pcc
primary care
collaborative

December 14, 2023

The Honorable Jason Smith
1139 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Richard Neal
1129 Longworth House Office Building
United States House of Representatives
Washington, DC, 20515

Dear Chairman Smith and Ranking Member Neal

On behalf of the Primary Care Collaborative (PCC), I write to applaud the Committee for its interest in health care in rural and underserved communities and share our specific policy recommendations in this area.

The Primary Care Collaborative (PCC) is a non-profit, nonpartisan, multi-stakeholder coalition of 73 organizational Executive Members ranging from clinician and patient advocacy organizations to employer groups and health plans. PCC's members share a commitment to an equitable, high-value health care system with primary care at its base. (See the Shared Principles of Primary Care).

Rural and underserved communities grapple with health burdens that exceed those facing other communities, with respect to heart disease, diabetes, addiction, other mental health disorders, and maternal mortality. Primary care is foundational to efforts to lift those burdens:

> *"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.*"[1]
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> National Academy of Science, Engineering and Medicine's 2021 Report, *Implementing High-Quality Primary Care*

The foundation for population health and affordability, which primary care provides, is showing serious cracks. Approximately 80% of rural America is medically underserved.[2] As of June 2023, rural areas comprise 65% of primary care health professional shortage

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[1] McCauley, L., Phillips, Jr., R. L., Meisnere, M., & Robinson, S. K. (Eds.). (2021). (rep.). *Implementing High Quality Primary Care: Rebuilding the Foundation of Health. Care*. Washington, D.C.: The National Academies Press.
[2] *Rural health: Addressing Barriers to Care*. NIHCM. (2023, October 23). https://nihcm.org/publications/rural-health-addressing-barriers-to-care?x-craft-preview=500l2VTUmx&token=Mh_dUNRmnLD5mkklxDAy6p0X0Sw8zip-

areas (HPSAs).[3] PCC's 2023 evidence report documents erosion in the overall supply of primary care clinicians – MDs, DOs, NPs, and PAs -- across all fifty states.[4] Across urban, rural, and suburban underserved communities, these trends are observed by the staffing challenges faced by community health centers.[5] To roll back these trends, Congress must act. That action begins by strengthening the foundation for rural and underserved Americans' health: whole-person primary care.

Invest in Primary Care

Headlines and recent research have documented alarming workforce shortages. However, those shortages, particularly in primary care, are not evenly distributed. Instead, those counties with Primary Care Health Professional Shortage Areas tend to be older and experience more poverty and higher unemployment.[6]

Consequently, the payment policies adopted by Medicare and Medicaid are essential for access to care in rural and other underserved communities than elsewhere. Rural communities rely on Medicare and Medicaid as a source of health insurance coverage than other communities.[7] Even available private coverage sources, whether commercial or employer-provided, typically build their payments on Medicare, despite CMS officials acknowledging that Medicare payments under resource primary care.[8] MedPAC has recommended several policies that address this shortfall, yet many have gone unimplemented.[9] Until policymakers show the leadership necessary to address this underlying problem – aggressively and at scale - even the most innovative state-led reforms and private or non-profit sector initiatives will be inadequate.

The Primary Care Collaborative urges the Ways and Means Committee to seize this opportunity for bipartisan leadership. Working with their House and Senate colleagues, the Committee should remove critical barriers that current statutes and regulations have

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[3] *Rural health: Addressing Barriers to Care*. NIHCM. (2023, October 23). https://nihcm.org/publications/rural-health-addressing-barriers-to-care?x-craft-preview=500l2VTUmx&token=Mh_dUNRmnLD5mkklxDAy6p0X0Sw8zip-

[4] Huffstetler, A., Greiner, A., Siddiqi, A., Kempski, A., Walter, G., Park, J., Topmiller, M., Filippi, M., Bianco, A., & DeKlotz, J. (2023). (rep.). *Health is Primary: Charting a Path to Equity and Sustainability*.

