September 11, 2023

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Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Re: 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 (CMS–1784–P)

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 this Notice of Proposed Rulemaking (NPRM).

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 70 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). In March 2022, PCC launched the Better Health – NOW (BHN) campaign to realize bold policy change rooted in a simple principle: We need strong primary care in every community so we can achieve better health for all.

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.[1] [2] 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.[3]

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[1] 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
[2] Shi L. The impact of primary care: a focused review. Scientifica (Cairo). 2012;2012:432892. doi:10.6064/2012/432892
[3] Kempski A, Greiner A. Primary Care Spending: High Stakes, Low Investment. Primary Care Collaborative – Executive Summary. December 2020. https://thepcc.org/sites/default/files/resources/Executive_Summary-PCC_2020.pdf -0

Today, after years of this erosion in investment in primary care and challenges associated with the pandemic, primary care in the United States has reached a crisis point.[4] Bold policy changes are urgently needed - changes capable of transforming both how much health care payers invest in primary care and the payment models through which those resources flow.

Primary Care Investment in Medicare Part B

Over time, policy choices guiding Medicare Part B's fee-based payment structure have generated distortions that have systematically undercut investment in primary care[5] and undermined health equity.[6] Improvements to office/outpatient Evaluation and Management valuations in the CY 2021 rule and updates to clinical labor pricing begin to correct for important flaws in the PFS. However, as CMS accurately concludes in this year's NPRM, those changes alone do not "fully account for the resource costs associated with primary care and other longitudinal care of complex patients."[7]

This persistent under-resourcing of primary care undermines the health of Medicare beneficiaries and the sustainability of the primary care workforce. Moreover, because all Medicare APMs and most private APMs are built upon Medicare PFS valuations to one extent or another, shortcomings in Medicare's support for primary care are magnified throughout the nation's health care system.

It is essential, therefore, that CMS continues to refine the Medicare fee schedule in ways that support comprehensive, longitudinal and team-based primary care. In this regard, the proposed rule would take additional steps forward. We strongly support:

- Implementation of the proposed G2211 inherently complex care add-on 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. By paying clinicians for providing this highly effective, low-cost care, G2211 will help improve patient and population health outcomes and strengthen the Medicare program. We appreciate that CMS has revised its assessment of this policy's impact on the conversion factor. However, we encourage CMS to further reevaluate those assumptions to align with experience with coding for newly introduced services.
- Increased valuation of General Behavioral Health Integration Care Management (CPT code 99484, and HCPCS code G0323). This policy is a helpful step toward promoting evidence-based models of behavioral health integration within primary care practices, such as the Primary Care

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[4] Larry A. Green Center & the Primary Care Collaborative. QUICK COVID-19 PRIMARY CARE SURVEY SERIES 37 FIELDED MARCH 13-19, 2023. Forthcoming.
[5] MedPAC (Medicare Payment Advisory Commission). 2006. Report to the Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission.
[6] McNeely, L., Douglas Megan, Westfall, N., Greiner, A., Gaglioti, A., & Mack, D. (2022). PRIMARY CARE: A Key Lever to Advance Health Equity. The Primary Care Collaborative. https://thepcc.org/sites/default/files/resources/PCCNCPC%20Health%20Equity%20Report.pdf
[7] Re: 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. 88 F.R. 52262 (proposed August 7, 2023)

Behavioral Health model. (See below for our comments below on how to promote broader implementation of the Collaborative Care Model as well.)

- Medicare Part B Payment for Preventive Vaccine Administration Services
  CMS' proposals to extend enhanced payment for in-home delivery of COVID-19 vaccine and expand that enhanced payment to all Part B vaccines (pneumococcal, influenza and hepatitis B) are sensible steps that will help extend the benefits of preventive vaccinations to more Medicare beneficiaries, particularly those who may face difficulty accessing transportation or limitations to mobility.

As patients and their communities face a crisis in primary care access and workforce, these investments are absolutely necessary, yet they are only a start. Further action will be necessary to realize better health and deliver whole-person primary care for all Medicare beneficiaries. Primary care practices require further investments to support robust clinical teams and retain clinicians. They also need workable pathways to transition from FFS to population-based, prospective payment. Our comments below on Evaluating E/M Services and Strengthening Primary Care in ACOs are aimed at realizing those objectives.

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

We appreciate the agency's request for further comment on this issue. The Medicare Payment Advisory Commission has long advised policymakers to address the underpricing of PC services in FFS.[8] The National Academies of Science, Engineering, and Medicine (NASEM) 2021 consensus report concluded that the current approach to FFS valuation has "resulted in systematically devaluing primary care services relative to other services and its population health benefit..."[9]

Relationship-based care for patients is fundamental to the practice of primary care and the health of beneficiaries alike; it can support longitudinal care outcomes and sustained patient engagement. To better support such care, policymakers must create pathways to rapidly transition primary care from a predominantly fee-for-service model to predominantly population-based prospective payment (hybrid) models coupled with up-front and ongoing investments and guardrails to assure quality and access in rural and underserved communities.

Nonetheless, as remarked above, all Medicare APMs and most APMs utilized by other payers continue to rely on Medicare PFS valuations to some extent. Striving for more accurate and equitable valuation is essential – both for beneficiaries attributed to APMs and for those who are not. Ensuring that FFS payments fully support and invest in primary care services will secure primary care access in beneficiaries' own neighborhoods, drive meaningful quality improvement, and advance equity. Comprehensive and sustainable primary care payment enables practices to accept more

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[8] MedPAC (Medicare Payment Advisory Commission). 2006. Report to the Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission.
[9] 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/10.17226/25983.

low-income patients and is associated with better health access.[10] [11] Therefore, we encourage CMS to look expansively at ways to both improve E/M valuation and the effectiveness of its overall approach to supporting primary care.

One possible approach would be to create a new expert panel that could help CMS ensure E/M and other primary care services are appropriately valued using the best available data to reflect the complexity of care delivered. This expert panel can ensure that these services are evaluated at more regular intervals, limiting significant redistributive effects associated with major valuation and policy changes as we have seen in recent years. An assessment of available data and the resulting data driven policy recommendations will stabilize what has evolved to become an irregular process and help ensure primary care is fairly valued in the MPFS, which may also have the added benefit of improving access to a well-trained primary care workforce.

Strengthening Primary Care in ACOs

Comments on Potential Future Developments to Shared Savings Program Policies - Background (Section III.G.8.a)

We thank CMS for its acknowledgment of the value of prospective population-based primary care payment within MSSP.

As you know, in a letter dated March 22nd led by PCC and NAACOS, twenty-seven stakeholders jointly called for a new, hybrid approach to paying for primary care in the MSSP. Our proposal would offer practices a combination of prospective and fee for service payments to bring better health outcomes, greater equity, and lower costs. The letter advanced six principles for the design of this MSSP hybrid primary care payment option:

- Equity considerations must be embedded in the hybrid payment option.
- There will be added value for the Medicare beneficiary.
- The option must result in increased investment in primary care.
- The option must be fully voluntary.
- The option must be available rapidly and in all geographies.
- Implementing this option will create additional value for Medicare.

We deeply appreciate the CMS team's active engagement on our proposal and urge the agency to move toward making this model available as soon as possible.

Discussions with BHN Campaign participants and other stakeholders have identified additional design features for this MSSP hybrid primary care payment option. Together, these features would ensure that such a model can maximize progress toward CMS' value and health equity goals.

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[10] Candon M, Zuckerman S, Wissoker D, et al. Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients. JAMA Intern Med. 2018;178(1):145–146. doi:10.1001/jamainternmed.2017.6302

[11] Increased Medicaid Reimbursement Rates Expand Access to Care. (2019). National Bureau of Economic Research. https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care

Ensure that Investment Reaches Primary Care: To promote the widest participation, the model's design must provide primary care practices with assurance that they will share directly in additional financial incentives. Meaningful participation of *primary care* clinical leaders in ACO governance is one powerful means to that end and should be incorporated into the model. Insofar as current policy already requires submission of ACO contracts with participating practices to CMS, an additional, auditable within-performance-year attestation that payment is proceeding as mutually agreed could provide additional assurances to primary care practices. Such an attestation could also allow CMS to ensure model funds are being used for their intended purpose – to invest in primary care practices' ability to provide comprehensive, patient-centered care.

Enable All MSSP Tracks to Participate: The added flexibility and increased revenue associated with our proposed model is likely to encourage primary care practice participation in MSSP. The hybrid model approach would provide primary care practices with prospective, population-based payments, which more effectively support the provision of high-quality primary care, thus attracting new participants. Further, data clearly demonstrate that primary care is essential to the success of the Shared Savings Program, with physician-led ACOs achieving significantly greater shared savings and ACOs with more primary care clinicians also achieving greater success.[12] To maximize MSSP participation both overall and specifically in rural and underserved communities, the hybrid option should be made available across all MSSP BASIC and ENHANCED tracks.

Provide Greater Incentives for Independent Practices and Those Serving Rural or Underserved Communities: As envisioned in our March 22nd letter, this model concept aims to increase investment for all participating primary care practices. However, securing truly equitable participation will require additional steps. CMS should provide an enhanced, regular population-based payment for ACOs composed of practices that are independent or serve rural and underserved communities. Such ACOs should also be given additional time before reconciling payments against benchmarks.

Support Participation by Practices that are Small, Independent or New ACO models: Small, independent, or new entrants should be eligible for both the Advanced Incentive Payment (AIP) and hybrid primary care payment. To support the formation of ACOs CMS could also provide an entry point at a lower beneficiary alignment threshold, like the new entrant track of ACO REACH.

Allow Choice of Payment Approach: Because ACOs and primary care practices may have varying capabilities for managing population-based payments, the model should allow per-beneficiary payment to be paid either directly to the practice or to the ACO. To meet both practices and ACOs where they are and support broader participation, we advocate two payment approaches within the hybrid primary care payment option, described below.

- *Approach 1:* CMS pays prospective and per-visit payments directly to the primary care practices, with a portion paid to the ACO as the practices should mutually agree.

[12] *Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-Quality Care | CMS*. https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high. Accessed 6 Sept. 2023.

- *Approach 2:* CMS makes payments directly to the ACO, which administers the capitated payments to participating primary care practices. This approach is similar to the methodology being tested in the ACO Realizing Equity, Access, and Community Health (REACH) Model and is likely most suitable for ACOs with the experience and infrastructure to pay practices. Participating ACOs would be required to provide assurance and verification that additional investments reach primary care and benefit beneficiaries.

Consider Incorporating Successful Features of Other CMS Innovation Center Models: We encourage CMS to review experiences with, and build upon specific features of, other CMS Innovation Center models including, but not limited to,

- *Better access to data* – Managing populations requires access to data to understand patients, their health, their needs and where they are seeking care. The Next Generation ACO model provided data dashboards that were well-received. This information could be useful for primary care practices participating in the hybrid option.
- *Paper-based voluntary alignment* – ACO REACH's paper-based voluntary alignment has been well utilized and helps clinicians and ACOs better engage patients.
- *Cost-sharing relief:* Cost-sharing relief is needed for any services covered by the per-beneficiary payment. Practices and attributed beneficiaries may also benefit from additional cost-sharing support flexibilities.

MSSP Attribution Policy/Patient Matching (Section III.G.3)

We support CMS' proposed expanded window for assignment to an ACO. This would allow for attribution of beneficiaries based on primary care services from other ACO-affiliated primary care clinicians over the past 12 months, provided they had seen an ACO-participating physician within the past 24 months.

RFI: Incorporating a Higher Risk Track than the ENHANCED Track (into MSSP) (Section III.G.8.b)

With the ACO REACH model scheduled to conclude in 2026, CMS is considering incorporating an MSSP track with a higher level of risk (responsibility for shared savings or losses) within the statutory MSSP program.

We agree that a higher-risk track in MSSP has the potential to retain and attract participation and help CMS attain its goal of having all beneficiaries in the traditional Medicare program in a care relationship with a health care provider who is accountable for the costs and quality of their care. Some organizations have demonstrated the ability to leverage higher risk payment models to support and strengthen primary care through partnerships with Medicare Advantage Organizations or private commercial payers or through participation in the Next Gen ACO and ACO REACH. A higher risk track in MSSP could harness these improvements in service to better health for Medicare Part B beneficiaries.

However, whether such a higher-risk track will, in practice, promote improvement in primary care will depend on the specifics of its design and implementation. So, we are pleased CMS is seeking stakeholder feedback on these issues.

BHN could support a higher risk track if that track was properly designed to bolster the Medicare program, primary care access and the health of beneficiaries. Specifically, a Higher Risk Track should include:

- Strong beneficiary protections – informed by protections established in ACO REACH;
- Safeguards to ensure investments reach primary care, similar to those we suggested above in our discussion of primary capitated payment across MSSP; and
- Adoption of a population-based, prospective payment approach for primary care within the Enhanced Risk track.

Whole-Person Primary Care

PCC applauds the steps taken in this NPRM to better support whole-person primary care, by improving reimbursement for behavioral health integration, lifestyle change interventions and integration of SDoH-related services. A substantial body of research suggests comprehensiveness of primary care is associated with improved outcomes.[13] [14] Access to comprehensive, integrated care is particularly important to communities that are structurally disadvantaged by discrimination and other social drivers as well as those with complex medical and behavioral health needs.

