CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

September 6, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attention: CMS-1770-P,
P.O. Box 8013
Baltimore, MD 21244–1850

Re: CMS-1770-P Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

Submitted electronically via Regulations.gov

Dear Administrator Brooks-LaSure:

Consumers First is an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care working to change the fundamental economic incentives and design of the health care system. Our goal is to ensure the nation's health care system fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone. *Consumers First* appreciates the opportunity to provide comments on the Medicare Physician Fee Schedule proposed rule for Calendar Year 2023.

Medicare payment policy often establishes a standard that is then adopted by commercial payers and Medicaid. *Consumers First* offers these comments both to strengthen physician payment, and because the policy changes reflected in this comment letter represent an important step toward realigning the fundamental economic incentives in the health care system to meet the needs of all families, children, seniors, adults, and employers across the nation. If implemented, the payment changes being recommended by *Consumers First* have the potential to catalyze the transformational change that is needed to drive high value care into the health care system and across health care markets in the U.S.

The comments detailed in this letter represent the consensus views of the *Consumers First* steering committee as well as other signers, and interested parties. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments focus on the following sections of the proposed rule:

- **III.G.2 - Shared Savings Program Participation Options**
- **III.G.5.c - Strengthening Participation by Reducing the Effect of ACO Performance on Historical Benchmarks, Addressing Market Penetration, and Strengthening Incentives for ACOs Serving Medically Complex and High Cost of Care Populations**
- **II.D - Payment for Medicare Telehealth Services Under Section 1834(m) of the Act**
- **II.E.34 - Proposed Revisions to the "Incident to" Physicians' Services Regulation for Behavioral Health Services**
- **II.F - Evaluation and Management (E/M) Visits**

III.G.2 - Shared Savings Program Participation Options and III.G.5.c - Strengthening Participation by Reducing the Effect of ACO Performance on Historical Benchmarks, Addressing Market Penetration, and Strengthening Incentives for ACOs Serving Medically Complex and High Cost of Care Populations

It is well-established that the financial incentives associated with fee-for-service (FFS) payment lead to an increase in the volume of services provided within the health care system, which in turn drives up health care spending without any corresponding increase in the quality of care. In fact, FFS health care is a significant driver of poor health outcomes[1] and billions of dollars of waste in our health care system.[2] FFS payment does not support care coordination services or services that address the social determinants of health. The result is that FFS incentivizes fragmented care delivery that fails to provide the full spectrum of services required to meet peoples' health needs and improve their health. The shortcomings of FFS were amplified by the COVID-19 pandemic, in which providers faced significant revenue shortfalls as the volume of routine visits and procedures plummeted and patient needs rapidly changed. At a time when many people needed health care the most, FFS payments left physician practices and the patients they serve in a precarious and untenable position. These shortcomings underscore the importance of transitioning to alternative payment models (APMs).

At the same time, the transition to APMs must work for diverse providers, serve to improve health equity, and be sustainable for participating providers. Safety net and small community providers face unique barriers to implementing new value-based payment models. Many of these models require significant up-front investments that safety net providers may be unable to make.

[1] Stuart Guterman, "Wielding the Carrot and the Stick. How to Move the U.S. Health Care System Away from Fee-for-Service Payment," To the Point (Blog), The Commonwealth Fund, August 27, 2013, https://www.commonwealthfund.org/blog/2013/wieldingcarrot-and-stick-how-move-us-health-care-system-away-feeservice-payment.

[2] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," *JAMA* 322, no. 15 (2019): 1501–1509, doi:10.1001/jama.2019.13978.

Although these investments are important for any provider preparing to manage health outcomes for a whole population, upfront costs are likely to be larger, more mission-critical, and potentially out of the financial reach of providers working with low-income people, including safety net providers and small, independent community providers.[3] Small physician practices play a particularly important role in caring for racial and ethnic minorities, and face distinctive challenges under MACRA and other new payment models.[4]

APMs must also be sustainable for participating providers and not punish Accountable Care Organizations (ACOs) that limit cost growth while improving or maintaining the quality of care for beneficiaries. APMs should also account for the higher costs associated with caring for underserved populations and must not penalize ACOs that spend more to invest in primary care, target historical and ongoing health inequities, and address social determinants of health. Absent careful design, the process for updating spending targets for APM participants can serve to discourage participants from implementing reforms that reduce costs or address health inequities.[5]

Consumers First supports CMS's efforts in the proposed rule to facilitate inclusion of safety-net providers in APMs. Specifically, *Consumers First* supports the proposal to offer Advanced Investment Payments to new ACOs comprised of less-well-resourced providers that care for underserved communities. *Consumers First* also supports the proposal to increase Merit-based Incentive Payment System (MIPS) quality performance scores for ACOs serving underserved populations. This provision will serve to encourage ongoing participation from providers serving populations most in need of care. *Consumers First* also supports the proposed modifications to ACO benchmarks, specifically using a blend of national, regional and ACO-specific cost growth trends to update benchmarks and adjusting benchmarks for renewing or reentering ACOs with a history of savings. These provisions serve to enable successful ACOs to continue to participate in MSSP without penalizing them for success at constraining price growth and encourage investments in addressing health inequity and historical underinvestment in primary care.

II.D - Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

The COVID-19 pandemic catalyzed the integration of telehealth services into the mainstream of health care delivery and payment. As stay-at-home orders drove down visit volume, and therefore revenue, for providers across the country, many health care providers and health systems worked to ramp up their ability to deliver telehealth services. Telehealth quickly became

[3] Justin Timbie, Peter Hussey, Claude Messan Setodji, Amii Kress, Rosalie Malsberger, et al., "Association Between Patient-Centered Medical Home Capabilities and Outcomes for Medicare Beneficiaries Seeking Care from Federally Qualified Health Centers," Journal of General Internal Medicine (May 2017), available online at https://www.rand.org/pubs/external_publications/EP67197.html.

[4] Comments on Proposed Rule on Medicare Program; CY 2018 Updates to Quality Payment Program, National Council Of Asian Pacific Islander Physicians (August 21, 2017), available online at https://www.regulations.gov/document?D=CMS-2017-0082-0863.

[5] Medicare Payment Advisory Commission (MedPAC), "Chapter 1: An approach to streamline and harmonize Medicare's portfolio of alternative payment models," in Report to Congress: Medicare and the Health Care Delivery System (June 2022).

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both an essential tool for families to continue accessing needed health care services during the public health emergency (PHE) and enabled practices to keep their doors open in the wake of reduced in-person volume. *Consumers First* applauds CMS's ongoing efforts to modify Medicare regulations to ensure the delivery and payment of an expanded set of telehealth services are available to patients during the PHE, and for its efforts to permanently expand telehealth services through Medicare beyond the PHE.

Consumers First opposes CMS's proposal to sunset separate coverage and payment of audio-only services after the end of the PHE. Instead, we strongly encourage CMS to maintain current coverage for audio-only services, and to expand access to audio-only communication equal to video-enhanced services for additional services beyond the public health emergency. Although audio-only services may not be appropriate in all instances, expanding access to additional audio-only services can help to ensure that families are able to receive needed health care services and is critical to overcoming some of the barriers in accessing telehealth services for low-income families to provide more equitable, high value health care.[6] Second, video medical visit platforms do not always work well and audio is an important alternative for people at all income levels. Third, existing payment distinctions between audio and video telehealth are arbitrary and not clinically supported. Failing to expand audio-only communications deprives beneficiaries of a clinically important communication modality in their health care.

Consumers First supports CMS's proposal to implement provisions of the Consolidated Appropriations Act, 2022 that extend telehealth flexibilities for 151 days after the expiration of the PHE and to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023 to ensure that families have access to an expanded set of telehealth services and that physicians are able to receive reimbursement for furnishing those services. However, we urge CMS to work to incorporate telehealth services into delivery system reform efforts going forward.

More than two years into the COVID-19 pandemic, telehealth services are considered a mainstream modality of care in US health care delivery and payment both for patients and for health care providers. Importantly, because the cost of telehealth services is less than the cost of in-person visits,[7] we are concerned that an across-the-board extension of telehealth payment parity beyond the PHE that is reliant on the fee-for-service payment model will result in a high volume of fragmented, low-value telehealth encounters.

Pricing telehealth, and in particular phone calls, in a fee schedule designed and deeply researched over many years to reimburse for the cost and resources used for face-to-face encounters is incompatible with driving high value care and fails to account for the costs of implementing telehealth care in existing delivery systems. Paying for telehealth through FFS is yet another example of the ways the broken incentives of FFS drive fragmented care delivery, and ultimately

[6] The Future of Telehealth: How Audio-Only Services Improve Access and Health Equity. Fierce Health Care (March 2021) https://www.fiercehealthcare.com/sponsored/future-telehealth-how-audio-only-services-improve-access-and-health-equity

[7] J. Scott Ashwood et al., "Direct-to-consumer telehealth may increase access to care but does not decrease spending," *Health Affairs* 36, no. 3 (Mar. 2017), https://doi.org/10.1377/hlthaff.2016.1130.

lead to high cost low quality care for Medicare beneficiaries. *Consumers First* believes that this is a critical moment for our nation to grapple with how to effectively and sustainably integrate high value telehealth into our physician payment and delivery system by facilitating participation in alternative payment models and ensuring appropriate payment and coverage of high-value telehealth services that are delivered as part of comprehensive, longitudinal care. While we support expanded access to telehealth and the establishment of a permanent and sustainable payment system to support the integration of telehealth into health care delivery, we are concerned by the significant limitations of relying on fee-for-service payment to achieve that goal, which was detailed in our comment letter on the CY 2021 Medicare Physician Fee Schedule.[8] Both Congress and CMS have long stated the goal of moving physician payment away from a fee-for-service basis, most notably in that the Medicare Access and CHIP Reauthorization Act of 2015's (MACRA) incentive payments for clinicians participating in Advanced Alternative Payment Models (A-APMs) are designed to encourage clinicians to move toward these models. *Consumers First* acknowledges that temporarily expanding access to telehealth during the COVID-19 public health emergency has been an effective way to both bolster access to care for patients and ensure providers continue to be paid for their services during the pandemic so they can continue providing comprehensive, continuous health care for our nation's families. However, as CMS plans for telehealth access for Medicare beneficiaries after the PHE, it is critical that CMS build a payment system that does not push patients towards fragmented telephonic and video "encounters." Effectively building telehealth into alternative payment models is one vital step to achieving this. Particular alternative payment models, by design, shift the economic incentives of provider payments to support the clinician and patient's freedom to choose the most appropriate modality of care including telehealth when appropriate.

Consumers First is also concerned that CMS has not provided sufficient guidance to health care providers on how to provide high quality, high value telehealth visits on a permanent basis. Without clearly defined guardrails to ensure the provision of high value telehealth services, such as services provided by a patient's medical home, *Consumers First* believes there is a significant risk that fee-for-service telehealth services will further fragment care, generate increased volume and result in increased costs for the Medicare program, while having negligible or negative impact on the quality of those services and the health of Medicare beneficiaries.

***Consumers First* recommends that CMS:**

- **Repeal proposal to sunset coverage of audio-only telehealth services.**
- **Expand access to audio-only communications equally as video-enhanced services beyond the public health emergency.**
- **Promulgate a regulation to ensure all telehealth visits meet quality standards and serve the needs of Medicare beneficiaries.**
- **Integrate telehealth into existing alternative payment models that utilize prospective, population-based payments. By design, alternative payment models**

[8] Consumers First, Comment Letter to CMS on CY2021 Medicare Physician Fee Schedule proposed rule, October 5, 2020. Available at: https://familiesusa.org/wp-content/uploads/2020/10/Consumers-First-2021-MPFS-comment-letter-10.5.20.pdf.

shift economic incentives so that payment to providers is based on clinical judgment and improving patients' health, not churning on fee-for-service payment which drives up volume and in turn increases Medicare spending and costs for Medicare beneficiaries. The Primary Care First track is an example of alternative payment models that are able to be scaled nationally, made broadly available to all relevant practices for which a model is designed, and should be the preferred model for paying for telehealth services, rather than through the standard Medicare Physician Fee Schedule.

II.E.34 - Proposed Revisions to the "Incident to" Physicians' Services Regulation for Behavioral Health Services

Ensuring an adequate workforce is critical to achieving a high-value health care system that meets the needs of the people it serves, including ensuring access to health care services. However, the current supply, makeup, and distribution of the U.S. health workforce is not adequate to meet the needs of our nation's families, children, and seniors.[9] This workforce shortage is particularly pronounced in behavioral health, which has seen increased demand during the COVID-19 pandemic exacerbate challenges for an already overtaxed community of providers.[10] Enabling all providers to work to the full extent of their scope of practice is essential to addressing these workforce and access to care concerns, especially with respect to behavioral health care.

To that end, *Consumers First* supports CMS's proposal to allow marriage and family therapists, licensed professional counselors, addiction counselors, and certified peer recovery specialists to provide behavioral health services while under general supervision rather than "direct" supervision. These provisions will serve to engage the full panoply of behavioral health care providers in meeting the needs of Medicare beneficiaries.

II.F - Evaluation and Management (E/M) Visits

Central to improving the health and health care of our nation's families is ensuring that primary care clinicians are valued and empowered in our health care delivery system.[11] Historically low reimbursement for primary care has resulted in an inadequate supply of primary care clinicians in our nation and reduced access to primary care for many families.[12] Moreover, much of the waste

[9] Ollove, Michael. "Health Worker Shortage Forces States to Scramble." *Stateline* (blog). Pew Charitable Trusts, March 25, 2022, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/25/health-worker-shortage-forces-states-to-scramble.

[10] U.S. Government Accountability Office, Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic, GAO-21-437R (Washington, DC, 2021), https://www.gao.gov/assets/gao-21-437r.pdf.

[11] Naomi Freundlich and staff of The Commonwealth Fund, "Primary Care: Our First Line of Defense," The Commonwealth Fund, June 12, 2013, https://www.commonwealthfund.org/publications/other-publication/2013/jun/primary-care-our-first-linedefense.

[12] 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.

in our health care system is anchored in high-cost specialty care.[13] Office/outpatient evaluation and management (E/M) services — a category of Current Procedural Terminology (CPT) codes most commonly used by family physicians and other primary care and office-based clinicians — 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.

Recognizing the need to reevaluate office/outpatient E/M codes, CMS increased the relative value units (RVU) for E/M services. In the CY2021 Medicare Physician Fee Schedule final rule, CMS also finalized an add-on code (G2211) that physicians can bill for complex office visits, including primary care visits. However, Congress acted to supersede CMS by extending a one-time across-the-board payment increase of 3.75 percent for physicians and other professionals, and delaying implementation of G2211 until January 1, 2024 in order to help offset budget neutrality cuts to certain specialist providers through the Consolidated Appropriations Act of 2021. This legislation preserved the historical imbalances in payment between primary care and specialists that CMS had attempted to correct. Congress's action in this instance also exposes the limitations of the statutory framework for budget-neutral relative value units that can serve to impede adequate payment for primary care clinicians and other essential health care professionals in the US health care system. It is yet another sign that CMS needs to move towards a new payment model for physician payment through Medicare. Unfortunately, the current suite of advanced APMs are too limited. ***Consumers First* recommends that CMS implement G2211 when the statutory prohibition ends and work to develop and incentivize participation in a broad suite of stable, voluntary models centered on primary care that will help clinicians move from fee-for-service to APMs.**

Consumers First supports expanded access to, reimbursement for, and investment in primary care. It is well-established that primary care is high-value, cost-effective, and patient centered care. However, the existing fee-for-service payment system fails to robustly support the comprehensive, longitudinal care provided by interprofessional primary care teams (made up of physicians, advanced practice nurses, care managers, and other professionals). Increasingly insufficient payment rates are eroding Medicare beneficiaries' equitable access to recommended primary care in their own communities, particularly in underserved areas. *Consumers First* recognizes and appreciates that CMS has taken significant steps to address the historical underinvestment in primary care. **We encourage CMS to improve access to essential primary care services by ensuring payment rates reflect the comprehensive, longitudinal, and often complex, nature of primary care visits and the steep rise in practice costs across primary care providers.**

Thank you for considering the above recommendations. Please contact Sophia Tripoli, Director of Health Care Innovation at stripoli@familiesusa.org for further information.

[13] Shrank, Rogstad, Parekh, "Waste in the US Health Care System."

Sincerely,

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