



September 1, 2022

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**Re: Medicare and Medicaid Programs: Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc.**

Dear Dr. Seshamani:

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (the Campaign), we appreciate this opportunity to offer comment on the Notice of Proposed Rulemaking (NPRM) for CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies and Medicare Shared Savings Program (MSSP) Requirements. PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 66 organizational Executive Members ranging from clinicians and patient advocates 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: care that emphasizes comprehensiveness, longitudinal relationships, and “upstream” drivers for a better patient experience and better health outcomes. (See the Shared Principles of Primary Care). This year, PCC, with fifty other organizations, has launched the Better Health – NOW Campaign to realize bold policy change to realize the recommendations of the 2021 National Academy of Science, Engineering, and Medicine's (NASSEM) report, *Implementing High Quality Primary Care*. The principles guiding our Campaign are outlined in PCC's Concordance Recommendations for Primary Care Payment and Investment but rooted in a simple idea: We need strong primary care in every community so we can all have access to better health.

Primary care is the one component of the health care delivery system where increased supply is consistently associated with improved population health, lower costs and more equitable outcomes.<sup>1,2</sup> Yet despite growing chronic disease prevalence and persistent health disparities, the U.S. has devoted just 5% to 7% of health care dollars to primary care, a proportion that is trending down.<sup>3,4</sup>

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<sup>1</sup> Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med.* 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624

<sup>2</sup> Shi L. The impact of primary care: a focused review. *Scientifica (Cairo)*. 2012;2012:432892. doi:10.6064/2012/432892

<sup>3</sup> Kempfski, A. Greiner, A. Primary care spending: High stakes, low investment. Primary Care Collaborative. <https://www.pcpc.org/resource/evidence2020>. Published April 20, 2022. Accessed April 15, 2022.

<sup>4</sup> 2021 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; December 2021. AHRQ Pub. No. 21(22)-0054-EF.

**Medicare Part B’s reliance on fee-based payment as the primary means of primary care payment systematically undercuts investment in the sector<sup>5</sup> even as it undermines health equity.<sup>6</sup>** The improvements to Evaluation and Management valuation in the CY 2021 rule and the updates to clinical labor pricing in the CY 2022 final rule corrected important flaws in the PFS. Yet the statutory zero percent payment update and PFS budget neutrality requirements have now contributed to a proposed 10.54 percent payment cut for all PFS clinicians, effectively rolling back the CMS’ increased investments in primary care from the past two years. We are alarmed by potential impacts this uncertainty could have on the viability of small and independent primary care practices and on access in underserved communities, particularly amid steeply rising practice costs. We also note that increasingly insufficient fee-for-service rates undermine primary care practices’ ability to integrate behavioral health care or transform care delivery to successfully transition into a value-based care model. This fluctuation provides yet another illustration of how fee-for-service fails primary care and the health of communities.

Two separate National Academies of Science Engineering and Medicine reports have called for a new approach - built around more comprehensive payment alternatives and increased investment in primary care. The first of these reports was released in 1997 – a quarter century ago. **Yet to date, Medicare, the nation’s largest payer, has yet to implement widely available alternatives to fee-for-service reimbursement in primary care.**

**Primary care practices in Medicare need pathways to rapidly transition from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model.** These pathways should be coupled with up-front and ongoing investments and guardrails to ensure that patients and communities most affected by health and health care inequities, and the primary care clinicians and teams that care for them, realize the benefits of a high-value health system. Aligned across payers, these payment pathways should include adjustment for health status, risk, social drivers of health and social risk, historic under-investment, and other elements.

With this year’s NPRM, CMS has advanced several important proposals to strengthen the Medicare Shared Savings Program, support behavioral health integration and improve vaccination reimbursement. We appreciate the effort of CMS staff to craft sound policy in these areas, each of which is crucial to high-quality, equitable primary care. We provide supportive comments on specific proposals below.

That said, the policies advanced in this NPRM are only complements to, not substitutes for, the more fundamental reform of primary care payment that is needed. Confronted

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<sup>5</sup> Kumetz EA, Goodson JD. The undervaluation of evaluation and management professional services: the lasting impact of current procedural terminology code deficiencies on physician payment. *Chest*. 2013;144(3):740-745. doi:10.1378/chest.13-0381

<sup>6</sup> McNeely L, et al. Primary Care: A Key Lever to Advance Health Equity. Primary Care Collaborative & National Center for Primary Care, Morehouse School of Medicine. May 2022. <https://www.pcpc.org/sites/default/files/resources/PCC-NCPC%20Health%20Equity%20Report.pdf>

with concurrent epidemics of cardiometabolic disorders,<sup>7</sup> poor mental health, addiction and infectious disease, bold action to strengthen primary care is urgently needed.

Therefore, in our detailed comments below, we suggest one initial approach to supporting population-based prospective payment in traditional Medicare.

**Specifically, we call for a primary care hybrid payment option available within the MSSP. We further recommend that CMS seek public input to inform the design and implementation of such an option, as well as other possible pathways to support population-based, prospective payment in Medicare.**

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### **Determination of PE RVUs (section II.B.)**

*Overview:* In the context of the PFS, practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice (MP) expenses. CMS uses a resource-based system for determining PE Relative Value Units (RVUs) for each physicians' service, considering the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses.

Subsections:

#### **II.B.5 Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology**

*Description:* In this proposed rule, CMS is signaling its intent to move to a standardized and routine approach to valuation of indirect PE and welcomes feedback on what this might entail. CMS would propose the new approach to valuation of indirect PE in future rulemaking.

*PCC/Better Health – NOW Comment:* **We support moving to a routine approach to valuation of indirect practice expenses.** We are hopeful routine valuation could better support reimbursement sufficient to meet the actual expenses associated with furnishing primary care services. This routine valuation could be helpful as practices, particularly small and independent practices and those in underserved communities, grapple with rising rents and overall price inflation in the future.

### **Valuation of Specific Codes (section II.E.)**

*Overview:* Establishing valuations for newly created and revised Common Procedural Terminology (CPT) codes is a routine part of maintaining the PFS. Since the inception of the PFS, it has also been a priority to revalue services regularly to make sure that the payment rates reflect the changing trends in the practice of medicine and current prices

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<sup>7</sup> Mohebi R, Chen C, Ibrahim NE, et al. Cardiovascular Disease Projections in the United States Based on the 2020 Census Estimates. *J Am Coll Cardiol.* 2022;80(6):565-578. doi:10.1016/j.jacc.2022.05.033

for inputs used in the PE calculations. This section of the NPRM includes CMS' proposals on these topics.

Subsections:

### **II.E.33 Chronic Pain Management and Treatment (CPM) Bundles (HCPCS GYYY1, and GYYY2)**

*Description:* CMS is proposing to create two HCPCS G-codes to describe monthly Chronic Pain Management services.

*PCC/Better Health – NOW Comment:* **We support this establishment of Chronic Pain Management and Treatment bundles.** Current reimbursement options, based on discrete services and/or visits, are not well-suited to support appropriate management of chronic pain. These reimbursement challenges have the potential to impair access and contribute to gaps in care, amidst burgeoning epidemics of addiction and poor mental health. More comprehensive payments could decrease the complexity of payment, reduce the documentation burdens on practices, and better support the complex, frequent tasks needed for chronic pain management.

### **II.E.34 Proposed Revisions to Physicians Services Regulation for Behavioral Health Services**

*Description:* CMS is proposing to amend the direct supervision requirement under its “incident to” regulation to allow behavioral health services to be furnished under the general supervision of a physician or other qualified professional when these services or supplies are provided by auxiliary personnel, such as a licensed social worker or licensed professional counselor, incident to the services of a physician or other qualified professional.

*PCC/Better Health – NOW Comment:* **We support amending the incident to regulation to allow behavioral health services to be furnished under general supervision.** With this new flexibility, primary care practices will be able to leverage a broader range of behavioral health professionals in the delivery of team-based integrated primary care.

### **II.E.35 New Coding and Payment for General Behavioral Health Integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)**

*Description:* CMS is proposing to create a new G code describing General BHI to account for monthly care integration where the mental health services furnished by auxiliary personnel, such as a CP or CSW, are serving as the focal point of care integration.

*PCC/Better Health – NOW Comment:* **We support reimbursing General BHI Integration services when a CP or LCSW is a focal point of care integration.** Relying on a CP or CSW to coordinate behavioral health integration activities is an appropriate care strategy within an overall care team.<sup>8</sup> This proposal will provide additional flexibility to primary care practices to design their workflows to best suit the needs of beneficiaries and the care team’s capacities.

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<sup>8</sup> Schragar SB. Integrating Behavioral Health Into Primary Care. *Fam Pract Manag.* 2021;28(3):3-4.

The recent Pain in the Nation report documents disparities in mental health by rurality and economic circumstances, and, for the first time in several years, there are proportionally more drug-induced deaths among the Black population than the white population.<sup>9</sup> Leveraging team-based primary care that includes behavioral health integration is fundamental to a more effective, more equitable response to the national mental health and addiction crises. CMS' proposal, along with those described in II.E.33 and II.E.34, will give primary care practices new options to respond to these disparities.

### **II.E.38 Request for Information: Medicare Potentially Underutilized Services**

*Description:* CMS is seeking comments on ways to identify specific services and to recognize/address possible barriers to improved access to high value, potentially underutilized services by Medicare beneficiaries.

*PCC/BHN Comment:* As of 2015, only 8 percent of US adults received all of the high-priority, recommended clinical preventive services and nearly 5 percent of adults did not receive any preventive services at all.<sup>10</sup> Evidence suggests one or more primary care visits per year are associated with an increased rate of patient utilization with evidence-based guidelines for preventative health interventions (including vaccinations, mammography, and colonoscopy) that have been shown to be directly related to improvements in health outcomes.<sup>11</sup> According to one nationally representative study, while patients with and without primary care had a similar number of healthcare encounters (office visits, ED visits, hospitalizations), patients with primary care had a significantly greater number of preventive visits compared to patients without primary care and were more likely to receive high value cancer screenings like colorectal cancer screenings and mammography, vaccinations, diabetes care, and counseling.<sup>12</sup>

Yet despite primary care's vital role in promoting preventive services, primary care itself is underutilized. Between 2002-2015, receipt of primary care decreased for every decade of age except for Americans in their 80s.<sup>13</sup>

This erosion of primary care is rooted in both the level of reimbursement and the payment structures employed to finance primary care. Historically low reimbursement for primary care and other services like behavioral health has resulted in an inadequate supply of primary care clinicians in our nation and reduced access to primary care for

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<sup>9</sup> Pain in the Nation: Alcohol, Drug and Suicide Epidemics. Trust for America's Health and Well-Being Trust. May 2021. [https://www.tfah.org/wp-content/uploads/2021/05/2021\\_PainInTheNation\\_Fnl.pdf](https://www.tfah.org/wp-content/uploads/2021/05/2021_PainInTheNation_Fnl.pdf)

<sup>10</sup> Borsky A, Zhan C, Miller T, Ngo-Metzger Q, Bierman AS, Meyers D. Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. *Health Aff (Millwood)*. 2018;37(6):925-928. doi:10.1377/hlthaff.2017.1248

<sup>11</sup> Hostetter, J., Schwarz, N., Klug, M. et al. Primary care visits increase utilization of evidence-based preventative health measures. *BMC Fam Pract* 21, 151 (2020). <https://doi.org/10.1186/s12875-020-01216-8>

<sup>12</sup> Levine DM, Landon BE, Linder JA. Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care. *JAMA Intern Med*. 2019;179(3):363-372. doi:10.1001/jamainternmed.2018.6716

<sup>13</sup> Levine DM, Linder JA, Landon BE. Characteristics of Americans With Primary Care and Changes Over Time, 2002-2015. *JAMA Intern Med*. 2020 Mar 1;180(3):463-466. doi:10.1001/jamainternmed.2019.6282. PMID: 31841583; PMCID: PMC6990950.

many families.<sup>14</sup> For example, office/outpatient evaluation and management (E/M) services — a category of Current Procedural Terminology (CPT) codes most commonly used in primary care — encompass activities that require significant investments of the clinician’s time, such as taking a patient’s history, examining the patient, and engaging in medical decision-making — services that cannot be easily replaced or optimized by advances in technique or technology. Yet procedures or services with a technical component can. As a result, Medicare fee-for-service payment, always reliant on an accurate assessment of time, tends to undervalue value primary care relative to other services. This payment approach has generated a progressive and systematic undervaluation of primary care, behavioral health and other cognitive-heavy components of whole-person, comprehensive care.

PCC and its Better Health – NOW Campaign participants have united around five broad recommendations, further developing the payment recommendations in NASEM’s 2021 report, *Implementing High-Quality Primary Care*. They include establishment of pathways to rapidly transition primary care payment from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model across payers and enhanced overall investment in primary care. Availability of such pathways in permanent federal programs, like Medicare Part B, has the potential to improve uptake of underutilized preventive services and whole person primary care in general. In our response comments on the Medicare Shared Savings Program below, we outline one such pathway and encourage CMS to engage stakeholders in developing it.

Additionally, we wish to highlight three specific barriers to certain high-value services that should be addressed. Medicare does not allow the certification required for diabetic shoes to be performed by NPs or PAs. Medicare has erected similar barriers to ordering Medical Nutrition Therapy despite its proven role in addressing obesity, diabetes and other chronic conditions. Finally, Medicare Part B does not cover or reimburse for the Medicare Diabetes Prevention Program by CDC when delivered virtually. Despite the increasing prevalence of chronic conditions, primary care practices, including those participating in ACOs, and their patients encounter these barriers to high-value care. We encourage CMS to address them promptly.

## **II.E.41 Comment Solicitation on Payment for Behavioral Health Services under the PFS**

*Description:* CMS is soliciting comment on how CMS can best ensure beneficiary access to behavioral health services, including any potential adjustments to the PFS rate-setting methodology.

*PCC/Better Health – NOW Comment:* The mental health and addiction epidemics, along with glaring behavioral health disparities, have underscored the need for broad access to whole-person care, responsive to medical, behavioral, and social needs. Existing payment and time-limited grants, though important and needed, remain incommensurate with the scale of this crisis. CMS should act boldly across permanent programs to respond to these ongoing epidemics. **Over the medium- to long-term,**

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<sup>14</sup> Medicare Payment Advisory Commission (MedPAC), “Chapter 5: Issues in Medicare Beneficiaries’ Access to Primary Care,” in Report to Congress: Medicare and the Health Care Delivery System, June 2019, [http://www.medpac.gov/docs/defaultsource/reports/jun19\\_ch5\\_medpac\\_reporttocongress\\_sec.pdf](http://www.medpac.gov/docs/defaultsource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf).

**HHS should use its various demonstration authorities to develop and test prospective primary care payment models, such as per-member per-month, that adequately support integrated advanced primary care inclusive of whole-person services addressing both physical and behavioral health care needs.**

To meet the immediate crisis in mental health and addiction, we suggest three policy steps below:

- **Promote Medicare’s existing collaborative care and behavioral health integration codes.** Existing behavioral health integration codes, currently available in the Medicare Physician Fee Schedule, are underutilized in Medicare relative to the prevalence of behavioral health conditions among beneficiaries. Existing Medicare payment values for behavioral health integration should be reassessed to determine whether they are sufficient to expand utilization and meet the exigencies of the present crisis.
- **Waive the Medicare Fee Schedule Budget Neutrality Requirements for Primary Care - Behavioral Health Integration.** The Medicare Physician Fee Schedule’s budget neutrality requirements are a barrier to increased payment for and utilization of new payment codes for primary care-behavioral health integration. When new codes are adopted, these neutrality requirements can result in across-the-board cuts that affect other primary care services. Insofar as Medicare depends on fee-based payment to expand access to integrated behavioral health care in the current behavioral health crisis, CMS should seek Congressional authority to exempt new investments in behavioral health integration codes from the current fee schedule budget neutrality requirements. One approach would be to establish a new code available as an add-on code for all Evaluation and Management claims when a practice can demonstrate the capacity for integrated behavioral care. Such a code would complement and support broader utilization of the existing behavioral health codes, rather than replacing them. Practices would be required to attest to certain core functionalities, such as the ability to screen for behavioral health challenges, offer care management, medication management, participate in measurement-based care through a registry, deliver short-term psychosocial therapy in the practice, and integrate evidence-based treatment for behavioral health conditions, either in person or virtually.
- **Remove expenditures on Collaborative Care Management (CoCM) and BH Integration codes from the expenditures compared against spending benchmarks in MSSP and other benchmark-based payment models.** CMS has set a goal of having all Medicare beneficiaries in a relationship with a provider accountable for the quality and cost of care. We believe accountable payment has the potential to support broader adoption of behavioral health-primary care integration. Yet as currently structured, because expenditures associated with delivering the services can increase spending over the short-term, benchmark-based payment models like MSSP have a built-in disincentive to the delivery of and billing for integrated behavioral health. Upon conclusion of the PHE and the 151-day period following, we are also concerned that this same disincentive may discourage ACO practices from utilizing recently finalized telemental health flexibilities, established by the Consolidated Appropriations Act of 2021.

## **II.E.36. Request for Information: Medicare Part B Payment for Services Involving Community Health Workers (CHWs)**

We deeply appreciate this request for information and applaud CMS for offering it. **To promote whole-person care and achieve health equity, CMS should aim to support the full range of services provided by community health workers (CHWs), consistent with statute. Medicare’s approach to financing CHWs should provide adequate funding, meaningful quality guardrails, and assurance that CHW roles and identities are preserved and not over-medicalized.**

CHWs are trustworthy individuals who partner with individuals and families in their own communities to improve health. CHWs find and meet people where they are, get to know their clients’ life stories, and ask each client what she thinks will improve her life and health. CHWs then provide tailored support based on these needs and preferences.

Broader support for CHWs could offer substantial value to Medicare primary care—particularly in communities impacted by health inequities. As one example, the Penn Center for Community Health Workers developed IMPACT, a standardized, scalable CHW program. IMPACT, which has been tested in three randomized controlled trials, improves chronic disease control, mental health, and quality of care while reducing total hospital days by 65%.<sup>15</sup> IMPACT has provided a \$2.47 to \$1 annual return on investment for the Medicaid program.<sup>16</sup>

**Increasing investment in primary care and shifting more of that payment from defined fee-based reimbursement to more comprehensive, flexible approaches is not just an essential step toward equity and value in Medicare. Primary care payment reform and investment can also facilitate integration with and investment in CHWs.** However, primary care payment alone cannot ensure that CHWs take their proper role in Medicare.

Community-based organizations that employ CHWs can play a particularly important role in ensuring Medicare beneficiaries fully benefit from CHW work. These organizations often retain much of the community knowledge and trust which make CHW interventions so effective in communities where the usual medical system lacks reach or trust. CMS’ strategy for incorporating CHWs in Medicare should focus on leveraging Community Based Organizations (CBOs) that employ CHWs. In shaping its strategy, the agency should do more than consult with health care practices, plans and systems that employ CHWs. **We strongly recommend CMS convene and engage with CHW organizations, CBOs and other non-clinical CHW employers with the goal of crafting an approach that strengthens the community-based workforce and infrastructure.**

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<sup>15</sup> Vasan A, Morgan JW, Mitra N, et al. Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials. *Health Serv Res.* 2020;55 Suppl 2(Suppl 2):894-901. doi:10.1111/1475-6773.13321

<sup>16</sup> Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. *Health Aff (Millwood).* 2020;39(2):207-213. doi:10.1377/hlthaff.2019.00981



## **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.)**

*Overview:* CMS proposes to add the new chronic pain management and BHI services to the RHC and FQHC specific general care management HCPCS code, G0511, to align with the proposed changes made under the PFS for CY 2023.

*PCC/Better Health – NOW Comment:* RHCs and FQHCs are vital to quality care for communities most impacted by health inequities. **We support Medicare reimbursement for new chronic pain management and BHI services in these FQHC and RHC settings, consistent with similar proposals for those practices that rely on the physician fee schedule** (i.e., proposals described in II.E.33 and II.E.35).

## **Medicare Shared Savings Program (III.G)**

*Overview:* Today, nearly eleven million traditional Medicare beneficiaries receive care from MSSP ACOs. ACOs are groups of physicians, hospitals, and health care providers that agree to be accountable for the cost and quality of care delivered to their attributed beneficiaries. Under the Shared Savings Program, practices, providers, and suppliers that participate in an ACO continue to receive traditional Medicare FFS payments under Parts A and B. However, the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements, and in some instances may be required to share in losses if it increases health care spending. In this NPRM, CMS offers several proposals aimed at restarting plateaued MSSP participation, respond to underrepresentation of high-spending beneficiaries and correct for inequitable access to MSSP for racial/ethnic minority populations.

*Overall Comment:* To date, the most successful ACOs have been built upon a strong base of primary care. PCC's 2018 Evidence Report documented a clear correlation between ACO cost/quality performance with the proportion of those ACOs' practices which were patient-centered medical homes.<sup>17</sup> Indeed, CMS officials have signaled an explicit strategy to use the MSSP to synthesize and scale successful design features from multiple value-based payment programs. These features make the MSSP a powerful vehicle for redesigning overall primary care payment with a focus on improving health. **PCC and the BHN Campaign commend CMS for its thoughtful proposals to strengthen MSSP and improve participation among practices caring for rural and other underserved communities.** We provide detailed comment on specific proposals below.

**However, to realize MSSP's potential to advance value, quality and equity, bolder steps will be needed in future rulemaking.** As discussed above, the failings of fee-for-service reimbursement under-resource primary care practices, thereby eroding patients' timely, affordable access and undermining health equity. The MSSP as currently implemented does not offer an alternative to the fee-based reimbursement chassis for those ACOs that are prepared for a more advanced participation option.

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<sup>17</sup> Jabbarpour Y, et al. Advanced Primary Care: A Key Contributor to Successful ACOs. Primary Care Collaborative. 2018. <https://www.pcpcc.org/resource/advanced-primary-care-key-contributor-successful-acos>

The dependence on fees as the primary source of payment presents a barrier to further progress. Without bolder action to comprehensively finance primary care across traditional Medicare, employers, plans, states, and clinical organizations will continue to encounter barriers to scaling their primary care investments and reforms.

NASEM has argued that “CMS should increase the overall portion of spending going to primary care” while transitioning to a hybrid payment model for primary care comprised of both prospective payment and fee-for-service payment.<sup>18</sup> CMS should fully leverage its statutory authorities within permanent programs to move us closer to that goal.

**PCC and the Better Health – NOW Campaign call on CMS to offer Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) a hybrid primary care payment option with both population-based, prospective payment and fee-for service components.**

The population-based, prospective payment component should account for most of a practice’s payment and offer the flexibility to optimize the mix of services, as well as support diverse activities practices perform but are not paid for now, such as team-based care, emails and phone calls. Services such as hospital visits and health-critical services like immunizations would continue to be paid fully fee-for-service, to encourage their delivery. Payment levels for the population-based payment component should reflect significant increases over current reimbursement levels for the relevant services, to adequately compensate PCPs and allow them to invest the time necessary for addressing patients’ mental health and social needs. CMS should adjust population-based payments for patient complexity. Adjustments should also reflect the socioeconomic status of beneficiaries. CMS could consider multiple approaches to incorporate social risk, such as risk adjusting the population-based prospective payment, applying a separate health equity benchmark adjustment (as in ACO REACH), or some other approach. Because some services may be “invisible” to patients, such as practices’ reaching out to social service agencies for patients with complex needs, we suggest using MSSP’s waiver authority to remove patient cost-sharing for the population-based, prospective payment.

As a first step to developing such a hybrid payment approach, we recommend that CMS seek public input to inform design and implementation, as well as other possible pathways to support prospective population-based payment in Medicare. **We ask that CMS issue a Request for Information on a hybrid primary care payment option in MSSP at the earliest opportunity, potentially released with the CY 2023 Medicare Part B Physician Fee Schedule final rule.**

Primary care professionals are trained to focus on the health of the whole person, rather than one aspect of health, disease state, or bodily system. This makes primary care teams uniquely positioned to coordinate across physical health, mental health services, substance use disorder care, and social care. This is particularly crucial for Medicare beneficiaries, especially those facing health inequities, complex medical needs or unmet non-medical social needs.

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<sup>18</sup> National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/259>

The predominant fee-based payment methodology cannot adequately and consistently support such comprehensive care, but comprehensive, prospective payment can provide the resources and flexibility practices need to build and sustain robust care teams.

A hybrid payment option would represent one important step toward aligning Medicare's payment with leading private purchasers,<sup>19,20</sup> sophisticated MA plans,<sup>21</sup> and statewide multi-payer initiatives.<sup>22,23</sup> Making a primary care hybrid payment option available nationwide on a permanent basis could also prove more attractive to potential participants than more limited scope and limited duration model tests.

Under current law, CMS has the authority to make such a hybrid payment option available across Medicare. Specifically, under 42 U.S.C. 1395jjj (i), CMS has explicit authorization to implement partial capitation or alternative payment methodologies. Under 42 U.S.C. 1395jjj (f), Congress granted the agency certain waiver authorities for the express purpose of implementing MSSP.

## **Shared Savings Program Participation Options (III.G.2.)**

### **III.G.2.a. Advance Investment Payments (AIP)**

*Description:* CMS proposes to increase participation in accountable care models in underserved communities by providing an option for Advance Investment Payments to certain ACOs. Drawing on lessons learned in the ACO Improvement Model, the NPRM states that the payments are “designed to assist ACOs that face difficulty funding the start-up costs for forming ACOs, caring for beneficiaries in underserved communities, and achieving long term success in the Shared Savings Program.”

*PCC/Better Health – NOW Comment:* **The Advance Investment Payment proposal is a positive step forward.** The ACO Investment Model demonstrated that upfront resources for ACOs in rural and low-ACO-penetration areas can facilitate success in the program, lower program spending and maintain quality.<sup>24</sup> Smaller and independent primary care practices, as well as those serving underserved communities, often require support and technical assistance to effectuate the transition to new care delivery and payment models. The new Advance Investment Payments have the potential to help more such practices participate - and facilitate investment in social care

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<sup>19</sup> Primary Care Payment Reform Workgroup. Purchaser Business Group on Health.

<https://www.pbgh.org/initiative/primary-care-payment-reform-work-group/>

<sup>20</sup> Japinga M, et al. A Pathway for Coordinated, Affordable Employer-Sponsored Health Care.

Duke Margolis Center for Health Policy. September 2021.

<https://healthpolicy.duke.edu/publications/pathway-coordinated-affordable-employer-sponsored-health-care>

<sup>21</sup> Physicians Provide Higher Quality Care Under Set Monthly Payments Instead of Being Paid Per Service, UnitedHealth Group Study Shows. Businesswire. August 2020.

<https://www.businesswire.com/news/home/20200811005082/en/>

<sup>22</sup> California Advanced Primary Care Initiative. California Quality Collaborative & Integrated Healthcare Association. <https://www.pbgh.org/wp-content/uploads/2022/07/California-Advanced-Primary-Care-Initiative-MOU.pdf>

<sup>23</sup> Kumar S. Washington Health Plans Commit to Improving Primary Care Through Multipayer Model. Milbank Memorial Fund. November 2020. <https://www.milbank.org/news/washington-health-plans-commit-to-improving-primary-care-through-multipayer-model/>

<sup>24</sup> ACO Investment Model (AIM): Final Evaluation of Three AIM Performance Years. Center for Medicare and Medicaid Innovation. <https://innovation.cms.gov/data-and-reports/2020/aim-fg-finalannrpt>

integration processes needed to appropriately serve communities. Providing upfront capital to these practices, as well as federally-qualified health centers and rural health centers, will help CMS achieve its goal of moving all Medicare beneficiaries into accountable care relationships by 2030. **We urge CMS to ensure these safety-net practices and facilities can benefit from the AIP.** More generally, we encourage CMS to continue identifying features from public and private payment models and crafting proposals that make them broadly available to Medicare clinicians and their patients.

### **III.G.2.b. Smoothing the Transition to Performance-Based Risk**

*Description:* CMS is proposing to allow certain MSSP ACOs more time under one-sided risk. Specifically, for certain ACOs including those that are inexperienced with performance-based risk, the proposed rule would allow up to seven years in one-sided risk before transitioning to two-sided risk. CMS is also proposing to remove the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track; participation in the more exacting risk requirements of the ENHANCED track would be optional. These proposals address commenters' concerns that requiring a rapid transition to downside risk has deterred participation, particularly by small and rural practices and in underserved communities.

*PCC/Better Health – NOW Comment:* The appropriate role of downside risk in MSSP overall has been debated since the program's inception. Yet as CMS clearly documents in the NPRM, the facts are clear. Current policy deters participation, reduces overall number of beneficiaries who might benefit from MSSP, and makes MSSP less equitable. A new approach, like that proposed in the NPRM, is needed. We agree that CMS' CY 24 proposals would encourage MSSP participation by small and independent practices, as well as those working in underserved communities.

### **III.G.4.b(7) Health Equity Adjustment for ACOs that Report All-payer eCQMs/MIPS CQMs, and are High Performing on Quality, and Serve a High Proportion of Underserved Beneficiaries**

*Description:* CMS is proposing to implement a health equity adjustment of up to 10 bonus points to an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs, for the purposes of payment only.

*PCC/Better Health – NOW Comment:* **We agree that that a health equity payment adjustment is a promising approach with potential to support health equity in the MSSP.** Practices serving underserved populations systematically tend to show lower performance on quality measures, creating a disincentive for ACOs to serve these populations. To ensure this proposal has its intended effects of encouraging participation in MSSP and advancing health equity, we recommend CMS also apply the health equity adjustment to ACOs reporting via the Web Interface. To ensure that implementation of any adjustment does not shield disparities and outcomes, CMS should work with MSSP ACOs toward quality reporting, disaggregated across sub-populations.

### **III.G.5 Financial Methodology**

*Description:* CMS proposes to expand opportunities for certain low revenue ACOs participating in the BASIC track to share in savings even if they do not meet the minimum savings rate (MSR). The intent is to allow for investments in care redesign and quality improvement activities among less capitalized ACOs.

*PCC/Better Health – NOW Comment:* **This proposal is a constructive step forward.** We share CMS' hope that it will support smaller ACOs, including those with small and independent primary care practices and those with underserved patient populations.

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### **Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H.)**

*Overview:* In this proposed rule, CMS is proposing refinements to the payment amount for preventive vaccine administration under the Medicare Part B vaccine benefit.

*Overall Comment:* Studies show that higher vaccine administration payment rates are associated with higher rates of utilization.<sup>25</sup> We appreciate that CMS listened to comments from PCC, MedPAC and others about the importance of updating Part B vaccination payment. **We continue to urge CMS to consider an innovative payment methodology – one that would more effectively capture the value of vaccinations and optimize vaccination rates for Medicare beneficiaries than the traditional cost-based payment methodology.**

CMS must also do more to promote vaccine literacy. Patient conversations with trusted primary care clinicians are indispensable to combatting misinformation – even when they do not immediately result in a vaccination. **Both Medicare and Medicaid should make payment and coverage available for CPT code 99401 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)).**

#### Subsections:

#### **III.H.2.c. Proposed Adjustment to the Payment Amount for Administration of Preventive Vaccines for Geographic Locality**

*Description:* CMS proposes a geographic adjustment policy that would apply to preventive vaccine administration services for CY 2023 and subsequent years.

*PCC/Better Health-NOW Comment:* **We support establishing a geographic adjustment policy, to reflect increased costs of vaccine administration in some localities.**

#### **III.H.2.d. Proposed Annual Adjustment to the Payment Amount for Administration of Preventive Vaccines to Reflect Changes in Cost**

*Description:* To account for the change in costs of administering preventive vaccines, CMS is proposing to update the payment amount (that is, \$30) established in the CY 2022 PFS final rule for the administration of preventive vaccines based upon the annual increase to the MEI.

*PCC/Better Health-NOW Comment:* **We support updating the payment amount for preventive vaccines**

#### **III.H.3.c. Proposal for CY 2023**

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<sup>25</sup> Tsai Y. Payments and Utilization of Immunization Services Among Children Enrolled in Fee-for-Service Medicaid. *Med Care.* 2018;56(1):54-61. doi:10.1097/MLR.0000000000000844

*Description:* CMS believes continuing the additional payment for at-home COVID-19 vaccinations for another year would provide CMS time to track utilization and trends associated with its use, and thereby inform policy for CY 2024.

*PCC/Better Health-NOW Comment:* **We appreciate and support CMS' decision to extend an additional payment for at home delivery of the COVID-19 vaccinations.**

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PCC and our Better Health-NOW campaign appreciate this opportunity to provide comment on the proposed rule and look forward to working with the CMS team to strengthen primary care in Medicare. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at [lmcneely@thepcc.org](mailto:lmcneely@thepcc.org).

Sincerely,



Ann Greiner  
President & CEO  
Primary Care Collaborative