Reimbursement must support robust multidisciplinary primary care teams that can meet the needs of the diverse beneficiaries that rely on Medicare and connect those beneficiaries to other medical and social services as appropriate. Several CMS' proposals, addressed below, would move Medicare in this direction, furnishing Medicare primary care practices with the financial resources needed to build and support these robust teams.

Lifestyle Change and Self-Management: Lifestyle interventions can be effective components of successful management of chronic conditions and health risks. We strongly support the addition of lifestyle counseling to Medicare's list of covered telehealth services. We are pleased to support proposed changes to the DPP Expanded Model, including the simplified payment structure and alignment of definitions between MDPP and CDC Recognition. CMS proposals to allow for virtual delivery of Diabetes Self-Management Training (DSMT) and non-MD/DO clinicians to order DSMT are a step forward for beneficiary access to these services.

Social Care: Understanding a patient's health-related social needs can inform clinical care and can, in certain circumstances, help connect patients to community resources that improve health.[15] PCC and the Better Health – NOW Campaign supports the establishment of Caregiver Education, Community Health Integration (GXXX1, GXXX2), and Principal Illness Navigation (GXXX3, GXXX4) codes.

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[13] O'Malley, Ann S., et al. "Practice-site-level Measures of Primary Care Comprehensiveness and Their Associations with Patient Outcomes." *Health Services Research*, vol. 56, no. 3, June 2021, pp. 371–77. *DOI.org (Crossref)*, https://doi.org/10.1111/1475-6773.13599.
[14] Starfield B. Primary Care: Balancing Health Needs, Services, and Technology. New York, NY: Oxford University Press; 1998:1998.
[15] Davidson, K. W., Kemper, A. R., Doubeni, C. A., Tseng, C. W., Simon, M. A., Kubik, M., Curry, S. J., Mills, J., Krist, A., Ngo-Metzger, Q., & Borsky, A. (2020). Developing Primary Care-Based Recommendations for Social Determinants of Health: Methods of the U.S. Preventive Services Task Force. Annals of internal medicine, 173(6), 461–467.

To promote equitable access to CHI services, we encourage CMS to revise its proposed definition of a CHI initiating visit. An Annual Wellness Visit, if conducted as part of an ongoing care relationship, and certain targeted BH services, including CPT codes for psychiatric diagnostic evaluation (90791) and health behavior assessment, or re-assessment (96156), should be included in the definition of a CHI initiating visit. Unlike certain E/M services, such as inpatient/observation visits, ED visits, and SNF visits, which CMS specifically noted would not typically serve as CHI initiating visit, these services are typically delivered by providers in settings that would typically provide continuing care to the patient.

As growing mental health and substance use challenges confront communities around the country, primary care practices are increasingly turning to peer support specialists in their interprofessional teams. To ensure the new PIN and CHI services fully support peer support specialists, CMS should consider establishing a regulatory definition of peer support specialists and work with stakeholders to ensure the PIN adequately reflects and supports the education, support, and empowerment that are core peer support activities.

CMS's proposals to reimburse for SDoH risk assessment (GXXX5) and allow a social determinants of health risk assessment to be included as a billable element of the annual wellness visit are also important steps toward social care integration. Payment for risk assessment in MPFS would promote their incorporation into regular practice.

However, CMS can further improve on its proposals in two specific ways:

- Allow FQHCs to bill separately for SDoH screening: Although health centers have championed health-related social needs screening, adoption has not been universal or without challenges in implementation.[16] Denying health centers separate reimbursement for that assessment only imposes further pressure on resources for these essential primary care institutions.
- Recognize additional codes as eligible to be reported as part of the Annual Wellness Visit: Psychiatric diagnostic evaluation (90971), Health behavior assessment or re-assessment (96156), Neurobehavioral status exam (96116). Like social risks, behavioral health challenges and health risks can be crucial to Medicare beneficiaries' overall outcomes and care trajectory. In conjunction with the Annual Wellness Visit, primary care practices should have the option of providing these services as well.

As the agency moves forward with these and future efforts, we encourage CMS to acknowledge the challenges associated with integrating social care with primary care. Primary care practices, particularly those in underserved communities, are often under-resourced themselves. Many of the social services to which primary care might refer may lack capacity and funding.[17] One recent study found substantial costs associated with

[16] Ackerman, Sara L., et al. "'We Were Trying to Do Quality versus Quantity': Challenges and Opportunities at the Intersection of Standardized and Personalized Social Care in Community Health Centers." *SSM - Qualitative Research in Health*, vol. 3, June 2023, p. 100267. *DOI.org,* https://doi.org/10.1016/j.ssmqr.2023.100267.s

[17] Kreuter, Matthew, et al. "Assessing The Capacity Of Local Social Services Agencies To Respond To Referrals From Health Care Providers: An Exploration of the Capacity of Local Social Service Providers to Respond to Referrals from Health Care Providers to Assist Low-Income Patients." *Health Affairs*, vol. 39, no. 4, Apr. 2020, pp. 679–88. *DOI.org*, https://doi.org/10.1377/hlthaff.2019.012566

fully and systematically addressing unmet social needs.[18] The clinical setting does offer opportunity to identify unmet health-related social needs, particularly when they emerge in the context of a longitudinal care relationship or engagement with a trusted primary care team member like a community health worker. However, primary care cannot fully address these challenges alone, and progress will require broader action to strengthen social care programs and institutions. We note that the hybrid payment model we have proposed for MSSP would better enable primary care practices to establish long-term connections with local community-based organizations that provide community health integration services. Advancing prospective, population-based payment models for primary care is an essential step toward addressing unmet social needs and advancing health equity.

Primary Care - Behavioral Health Integration: We appreciate the agency's work in this rule to implement the behavioral health provisions of the CAA of 2022. Further, we are particularly encouraged that CMS has used its regulatory discretion to propose several additional steps to promote behavioral health integration, including:

- Increased valuation of General Behavioral Health Integration Care Management (CPT code 99484, and HCPCS code G0323);
- Allowing CSWs, MHCs and MFT to bill for Health Behavior Assessment and Integration (HBAI) codes in addition to Clinical Psychologists; and
- Adjustments to Payment for Timed Behavioral Health Services, resulting in a 19.1% increase to valuation for psychotherapy codes.

Request for Feedback on Ways to Increase Utilization of the Psychiatric Collaborative Care Model

We appreciate the agency's request for feedback on ways to increase utilization of psychiatric collaborative care model. Medicare's 2016 decision to cover and reimburse for integrated behavioral health services marked important policy progress. Unfortunately, actual utilization of these reimbursement codes has lagged far behind the need for integrated care. Implementation of the collaborative care model can be a significant undertaking, particularly for smaller or under resourced practices. Practices must implement new workflows, train team members, hire care manager staff, and establish an arrangement with a psychiatric consultant. Workforce shortages can exacerbate the challenges.

However, policy change can help bring CoCM implementation within reach for more practices. PCC and the Better Health – NOW Campaign are working with Congress to advance legislative solutions including relief from cost-sharing for integration services and the S. 1378 the COMPLETE Care Act. S. 1378 would enhance reimbursement for both the CoCM and the general BH integration codes. S. 1378 would also instruct CMS to provide appropriate technical assistance and quality measurement. With primary care and behavioral health alike facing serious workforce and access challenges we encourage CMS to work with Congress and Executive Branch agencies to move these important policy changes forward.

[18] Basu, Sanjay, et al. "Estimated Costs of Intervening in Health-Related Social Needs Detected in Primary Care." JAMA Internal Medicine, vol. 183, no. 8, Aug. 2023, pp. 762–74. Silverchair, https://doi.org/10.1001/jamainternmed.2023.1964.

While legislative discussions continue, CMS does have additional opportunities to use its existing authority to address barriers to broader utilization of the collaborative care model. We recommend that CMS

- Allow clinical staff to obtain consent under general supervision of the treating physician. Once consented, there should be no need to re-consent a patient during that episode of care. Consent should be tied to inclusion in the program within the practice and not to the identified treating clinician.
- Eliminate limitations on billing the 99494 code related to Medically Unlikely Edit (MUE) policies. Under current policy and practice, practices cannot bill more than two instances of the 99494 code a month. When managing a patient requires additional time, that additional care goes unreimbursed.
- Allow FQHCs and RHCs to bill the existing CPT codes (99492 - 99494, G2214). Most payers, including many Medicaid plans, use the CPT codes to bill for CoCM services. Consistency across payers will reduce the administrative burdens and potential errors that occur when required to do something differently for what is likely a small subset of patients.

PCC and our Better Health-NOW campaign appreciate this opportunity to provide comments on the proposed rule and look forward to working with the CMS team to further 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.

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative