update the MPFS budget neutrality threshold in tandem with the hybrid payment option.**

Any hybrid payment model should be voluntary for ACOs. While NRHA hopes that ACOs with rural providers would choose to participate, it should not be mandatory at the outset and ACOs should choose a hybrid option when it makes sense for them. The hybrid payment model should be scalable to all clinicians in Part B in the future. After measuring success in MSSP, a hybrid payment model should be broadly available in the MPFS.

Payment.
Hybrid payments should be tiered based on the scope of services provided. Higher tier payments should be available to practices or clinicians that deliver greater levels of integration, such has behavioral health integration or community health integration. Additionally, the hybrid payment must reflect rural beneficiaries' social determinants of health (SDOH) and health-related social needs. Any risk adjustment methodology should not reinforce existing patterns of underutilization due to poor access in rural communities. Payment for evaluation and management visits should account for evidence-based SDOH and behavioral health screenings. NRHA often hears from members that they do not perform these screenings because they do not have the capacity and financial viability to do so.

Cost-sharing barriers must be removed for rural beneficiaries to realize the full potential of comprehensive, whole-person primary care. Rural beneficiaries tend to be poorer than their urban counterparts and cost-sharing serves as a disincentive to seeking certain types of care. The *Pay PCPs Act* must include cost-sharing waivers for coinsurance and deductibles for services included in the hybrid payment option.

Services.
NRHA supports the services included in the hybrid payment option as outlined in *Pay PCPs Act*. In addition, NRHA suggests that the Secretary of Health and Human Services be granted authority to add additional services to be paid under the hybrid option as appropriate. We also ask that care management services must include and reimburse for services provided by members of the care team that Medicare has typically not paid for, such as community health workers or community paramedics. Rural providers are interested and willing to utilize these providers to help with addressing SDOH and making connections to community resources; however, the lack of or limited Medicare reimbursement available has not incentivized rural providers to do so without an alternative funding stream.

Quality.
For quality measures, NRHA agrees that patient experience, clinical quality measures, and service utilization are important. However, we are concerned about the measure for "efficiency in referrals" as this may disadvantage rural providers that struggle to make referrals to specialists. Many rural clinicians do not have a nearby specialist to which they can refer patients and shouldn't be penalized for limited access to specialty services for their patients.

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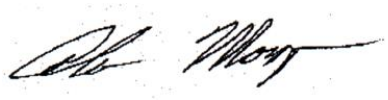
Thank you for the opportunity to weigh in on this important legislation. We look forward to continuing our work together on a sustainable hybrid payment option. If you have any questions or would like to discuss further, please contact Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

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