[5] Health Center Workforce: Caring for Today's Patients, Preparing for Tomorrow. (2023, March). https://www.hcadvocacy.org/wp-content/uploads/2023/03/Workforce_PolicyPaper_2023.pdf

[6] Streeter, R. A., Snyder, J. E., Kepley, H., Stahl, A. L., Li, T., & Washko, M. M. (2020). The geographic alignment of primary care health professional shortage areas with markers for social determinants of health. *PLOS ONE, 15*(4). https://doi.org/10.1371/journal.pone.0231443

[7] McBride Abigail Barker, T., Barker, A., Hernandez, E., Jost, E., Kemper, L., & Mueller, K. (2022). (rep.). *Key Facts About Insurance Coverage and Health Care Access in Rural America*. Rural Policy Research Institute.

[8] *Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program*. Federal Register . (2023). https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

[9] MedPac. (2018). (rep.). *Report to the Congress: Medicare and the Health Care Delivery System* (pp. 65–84).

erected between Americans living in rural and underserved communities and the whole-person primary care that produces better health. This will require attention to both *overall* primary care payment policy reforms and *targeted* measures aimed specifically at rural and underserved communities.

First, this Committee should support and encourage CMS efforts to move forward with two specific policies that strengthen primary care across all American communities.

- Stand Up A Hybrid Payment Option in MSSP: This Committee should support efforts by CMS to develop a new, hybrid payment option for primary care practices participating in Medicare Shared Savings Program ACOs. A permanent part of the Medicare program, MSSP has successfully improved both the quality of care for beneficiaries and reduced costs to beneficiaries – with primary care led ACOs generating twice the savings. PCC, NAACOS, and 25 other leading primary care, consumer, purchaser, and health plan organizations have proposed a hybrid payment that gives ACO primary care practices the option of receiving enhanced upfront, per member per month payments for their regular patients. As proposed, these new models would provide enhanced resources to primary care practices in underserved communities. CMS has repeatedly indicated that they are considering standing up just such an approach through its Innovation Center. With an ongoing primary care access and workforce crisis, the Committee should support CMS in launching this program and reject any curtailment of CMS Innovation Center authority or funding.

- Pay Adequately for Inherently Complex Care (the proposed G2211 code): Across two administrations, CMS has proposed and finalized payment across Medicare Part B for inherently complex care delivered in the context of an ongoing patient-clinician relationship through a new G2211 payment code. G2211 reflects the time, intensity, and practice expenses needed to meaningfully establish and maintain relationships with patients and address most of their health care needs with consistency and continuity. G2211 will help improve patient and population health outcomes and strengthen the Medicare program by paying clinicians to provide this highly effective, low-cost care. Congress should reject calls to delay or roll back this critical reform.

Additionally, Congress should move quickly to enact measures that specifically invest in the health of rural and underserved communities, including those identified below:

- Extend the Small Rural and Underserved Communities Support (SURS) Program Rural and safety net providers frequently lack the resources to transition from fee-for-service payment to value-based care. This vital program provides technical assistance on quality measurement, health information technology, and practice improvement. Unfortunately, the initial funding for the program, established under MACRA, has now expired. PCC supports HR 5395, the SURS Extension Act. This bipartisan legislation would renew the SURS program and help small, independent primary care practices and clinics on which rural and underserved communities depend take the critical first steps toward broader practice and care transformation.

- Expiring Primary Care Safety Net Programs: Increased funding for the National Health Service Corps, Community Health Centers, Teaching Health Centers, and Graduate Medical Education (THCGME) programs is indispensable for the

health of rural and underserved communities. Communities depend on them as well as other Title VII programs and VIII Nursing Workforce Development Programs. We appreciate the efforts to reauthorize and strengthen these programs in H.R. 5378, the Lower Costs, More Transparency Act, passed by the House on December 11th, 2023. The annual funding levels in that bill should serve as the floor for any enacted legislation.

