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

September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1784-P**
P.O. Box 8013
Baltimore, MD 21244–1850

Re: CMS-1784-P 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

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 (PFS) proposed rule for Calendar Year (CY) 2024.

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 itself, 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 United States.

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:

- II.E - Valuation of Specific Codes
- II.F - Evaluation and Management (E/M) Visits

- II.D - Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act)
- III.G - Medicare Shared Savings Program

II.E - Valuation of Specific Codes

Community Health Integration (CHI) Services

In the CY2024 proposed rule, CMS proposed creating separate coding and payment for community health integration (CHI) services. These services are designed to provide payment for services addressing the unmet social determinant of health (SDOH) needs of a patient that are negatively impacting their medically necessary diagnosis or treatment. CMS is proposing to create two new G codes associated with these CHI services and importantly the services may be performed by certified or trained auxiliary personnel, including a Community Health Worker (CHW), when under the general supervision[1] of a general practitioner or clinician. CMS is proposing that these CHI services may be billed only after an initial Evaluation and Management visit (i.e., CHI initiating visit), often referred to as an office visit, is performed by a general practitioner where it is found that CHI services are medically necessary (i.e., practitioner identifies the presence of an unmet SDOH need(s) that significantly impacts the ability to diagnosis and treat the patient). The same practitioner overseeing the CHI services must also be the practitioner that delivered the initiating CHI visit. Further, CMS is proposing to require that all auxiliary personnel who provide CHI services must be certified or trained to perform these services and are authorized to do so under State laws and regulations. Lastly, CMS is proposing to allow a billing practitioner to arrange to have CHI services provided by CHWs who are external to and under contract with the billing practitioner, such as through a community-based organization (CBO).

Consumers First **strongly supports the creation of two new G codes allowing primary care physicians and other clinicians to partner with CHWs and other auxiliary personnel to receive payments for CHI services through the Physician Fee Schedule.** The two proposed codes would reimburse trained or certified personnel, including CHWs, overseen by a Medicare billing practitioner for the provision of CHI services that address any social needs interfering with a patient's diagnosis or treatment. Included in the codes are integral community health services, such as peer support, system navigation, service coordination, care coordination, among others. This marks a significant step forward in creating long-term, sustainable funding to support CHWs and valuing the role the community-based workforce plays in meeting the health needs of America's families. There is longstanding evidence supporting the efficacy of a robust CHW workforce in providing culturally competent care, helping patients navigate the complexity of the health care system, and improving health outcomes. [2] Research shows that CHWs improve health outcomes, reduce hospital stays and admissions, and improve patient quality of life. This research also shows that CHW services are cost-effective, greatly reducing health care costs. [3] One study found that adding CHWs to clinical care teams saved hospitals $2.30 for every $1 spent on CHWs, amassing a net savings of $1,135 per patient.[4] Despite their proven effectiveness, community health

[1] According to CMS, "general supervision" means the service is furnished under the physician's or other practitioner's overall direction and control, but they are not required to be present during the delivery of the service.
[2] *Community Health Workers: Evidence of Their Effectiveness*. National Association of Community Health Workers. https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf
[3] Pinto, D., Carroll-Scott, A., Christmas, T., Heidig, M., & Turchi, R. (2020). Community health workers: improving population health through integration into healthcare systems. Current Opinion in Pediatrics, 32(5), 674–682. https://doi.org/10.1097/mop.0000000000000940
[4] Ibid.

workers have faced longstanding barriers to adequate and consistent payment for their important work within the health care system, including through the historic lack of reimbursement under the Medicare program. This in turn creates barriers for primary care practices to hire or otherwise partner with CHWs to more holistically meet patients' unmet social and other needs. The lack of sustainable payment for community health integration services, which are core services that community-based providers including CHWs and other auxiliary personnel deliver, is yet another example of the ways the broken incentives of a health care system dominated by fee-for-service economics does not adequately support the delivery of whole person and patient centered care and fails to incentivize improved health outcomes.

Previously CHWs received funding through a patchwork of sources including public health grants, private funds, cooperative agreements, and Medicaid reimbursement in select states.[5] Historically unsustainable and insufficient funding for CHWs has resulted in the workforce being largely underpaid, leading many CHWs to work without pay and/or utilize their own personal resources to meet the needs of their clients, such as covering the cost of gas to transport clients to health care appointments.[6] Importantly, relying on fee-for-service (FFS) economics to pay for community health integration services in the short term is critical to recognize the value of community-based providers including CHWs and other axillary personnel in the broader health care delivery system, and to build a comprehensive health workforce that drives population health improvements. However, in the long-term, there is a fundamental incompatibility between relying on FFS payment models as the primary reimbursement structure for any medical professional or service because care unattached to the quality or outcome fails our nation's families. FFS economics are a major driver of unaffordable, inequitable and low-quality care, and are at odds with the interests of families and consumers.[7] Not only does the FFS payment structure incentivize higher volumes of high price procedures at the expense of primary care services, it also provides a very narrow view of health and health care by signaling to providers that they can only be reimbursed for delivering the clinical care that drives only 10-20% of health.[8] Given that 80-90% of what drives variations in people's health is determined by the health-related socioeconomic and environmental factors in their lives, it is critical to build a payment structure that enables and incentives clinicians to deliver the health care services that drive health improvements by addressing the impact of the SDOHs on health outcomes.

While *Consumers First* sees the creation of these two new codes as a promising first step towards recognizing and compensating community health integration services, the scope, frequency, and duration of CHWs work (including that associated with the delivery of CHI services) are not easily condensed into distinct billing codes. Relying on billing codes under a FFS system in this way creates the opportunity for certain CHI services to go under-reimbursed or not reimbursed at all. CHWs work based on the needs of their patients, and often the work required involves varying amounts of time spent with their patients.[9] For example, a patient in need of health care education and medication management

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[5] *Funding for Community Health Workers Authorized in Consolidated Appropriations Act – How could this help children and families?* (2023, January 13). Center for Children and Families. https://ccf.georgetown.edu/2023/01/13/funding-for-community-health-workers-authorized-in-consolidated-appropriations-act-how-could-this-help-children-and-families/

[6] *Community Health Workers are Underpaid, We Deserve Better!* (2023, April 12). CHW Central. https://chwcentral.org/chw_voices/community-health-workers-are-underpaid-we-deserve-better/

[7] State Health Care Cost Containment Commission, Cracking the Code on Health Care Costs. Miller Center, University of Virginia https://www.cms.org/uploads/HealthcareCommission-Report.pdf

[8] Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives, 7(10). https://doi.org/10.31478/201710c

[9] Lloyd & Thomas-Henkel. Integrating Community Health Workers into Complex Care Teams: Key Considerations. Center for Health Care Strategies, Inc. https://www.chcs.org/media/CHW-Brief-5-10-17.pdf

support may need the support of a CHW for multiple extended periods of time a month while another patient in need of a referral to a social service agency may require less frequency and duration of care. As a result, we recommend adjusting the code for CHI services to allow billing in 20-minute increments for the first 60 minutes per month. **We also encourage CMS to continue to refine and modify the frequency and time descriptors associated with the billing of CHI services to ensure the reimbursement for these services adequately accounts for time required for primary care clinicians and auxiliary personnel to meet the needs of the patients they serve. This should include CMS pro-actively engaging and seeking feedback from CHWs and other community-based health care workers directly to inform any final billing rules related to CHI services. In the long-term, we encourage CMS to design, test and scale alternative payment models not only for the community-based workforce but that take meaningful steps in shifting our broader reimbursement system under Medicare away from FFS economics and towards population-based payment models.**

CHWs are not typically employed by physician offices but rather are primarily employed by CBOs, local governments, and individual and family services organizations.[10,11] CBOs play a critical role in supporting community health, often providing culturally and linguistically relevant services through culturally specialized workforce members, such as Promotores de Salud. Importantly, CBOs often face barriers receiving adequate reimbursement for health care services of community integration services which creates barriers to accessing critical health care services for Medicare beneficiaries in their communities.[12,13] Other barriers that reduce access to needed community-based services include a lack of billing infrastructure for CBOs and challenges around data sharing and interoperability between CBOs and the broader health care delivery system.[14] . *Consumers First* appreciates CMS allowing CHI services to be administered by external partners, including CBOs, under contract with the billing practitioner as community-based organizations remain an important source of culturally relevant health-related services. However, the persistent barriers between CBOs and the traditional health care system may prevent the community health workforce, primary care practices, and beneficiaries from realizing the full benefits of these new codes. Therefore, ***Consumers First*** **encourages CMS to provide technical assistance and ample guidance to CHWs, primary care practices, and other health care providers to aid in the billing of CHI services.**