- Support Rural Health Clinics (RHCs): RHCs are a bedrock of the rural health safety net. Over 5,300 RHCs across 45 states provide vital access to primary care services to rural residents. RHCs serve 37.7 million patients per year, more than 11% of the entire population and over 60% of the 60.8 million Americans living in rural areas. Overall, the Rural Health Clinic program has successful bolstered access to healthcare across rural America. We encourage the Committee to examine strategies to support rural health clinics.

- Extend Rural Telehealth Flexibilities: During the COVID-19 pandemic, Congress and CMS granted several Medicare telehealth flexibilities to FQHCs and RHCs, including waiver of geographic and originating site requirements and expanded telehealth flexibilities for Critical Access Hospitals. Certain telehealth services were permitted to be furnished using audio-only technology. These flexibilities should be permanently extended, and bipartisan legislation introduced in the 118th Congress, H.R. 3440 Protecting Rural Health Access Act, would accomplish that aim.

Integrate Mental Health and Addiction Services

The twin epidemics of poor mental well-being and addiction are afflicting families and communities, and primary care practices increasingly address these challenges in the course of patient care.[10] Almost a quarter of rural adults reported having a mental illness in 2021.[11] And while the prevalence of serious mental health illness and substance use may be similar in rural and urban areas, adults residing in rural geographic locations receive mental health treatment less frequently.[12] Access to mental health for children in rural and underserved locales can be even more challenging.

When adequately resourced, integrated, team-based primary care is uniquely positioned to help rural and other underserved communities make the most of their behavioral health workforce and limited public resources. Evidence-based models of mental health

[10] Rotenstein, L. S., Edwards, S. T., & Landon, B. E. (2023). Adult primary care physician visits increasingly address mental health concerns. *Health Affairs*, *42*(2), 163–171. https://doi.org/10.1377/hlthaff.2022.00705
[11] *Rural Mental Health Overview - Rural Health Information Hub*. Overview - Rural Health Information Hub. (2021). https://www.ruralhealthinfo.org/topics/mental-health
[12] *Rural Mental Health Overview - Rural Health Information Hub*. Overview - Rural Health Information Hub. (2021). https://www.ruralhealthinfo.org/topics/mental-health

integration have proven successful in these communities.[13] [14] Unfortunately, today's Medicare statute and regulations continue to hamper access to this kind of whole-person primary care - particularly practices in rural and underserved communities. The national behavioral health crisis makes removing these reimbursement and policy barriers an urgent priority.

PCC recommends the following specific strategies:

- Expand Primary Care – Behavioral Health Integration: In 2016, Medicare established payment to support the implementation of the collaborative care model and general behavioral health integration service codes in primary care. However, the costs and practice changes associated with the initial implementation of integrated care are substantial, and uptake has been limited. To implement evidence-based models, many practices, particularly rural and underserved practices, need additional technical assistance and funding to expand the team and build the infrastructure needed to support them. PCC supports HR 5819, the COMPLETE Care Act. By enhancing payment for integrated codes for three years and technical assistance, this bipartisan legislation would help more practices effectuate the practice changes and recruit the staff needed to implement integrated care. We also encourage Congress to remove barriers to broader implementation of evidence-based integrated care, including the cost-sharing required for Medicare's integrated care codes.

- Improve Medicare's Health Professional Shortage Area Bonus program: Under existing law, Medicare's Health Professional Shortage Area Physician Bonus provides a 10% bonus payment for services delivered in a primary care physician shortage area but does not include certain behavioral health clinicians and services. PCC supports targeted changes to this program to help address the mental health crisis. Specifically, Congress should make the bonus available to other eligible practitioners (such as psychologists, physician associates, nurse practitioners, social workers, and counselors) and increase the size of the bonus from 10% to 15% for mental health and substance use disorder services. Bipartisan legislation, S. 3157, the More Behavioral Health Providers Act, has been introduced in the Senate. That bill's provisions were incorporated into Section 101 of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, unanimously approved by the Senate Finance Committee on November 8th.

- Permanently Remove In-Person Visit Requirements for Telemental Health The Consolidated Appropriations Act of 2020 required a periodic in-person patient visit for Medicare telemental health. This requirement is an unnecessary barrier to care, can be a prohibitive factor for those seeking mental health services, and

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[13] Blackmore, M. A., Patel, U. B., Stein, D., Carleton, K. E., Ricketts, S. M., Ansari, A. M., & Chung, H. (2022). Collaborative care for low-income patients from racial-ethnic minority groups in primary care: Engagement and clinical outcomes. *Psychiatric Services*, *73*(8), 842–848. https://doi.org/10.1176/appi.ps.202000924

[14] Powers, D. M., Bowen, D. J., Arao, R. F., Vredevoogd, M., Russo, J., Grover, T., & Unützer, J. (2020). Rural clinics implementing collaborative care for low-income patients can achieve comparable or better depression outcomes. *Families, Systems, & Health*, *38*(3), 242–254. https://doi.org/10.1037/fsh0000522

should be removed. Without care, mental health problems can become exacerbated and lead to staggering costs, such as expensive treatment needs in the future and increased societal costs (e.g., incarceration, homelessness, unemployment).

- Remove Barriers to Integration in the FQHC and RHC programs: Congress should remove the cap on RHCs that requires them to provide no more than half of their total services for behavioral health. Congress should also instruct CMS to clarify that Medicare's same-day billing exceptions for FQHCs and RHCs include substance use treatment in addition to mental health visits.

- Support Tele-prescribing for Addiction Therapy: About three-quarters of rural counties lack a buprenorphine provider, so telehealth prescribing is critical to expanding access to areas without a practitioner. H.R. 5163, the Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act, allows patients to receive a medical exam via telehealth, including audio-only, in order to get a buprenorphine prescription for opioid use disorder.

Dually Eligible Beneficiaries

People living in rural and underserved communities tend to be older, experience higher rates of disability, and rely on lower incomes than in urban areas.[15] [16] For these reasons, individuals dually eligible for both Medicare and Medicaid make up a larger portion of primary care patient panels in these communities. Addressing specific misaligned Medicare policies that impact dually eligible beneficiaries is essential to strengthening primary care for rural and underserved Americans. We encourage the Committee to work collaboratively with the House Energy and Commerce and the Senate Finance Committee to advance legislation this Congress that would accomplish the following.

- Establish continuity of coverage protections for dually eligible beneficiaries: Disruption or churn in Medicaid eligibility can be a serious barrier to the health of dually eligible beneficiaries. This churn can also impose the administrative burden of helping their often vulnerable, dually enrolled beneficiaries navigate those barriers on rural and underserved primary care practices. PCC supports twelve-month continuous eligibility for all individuals on CHIP and Medicaid, including Medicare beneficiaries with dual coverage. However, at a minimum, we encourage you to extend continuous eligibility to dually eligible beneficiaries. This provision would be consistent with the 117th Congress' bipartisan work to extend continuous eligibility to children and post-partum women.

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[15] *Persistent primary care health professional shortage areas (hpsas) and health care access in rural America*. UW CHWS. (n.d.). https://familymedicine.uw.edu/chws/studies/persistent-primary-care-health-professional-shortage-areas-hpsas-and-health-care-access-in-rural-america/

[16] Davis JC, Rupasingha A, Cromartie J, and Sanders A. Rural America at At A Glance: 2022 Edition. USDA Economic Research Service. https://www.ers.usda.gov/webdocs/publications/105155/eib-246.pdf?v=4569.3

- Expand Access to the Program of All-Inclusive Care for the Elderly (PACE): PACE demonstrates lower readmissions and ER visits, as well as 15% lower Medicaid costs relative to other approaches to LTC. Strong primary care teams that can help coordinate a full range of clinical and other services are core to the PACE model of care. Unfortunately, nineteen states have yet to give beneficiaries in their states access to PACE. This year, an HHS Advisory Committee urged HHS to take steps to expand access in rural areas.[17] Congress can do its part by expanding PACE to all fifty states and, removing statutory barriers denying PACE enrollees the full choice amongst Part D plans, and barring Medicare beneficiaries under age 55 from PACE enrollment.

- Address lesser-of payment policies: Today, federal statute has permitted the establishment of serious coverage and reimbursement barriers for dually eligible beneficiaries: the so-called "lesser-of" payment policies. Under these policies, state Medicaid programs can elect to not cover the full Medicare cost sharing amount for dually eligible beneficiaries if the Medicaid payment allowance for that service is less than Medicare's allowance. These policies often result in primary care practices receiving just 80 percent of typical Medicare reimbursement for services delivered to dually eligible beneficiaries. Lesser-of policies are a strong disincentive for primary care practices to locate in and serve communities with a high percentage of dually eligible beneficiaries. Lesser-of policies cost practices an estimated $3.6 billion in revenue each year.[18] MedPAC has recommended a 15% bonus for primary care services delivered to dually eligible beneficiaries and Low-Income Subsidy recipients along with a 5% bonus for specialty care delivered to those beneficiaries. This policy would be a non-budget neutral add-on payment, not subject to beneficiary cost sharing. PCC supports this policy and urges its inclusion in the Committee's legislative efforts to support rural and underserved providers and practices.

We appreciate this opportunity to share our recommendations and look forward to working with the Committee as it moves toward bipartisan solutions. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions.

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative

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[17] Health Resources and Services Administration. (2023b, March). Programs of all-inclusive care for the elderly in rural America. https://www.hrsa.gov/sites/default/files/hrsa/rural-health/resources/nac-policy-brief.pdf

[18] Burton R, Winter A, Gerhardt G, Tabor L. (2022). Assessing Payment Adequacy and Updating Payments: Physician and Other Health Professional Services and Supporting Medicare Safety-net Clinicians. Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2021/10/Tab-E-Physician-Updates-8-Dec-2022.pdf

PCC Executive Members

Below is a list of the Primary Care Collaborative's executive members that pay dues to the organization and support its mission. Membership does not indicate explicit endorsement of this letter.

AARP
Alzheimer's Association
America's Agenda
American Academy of Child & Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Associates (AAPA)
American Association of Nurse Practitioners
American Board of Family Medicine Foundation (ABFM Foundation)
American Board of Internal Medicine Foundation (ABIM Foundation)
American College of Clinical Pharmacy
American College of Lifestyle Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Physicians
American Psychiatric Association Foundation
American Psychological Association
Amerihealth Caritas
Blue Cross Blue Shield Association
Blue Cross Blue Shield of Michigan
Blue Shield of California
Brigham and Women's Hospital Primary Care Center of Excellence
Catalyst Health Network
Cigna
Community Care of North Carolina
Community Catalyst
Converging Health
Crossover Health
Cummins
CVS Health
Elation Health
Elevance Health (Formerly Anthem)
Families USA
GTMRx Institute
Harvard Medical School Center for Primary Care
HealthTeamWorks
Humana
IMPaCT Care
Innovaccer
Institute for Patient- and Family-Centered Care
Johns Hopkins Community Physicians, Inc.
Johnson and Johnson
Mass General Brigham Health Plan
Massachusetts Health Quality Partners (MHQP)
Mathematica Policy Research
Mediclinics

Medis
MedNetOne Health Solutions
Mental Health America
Merck
MGH Stoeckle Center for Primary Care Innovation
Morehouse School of Medicine - National Center for Primary Care
National Alliance of Healthcare Purchaser Coalitions
National Association of ACOs
National Committee for Quality Assurance (NCQA)
National PACE Association
National Partnership for Women & Families
National Rural Health Association
Navina
Oak Street Health
PCC Pediatric EHR Solutions
Pediatric Innovation Center
Primary Care Development Corporation (PCDC)
Purchaser Business Group on Health (formerly Pacific Business Group on Health)
Society of General Internal Medicine
Society of Teachers of Family Medicine
St. Louis Area Business Health Coalition
UCSF Center for Excellence in Primary Care
UPMC Health Plan
Upstream USA
URAC
VillageMD
Waymark