As described above, CMS is proposing that CHI services may be billed only after an initial Evaluation and Management visit (I.e., CHI initiating visit) is performed by a general practitioner where it is found that CHI services are medically necessary. CMS is seeking comment on whether to consider additional types of professional medical services (other than E&M services) that could serve as an initiating visit for CHI services, such as Annual Wellness Visits (AWVs). It is the opinion of *Consumers First* that in order to promote the use of these high value services, providers and CHWs need a reasonable level of flexibility and discretion in initiating delivery of these CHI services. By expanding the pre-requisite initiating visit to include AWV, CMS can reduce barriers to initiating CHI services through expanded opportunity for initiation. For example, there is confusion and hesitation among providers to bill both an E&M service

[10] *Community Health Workers*. U.S. Bureau of Labor Statistics. https://www.bls.gov/oes/current/oes211094.htm
[11] *Community-Based Organizations are Essential to Public Health*. Public Health Institute. https://www.phi.org/about/impacts/community-based-organizations-are-essential-to-public-health/
[12] *RE: file codes CMS-4203-NC and CMS-1770-P*. National Association of Community Health Workers. https://nachw.org/wp-content/uploads/2022/09/NACHW-Letter-to-CMS-for-Medicare-RFI-9.6.22.pdf
[13] *State Community Health Worker Models*. National Academy for State Health Policy. https://nashp.org/state-community-health-worker-models/
[14] Ibid.

and an AWV at the same time.[15] If a provider is under the belief that they may only bill an AWV service during their visit, a patient with SDOH related needs may miss a critical opportunity to receive additional care and support. Therefore, ***Consumers First*** **recommends CMS add Annual Wellness Visits (AWVs) as a qualifying pre-requisite initiating visit alongside E&M services for the delivery of CHI services.**

SDOH Risk Assessments

In the CY2024 proposed rule, CMS proposed to establish a new billing code to separately pay for a SDOH risk assessment when delivered in conjunction with an E&M visit. This would provide payment to practitioners to formally assess the SDOH needs of their patients, including the SDOH(s) that are negatively impacting the ability of a patient to be appropriately diagnosed and treated. CMS is proposing to require that an SDOH risk assessment be delivered at the same date as an E&M visit, and that an "standardized, evidence based" risk assessment tool be used such as CMS' Accountable Health Communities tool. Further, CMS is proposing that the risk assessment code cannot be billed more than once every six months.

Consumers First **supports the addition of a new standalone code to reimburse clinicians for delivering a SDOH risk assessment.** Addressing the SDOHs within the health care setting is critical to reducing health inequities and driving improvements in health for all communities.[16] Establishing a specific code for physicians to bill for completing an SDOH risk assessment, including by more regularly assessing the social related health needs of patients, holds the promise of improving our collective understanding of patients' unique needs and the impact their lived experiences and social environment are having on their health.[17,18,19] When providers screen for SDOHs, they are able to identify and address the social needs that are driving an estimated 80[20] Instituting a standardized SDOH risk assessment using a standardized, evidence-based instrument can also allow for assessing social related health needs across populations, helping to inform the allocation of social resources and interventions at the population level to improve outcomes. Coupled with CHI services, SDOH risk assessments represent an important -- although incremental -- step to promoting the delivery of whole person and patient centered care in the US health care system.

Clinicians face numerous barriers to screening and addressing the social related health needs of their patients. [21] Amongst these barriers are patient reluctance to disclose social related information and insufficient time available for screening. [22] **While** ***Consumers First*** **applauds CMS for proposing the creation of this code, we are concerned that CMS' proposed billing requirements, including the six**

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[15] *Can physicians bill for both preventive and E/M services in the same visit?* American Medical Association. https://www.ama-assn.org/practice-management/cpt/can-physicians-bill-both-preventive-and-em-services-same-visit

[16] Social determinants of health; Healthy People 2030; U.S. Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health

[17] *Why Screening for Social Determinants of Health Helps Doctors Provide Better Care*. Michigan Medicine. https://www.michiganmedicine.org/health-lab/why-screening-social-determinants-health-helps-doctors-provide-better-care

[18] Ibid.

[19] Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. (2022). *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

[20] *Why Screening for Social Determinants of Health Helps Doctors Provide Better Care*. Michigan Medicine. https://www.michiganmedicine.org/health-lab/why-screening-social-determinants-health-helps-doctors-provide-better-care See also, Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives, 7(10). https://doi.org/10.31478/201710c

[21] *Screening for Social Needs: Guiding Care Teams to Engage Patients*. American Hospital Association. https://www.aha.org/system/files/media/file/2019/09/screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf

[22] Ibid.

month frequency limitation, may undermine the promise of effectively screening for the social related health needs of patients. For example, four months after conducting an SDOH risk assessment, a provider may notice their patient is struggling with adherence to a treatment plan and feel the need to conduct another SDOH risk assessment to ensure there have been no escalation of needs or needs that were not disclosed during the first assessment. Providers should subsequently have the opportunity to conduct an SDOH risk assessment more often than every six months, if beneficial to an individual patient. Even CMS has suggested in other programmatic contexts that patients should be screened multiple times for social related health needs as much as during each patient visit.[23]

We applaud CMS for proposing new payment codes for both CHI and SDOH Risk Assessment services. Coupled together, these represent important steps to incentivizing the delivery of whole person and patient centered care, which increasingly focuses on the underlying social drivers of patient health. While *Consumers First* is supportive of these short-term reforms, we also believe it is imperative that CMS continue to take steps towards more fundamental payment and delivery reform that includes a complete orientation away from our current health care payment system and its overreliance on FFS payments. It is well established that the financial incentives associated with FFS lead to an increase in the volume of services provided within the health care system without any connection to cost or quality, 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[24] and billions of dollars of health care waste in our system.[25] As noted above, FFS payment does not support care coordination services or services that address the social determinants of health and tend to undervalue primary care and other high value services while tending to overvalue high-cost specialty care. 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. Providing sustainable payments to community health workers and reorienting the health care system to directly address the social drivers of health can be better accomplished under alternative payment models, which hold the promise to truly delivering high value and whole person care. For example, instead of paying for CHI services under a FFS system with a discrete set of codes that limit when and how CHWs deliver services, Alternative Payment Models (APMs) could provide the flexibility needed to provide truly sustainable funding for CHI that is person-centered and responsive to patients personalized and evolving needs[26] **Therefore, *Consumers First* strongly encourages CMS to continue to drive towards widespread adoption of alternative payment models that provide prospective, population-based payments for comprehensive primary care and include a strong emphasis on addressing the social drivers of health and incorporate opportunities to recruit and sustain a community-based health workforce such as CHWs.**

[23] *Hospital Inpatient Quality Reporting (IQR) Program Frequently Asked Questions: Social Drivers of Health (SDOH) Measures*. Quality Reporting Center. https://www.qualityreportingcenter.com/globalassets/2023/04/iqr/sdoh-measure--faqs_vfinal_04012023508.pdf

[24] 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/wielding-carrot-and-stick-how-move-us-health-care-system-away-fee-service-payment

[25] 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.

[26] *A Hard Day's Work: Promoting Sustainable Financing for Community Health Workers.* Families USA. https://www.familiesusa.org/wp-content/uploads/2022/09/CHW-Sustainable-Financing.pdf

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

In the CY2024 proposed rule, CMS proposed to change the status of the HCPCS G2211 add-on code to "active" so it is separately payable under the PFS starting January 1, 2024. [27] The add-on code would allow physicians to receive additional payment related to the management of complex and chronic conditions during Evaluation and Management visits.

CMS had previously finalized this code in the CY2021 Medicare Physician Fee Schedule final rule. 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 the impact of budget neutrality cuts to certain specialist providers due to COVID-19 through the Consolidated Appropriations Act (CAA) of 2021. In response, CMS assigned the G2211 add-on code with a bundle payment status indicator until 2024, which restricted additional or separate payment associated with the billing of G2211.[28] This legislation preserved the historical imbalances in payment between primary care and specialists that CMS had attempted to help correct. Congress's action in this instance also exposes the limitations of the statutory framework for Medicare physician payment that can serve to impede adequate payment for primary care clinicians and other essential health care professionals in the U.S. health care system. It is yet another sign that CMS needs to move towards a new payment model for physician payment through Medicare.

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.[29] 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.[30] Moreover, much of the waste in our health care system is anchored in high-cost specialty care.[31] 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 evaluating a patient's health, diagnosing a condition, or engaging in shared decision making to create a treatment plan — services that cannot be easily replaced or optimized by advances in technique or technology. Studies show that the evaluation and management office visits provided by primary care clinicians are more complex than visits provided by other types of clinicians. Primary care visits involve a variety of substance use and cancer screenings, keeping patients up to date on immunizations, the management of multiple chronic and acute conditions, behavioral health screenings, referrals, and counseling, as well as coordination across the care team. The comprehensive nature of primary care office visits means that

[27] 2023-14624.pdf (federalregister.gov)
[28] Novitas Solutions, *Medicare Physician's Fee Schedule (MPFSDB) indicator descriptions*, February 9, 2021. https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004345. See also, CMS, *Fact Sheet – Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits.* *https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf*
[29] Naomi Freundlich and staff of The Commonwealth Fund, "Primary Care: Our First Line of Defense," The Commonwealth Fund, June 12, 2013, https://thepcc.org/sites/default/files/resources/Primary%20Care_Our%20First%20Line%20of%20Defense.pdf
[30] 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, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf
[31] Shrank, Rogstad, Parekh, "Waste in the US Health Care System."

they are more resource intensive, but these additional costs have not been historically recognized by the Medicare physician payment system. G2211 is needed to fill this gap.

***Consumers First* supports CMS' proposal to implement the G2211 and make it separately payable under the PFS, starting January 1, 2024.** This add-on code will take an important, although incremental step, towards recognizing the true value and costs associated with delivering high quality primary and longitudinal care under the PFS.

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 FFS 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 build upon its proposal to implement G2211 and continue to improve access to essential primary care services by ensuring payment rates truly reflect the comprehensive, longitudinal, and often complex, nature of primary care visits and the steep rise in practice costs across primary care providers.**

We also encourage CMS to continue working 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 prospective, population-based payment models.

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

In the CY2024 proposed rule, CMS proposed allowing telehealth services, including behavioral health services delivered to Medicare patients in their homes to be paid at the higher "non-facility" PFS rate. This represents a significant increase in compensation for physicians who continue to deliver behavioral health services via telehealth to their patients. Previously, these physicians were paid at the relatively lower "facility" PFS rate when delivering telehealth services to patients at home. According to CMS, since the onset of the Public Health Emergency, behavioral health providers are increasingly delivering services via telehealth while still maintaining their office-based setting.[32] As a result, CMS concluded that behavioral health providers continue to deliver some care in-person even as a significant percentage of their patients are being seen via telehealth.[33] CMS is proposing this increase in reimbursement to better reflect the added costs behavioral health providers are subjected to for maintaining their office presence in the context of increased use of telehealth in an effort to protect access to mental health services.[34]

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

[32] 2023-14624.pdf (govinfo.gov)
[33] Ibid.
[34] Ibid.

nation's families, children, and seniors.[35] This workforce challenge 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.[36] In a 2021 study, nearly half of Americans surveyed reported recent symptoms of an anxiety or depressive disorder, and a significant proportion felt their mental health needs were not being met.[37]

The COVID-19 pandemic and public health emergency catalyzed telehealth to become an important option for families to access health care services. This is particularly true for behavioral health services and providers, as Medicare beneficiaries disproportionately accessed behavioral health services via telehealth as compared to other types of services.[38] In recognition that telehealth services are now considered a mainstream modality of care in US health care payment and delivery, Congress has extended and made permanent certain telehealth related flexibilities, including after the end of the PHE. For instance, on December 21, 2020, Congress passed the Consolidated Appropriations Act, 2021 which permanently expanded access to behavioral health services via telehealth to all Medicare patients by removing certain geographic and originating site restrictions.[39]

***Consumers First* supports the CMS' proposal to provide behavioral health providers delivering care via telehealth to patients in their home, increased reimbursement through Medicare payment at the non-facility rate. We believe this is a necessary short-term solution to address the persistent challenges that Medicare patients face in obtaining behavioral health services across the nation, and to help meet the heightened demand for behavioral health services after the PHE. Payment at the non-facility rate will ensure physician practices can continue offering telehealth services to their patients and enable them to use the modality of care that is most appropriate for each patient and visit.**

Low reimbursement rates for behavioral health providers are a major problem for building an adequate behavioral health workforce that can truly meet the behavioral health needs of Medicare beneficiaries.[40] Given historically low reimbursement rates, it is no surprise that behavioral health providers are most likely to opt out of Medicare.[41] Behavioral health providers such as psychiatrists are less likely than other specialties to accept Medicare patients.[42] CMS' proposal to increase reimbursement for mental health services when delivered to patients in their home (among other proposals related to behavioral health payment) is an important incremental step to better compensating behavioral health providers in the Medicare program and reflecting the value they bring to a high-quality health care system that is truly meeting the needs of patients.

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[35] 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

[36] 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

[37] National Health Institute, *Mental Health During the COVID-19 Pandemic* (March 20, 2023), https://covid19.nih.gov/covid-19-topics/mental-health

[38] HHS OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic.* March 2022. https://oig.hhs.gov/oei/reports/OEI-02-20-00520.pdf

[39] Katie O'Connor, *Congress Passes Parity, Increases Some MH Funding*, Psychiatric News, February 24, 2021. https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.3.5

[40] U.S. Government Accountability Office. (2022). *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*. Www.gao.gov. https://www.gao.gov/products/gao-22-104597

[41] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch4_medpac_reporttocongress_sec.pdf

[42] Nicole Rapfogel, *The Behavioral Health Care Affordability Problem*, May 26, 2022. Center for American Progress. https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/

While we support the establishment of a permanent and sustainable payment system that appropriately integrates telehealth, and in this case tele-behavioral health, into health care delivery, we are concerned by the significant limitations of relying on FFS payment to achieve that goal, which was detailed in our comment letters on the CY 2022 and CY2023 Medicare Physician Fee Schedule.[43] 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 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 implements its 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. Therefore, ***Consumers First*** **recommends that CMS continue to integrate telehealth into existing alternative payment models that utilize prospective, population-based payments. By design, alternative payment models 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.**

III.G - Medicare Shared Savings Program:

In the CY2024 proposed rule, CMS proposed changes to the Medicare Shared Savings Program (MSSP) to expand the assignable beneficiary period from 12 to 24 months and to expand the definition of assignable beneficiary to include individuals who have seen only non-physician clinical staff within the prior 12 months for primary care services. This change is designed to better account for beneficiaries who received primary care from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month period and for those who received at least one primary care service in the preceding 12-month period. These beneficiaries would still have to have a qualifying physician visit to be eligible for attribution to an ACO. According to CMS, this would result in an estimated 3% increase of the population of assignable beneficiaries, which represents more than 300,000 additional beneficiaries connected to care through Accountable Care Organizations (ACOs). This is a critical change that ensures ACOs are held accountable for the care of beneficiaries that may be receiving care less frequently but whose care nonetheless is primarily overseen by an ACO.

Consumers First **supports CMS proposal to expand and refine the definitions of assignable beneficiary and the assignable beneficiary period. However, we urge CMS to ensure that these policies do not have the unintended consequence of attributing beneficiaries to clinicians in specialty care or non-primary care settings outside the ACO, which could cause care fragmentation. Existing challenges with**

[43] Consumers First Regulatory Comments on MPFS for CY 2022. (2021). https://familiesusa.org/wp-content/uploads/2021/09/Consumers-First-Comments-on-MPFS-CY-2022-9.13.21.pdf. See also, Consumers First Regulatory Comments on MPFS for CY 2023. (2022). https://familiesusa.org/wp-content/uploads/2022/09/Consumers-First-CY23-MPFS-comment-letter-Final-9.6.22.pdf

taxonomy code identification for advanced practice providers do not enable those clinicians to identify their specialty. This creates challenges with determining which advanced practice providers work in a primary care setting versus a sub-specialized setting.

Payment reform models must keep up with the rapidly changing primary care landscape to best connect patients to team-based, whole-person, value-based care in whatever way they receive it. An estimated 44% of primary care is now performed by non-physician clinical staff[44], which should not preclude any patients from the benefits of connection to an ACO. The 456 Accountable Care Organizations (ACOs) participating in MSSP earned a total of $2 billion in shared savings in 2021[45], which suggests that ACO participants can consistently outperform their benchmarks for care. Additionally, MSSP participants improved their performance on 82% of quality measures and outperformed fee-for-service providers on 81% of quality measures within the first three years of program participation[46]. *Consumers First* believes this is strong evidence to justify a continued push toward APM participation under MSSP for providers and beneficiaries.

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

Sincerely,

Consumers First Steering Committee
American Academy of Family Physicians
American Benefits Council
American Federation of State, County & Municipal Employees
Families USA
Purchaser Business Group on Health

Supporting Partners
ACA Consumer Advocacy
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Community Access National Network
ERISA Industry Committee (ERIC)
National Partnerships for Women and Families
National Rural Health Association
Northwest Health Law Advocates
Small Business Majority
Tennessee Justice Center
Virginia Coalition of Latino Organizations

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[44] *A Window into Primary Care*. (2023). FAIR Health. https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/A%20Window%20into%20Primary%20Care%20-%20A%20FAIR%20Health%20White%20Paper.pdf

[45] Ibid

[46] *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality 08-28-2017 Report (OEI-02-15-00450)*. (2017, August 28). https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp