Primary Care Development Corporation

September 6, 2023

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

To Whom It May Concern:

The Primary Care Development Corporation (PCDC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS)'s Notice of Proposed Rulemaking (NPRM) for Calendar Year 2024 (CY24) Payment Policies under the Physician Fee Schedule (PFS) and other changes to Part B Payment Policies and Medicare Shared Savings Program (MSSP) requirements.

As background, PCDC is a national non-profit organization and Community Development Financial Institution (CDFI) founded and based in New York City. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care through capital investment and practice transformation, as well as policy and advocacy. Over the past three decades, PCDC has leveraged more than $1.7 billion to finance over 249 primary care projects, with strategic community investments that have created or preserved nearly 20,000 jobs in low-income communities and transformed more than 2.8 million square feet of space into fully functioning primary care and integrated behavioral health practices. Our staff have also trained and coached thousands of health workers to deliver superior patient-centered care. Over 30 years, PCDC's work has created capacity for more than 4.8 million estimated medical visits for over 1.4 million estimated patients across 45 states as well as the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

High-quality, integrated, patient-centered primary care saves lives, leads to better individual and community health, and is central to health equity.[i] Primary care is the foundation of our health care system and is key to prevention, early detection, and treatment to ensure that chronic diseases like diabetes and heart disease do not turn into acute conditions.

As advocates, consultants, and non-profit CDFI investors in high-quality primary care, PCDC's comments relate specifically to the elements of the Proposed Rule that most directly impact access to that care, including the G2211 code, social determinants of health (SDOH), telehealth, behavioral health services, provisions related to vaccines, Rural Health Clinics (RHCs), and

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Federally Qualified Health Centers (FQHCs), and the proposed changes that would strengthen primary care under the MSSP. PCDC encourages CMS to shift resources towards primary care and to take every opportunity to shore up the existing primary care system while creating more stable and effective mechanisms for care delivery, continuity, and quality in the future.

I. CMS Budget Neutrality/Proposed Cuts

PCDC urges CMS to take any action possible within its authority to blunt the effects of budget neutrality constraints of the PFS that result in a negative proposed conversion factor (CF) update. The CY24 fee schedule proposes cuts of more than 3.34% for the CF of the amount Medicare pays per relative value unit (RVU).[ii] This results in a CF of $32.75 or a decrease of $1.14 from CY 2023 for physicians and other clinicians. It is well understood that rate cuts such as these in primary care have a negative effect on both patients and providers.[iii]

PCDC is aware that CMS has estimated that physicians, particularly primary care providers, will ultimately receive a 3% increase in the CY24 fee schedule, but this is largely due to the implementation of the G2211 code. We strongly support the G2211 code, which ultimately accounts for 90% of increases in primary care in PFS and therefore offsets some of the impact of the conversion factor this year – nonetheless, the G2211 code was not intended as a replacement for current reimbursement rates but rather as an increase in order to incentivize comprehensive, coordinated care.[iv] Using it to offset cuts will undermine its purpose and will not allow practices to implement the comprehensive, whole person care the code was intended to support.

Under a provision of the Omnibus Budget Reconciliation Act of 1989, any estimated increases of $20 million or more to the Medicare PFS are mandated to be offset to ensure budget neutrality. The budget neutrality constraints of the fee schedule continue to result in a negative proposed conversion factor update. Because of the budget neutrality mandate, physicians have seen their inflation-adjusted payments drop 26% from 2001 to 2023.[v] While primary care practices are impacted by these cuts all over the country, the most serious impact is felt in already underserved communities, particularly those where underinvestment in primary care has already led to a shortage of access.[vi]

Experiences with Medicaid can be instructive in understanding the importance of primary care physician reimbursement rates. Studies of Medicaid acceptance have demonstrated that health care providers are often disincentivized from accepting Medicaid by low reimbursement rates, excessive administrative burden, delays in payment, and other factors. Conversely, according to a 2018 study by the National Bureau of Economic Research, higher Medicaid reimbursement rates increased primary care access and improved behavioral health outcomes among enrollees.[vii] Medicaid is not the only type of coverage with low reimbursement rates for primary care – across the board, low reimbursement rates for primary care impact providers' ability and willingness to provide the care.[viii] Indeed, lower reimbursement rates and ongoing underinvestment in primary care have been proven to discourage doctors from entering primary care at all – exacerbating an already dire workforce shortage.[ix]

While Congress has provided temporary partial fixes to physician payment in the last several years, its latest fix in the Consolidated Appropriations Act, 2023 (CAA, 2023), enacted at the end of

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2022, does not offset all the proposed cuts in this rule. Given the current political climate, it is unlikely that Congress will include any provisions in this year's budget appropriations packages that would offset the proposed cuts.

Once again, PCDC would like to reiterate its hope that CMS will take any possible action within its authority to offset proposed cuts that will harm both patients and providers.

II. G2211 Code

As mentioned, PCDC supports the G2211 code and urges both CMS and Congress to avoid any further interference with its implementation. Originally slated to be instituted in 2021, Congress delayed the implementation until CY24. Once in place, G2211 will advance more appropriate payments for primary care and other longitudinal, continuous care under the PFS.

The G2211 code will help ensure that physicians can provide the continuous, comprehensive, coordinated primary care that their patients need – care for which Medicare has historically underpaid.[x] Despite studies proving that having a "usual source of care" enhances patients' health care access, improves the quality of care, lowers health care expenditures, and decreases health care disparities, the percentage of Americans with an ongoing primary care provider relationship has been declining, falling 10% between 2000-2019, from 84% to 74%.[xi] The G2211 code promotes a "usual source of care" and encourages providers to build long-term relationships with their patients in order to tackle chronic illness. According to the American Academy of Family Medicine, G2211 can be used when a physician is serving as the focal point for the patient's care and "addressing the broad scope of the patient's health needs by furnishing care for some or all of the patient's conditions across a spectrum of diagnoses and organ systems with consistency and continuity over time."[xii] This add-on code would strengthen the patient-physician relationship as it directly supports physicians' ability to foster longitudinal relationships, address unmet social needs, and coordinate patient care across the team.

The reality is that existing codes do not reimburse for the continuous care that is fundamental to high quality primary care and that has the potential to help move all communities towards health equity. Without this code, providers are not paid for following up with patients and providing continuous care. Instead, providers must stretch already thin resources or not provide these services at all – placing an additional burden on an already thin primary care workforce that has increasingly faced burnout. By advancing fair and accurate payment in Medicare, G2211 will help sustain primary care and other physician practices that Medicare beneficiaries rely on.

While the G2211 isn't a perfect solution to the many issues associated with a fee-for-service (FFS) payment system, it is a positive addition to the PFS that will help support providers as CMS continues to move away from FFS and towards value-based care. As previously mentioned, most of the potential gain in allowed charges for family medicine in the CY24 PFS can be attributed to CMS moving forward with the implementation of an add-on code (G2211) for office visits.[xiii]

Implementing G2211 will advance several of CMS' strategic priorities by helping to stabilize and strengthen community-based primary care practices. For these reasons, PCDC urges CMS to institute the G2211 add-on code without any further delay.

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III. Vaccines

PCDC supports CMS' proposal to renew the additional payment for at-home COVID-19 vaccination and extend it to other Part B-covered vaccines, including vaccines for pneumococcal, influenza, and hepatitis B. This policy was originally established in 2021 to increase COVID-19 vaccination rates.[xiv]

As vaccine hesitancy continues to rise throughout the United States and around the world, primary care providers have a critical role to play in combatting disinformation and ensuring that everyone is receiving the vaccines they need to stay healthy. As a result, it is more important than ever that primary care providers are given adequate resources to provide proper preventative vaccine services.

According to a recent study of 700 Americans over 18 years old, 49% of the respondents were classified as having general vaccine hesitancy, 17% had not received the COVID-19 vaccine, and 36% had not had flu vaccinations.[xv] In another study, even 48.8% of already vaccinated adults reported some level of hesitancy.[xvi] Even before the COVID-19 pandemic, the World Health Organization (WHO) determined that vaccine hesitancy was a global health threat, with many countries seeing a rise in measles and flu cases.[xvii]

CMS also proposes an increase in payment to ensure that all four vaccine payments are identical. This additional payment amount will be annually updated using the percentage increase in the Medicare Economic Index and adjusted to reflect geographic cost variations.[xviii] PCDC supports all these proposals, which would encourage primary care providers to prioritize the vaccination of their patients.

IV. Health Related Social Needs

PCDC supports CMS' proposed changes that will allow for greater reimbursement and consideration of patients' Health Related Social Needs (HRSNs), including those related to Social Determinants of Health (SDOH). According to the US Department of Health and Human Services, "SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[xix] Access to primary care itself is a key SDOH recognized by the WHO and the U.S. Healthy People initiative framework.[xx] Related but not identical, HRSNs are *individual level,* non-medical social conditions that affect individuals' access to and utilization of health care, as well as health outcomes. They include housing instability, food insecurity, and lack of access to transportation. When these needs are unmet, they can exacerbate poor health outcomes and contribute to health inequity. Primary care providers are increasingly investing time into determining patients' HRSNs and taking these factors into account while determining a diagnosis.[xxi]

PCDC supports the CMS proposal to create three separate billing codes that aim to address time spent by a provider and their staff addressing HRSNs, including SDOH, Community Health Integration (CHI), and Principal Illness Navigation (PIN) services.

CHI and PIN services include: a person-centered assessment to better understand the patient's life story; care coordination; contextualizing health education; building patient self-advocacy skills;

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health system navigation; facilitating behavioral change; providing social and emotional support; and facilitating access to community-based social services to address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems.

CMS also proposes the inclusion of CHI and PIN services under the G0511 general care management HCPCS code. While currently RHCs and FQHCs are not permitted to bill under this code, this proposal would allow them to bill for these services either alone or with other payable services. As a CDFI that solely invests in the health care sector and specifically primary care providers, PCDC works with many FQHCs and RHCs in low-income communities and communities of color and we believe this proposal will help support the whole-person, team-based model that these important institutions provide.

PCDC urges CMS to finalize G05111 and to add health care common procedure coding system (HCPCS) code GXXX5, screening for SDOH, to the Medicare Telehealth Services List on a permanent basis, contingent on finalizing the service code definition. As explained in further detail in the following section of this letter, PCDC also supports the proposal to add the HCPCS code GXXX5 to permanent status on the Medicare Telehealth Services List.

The proposed coding and payment for SDOH risk assessments recognize that practitioners spend time and resources assessing SDOH that may relate to their patients' health status and treatment needs. As a result, PCDS supports the PFS proposal to add the SDOH risk assessment to the annual wellness visit as an optional additional element with an additional payment. PCDC believes that this will help providers properly assess SDOH and will have a positive effect on community determinants of care, such as education, employment, and housing.

We would also like to directly respond to one of the questions that CMS sought external comment on, specifically whether patient consent should be required for CHI or PIN services. PCDC urges CMS, at the very least, to include a provision in the CY24 PFS that would require providers to give patients notice that they are receiving services for which they may have to pay. While the benefits of CHI and PIN services are clear, consent in any non-emergency medical intervention is key for providers to build a long-term relationship with their patients. If patients feel that they were charged for a service that they were not aware of receiving or not aware they might have cost-sharing responsibilities for, it is more likely they will lose faith in their providers, further decreasing the number of those with a "usual source of care." [xxii]

V. Additions of Codes to the Medicare Telehealth Services List

PCDC supports the addition of any code to the Medicare Telehealth Services List that would expand access to care. Telehealth allows providers to serve communities that experience access barriers to primary care, mental health care, or other health care services. For example, many rural communities lack access to primary care providers and residents of such communities are more likely to die prematurely from five of the leading causes of death than their urban counterparts.[xxiii] PCDC's research of primary care access in New York State, specifically, found that on average, urban areas have 15 primary care providers per 10,000 residents, while rural areas have only 3.4.[xxiv] By expanding access to providers located elsewhere, telehealth services can allow rural

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residents better access to chronic disease prevention and management programs, specialist care, and can save lives by providing access to care quickly in an emergency, such as a stroke.[xxv]

CMS' efforts to increase access to telehealth services will not only help those in rural areas but also other populations that face barriers to access unrelated to living in rural areas, such as disability, lack of access to adequate public transportation, childcare or time off from work, as well as those who are deterred from seeking care due to the stigma that can be associated with accessing needed mental health treatment.[xxvi]
Further, PCDC supports the proposal to permanently implement several provisions of the Consolidated Appropriations Act of 2023 (CAA), including:

- Delayed requirement for regular in-person visits: This provision delays the requirement that patients have an in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services, including for RHCs and FQHCs, and allows the Secretary to delay the requirement at subsequent intervals as the Secretary determines appropriate. PCDC believes that this provision expands mental health services for society's most vulnerable and should be under consideration for being made a permanent policy.
- Originating Site and Geographic Restrictions: This provision expands the scope of telehealth originating sites for services furnished via telehealth to include any site in the U.S. where the beneficiary is located at the time of the telehealth service, including an individual's home.
- Audio-Only Services: This provision continues coverage of certain audio-only telehealth services.
- The provision maintaining the expanded list of telehealth practitioners through CY 2024.

VI. Behavioral Health Services

PCDC strongly supports the integration of primary care and behavioral health services. Integrating primary care and behavioral health services is increasingly recognized as a critical component of whole-person care and improved health outcomes.[xxvii] Although many primary care providers screen for and treat common behavioral health conditions such as depression and anxiety, they are only able to reach a fraction of people who require those services, particularly given the lack of a "usual source of care" for many people.[xxviii] Meanwhile, those living with a serious mental illness, who are often seen in behavioral health settings, generally lack access to adequate primary care.[xxix]

For these reasons, we want to highlight the proposal to implement Section 4121 of the CAA, 2023, which provides for Medicare Part B coverage and payment under the PFS for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs). We urge CMS to approve this proposal, as well as the proposal to increase the valuation for timed behavioral health services under the PFS. Specifically, CMS proposes to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS. We understand that CMS proposes to implement this over a four-year transition, but we urge CMS to move more quickly as this could make an important difference for access to critical mental health care.

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PCDC believes there are multiple additional steps that could be taken to help integrate primary care and behavioral health, which would expand access to behavioral health services. As outlined in PCDC's 2019 report titled, "Closing the Health Integration Gap," we recommend: simplifying facility requirements, both at the federal and state level; establishing or supporting the establishment of integrated systems to share patient information; promoting team-based approaches to care; and expanding financing and reimbursement options for integration whenever possible.[xxx]

VII. MSSP

PCDC would like to highlight specific provisions of the MSSP that we believe are most beneficial to primary care, including: expansions to the definition of primary care services used in the shared savings benefit program; allowing providers such as Nurse Practitioners (NPs) and Physician Assistants (PAs) to be assigned to beneficiaries under MSSP; and, adding a third step to the Step-Wise assignment methodology used to assign beneficiaries to ACOs.

With regard to the definition of primary care services used in the MSSP, PCDC supports the addition of a number of services, including several behavioral health services, several sexual and reproductive health-related services, and several team-based care services. All of these additions will help primary care practices in ACOs continue to move closer to providing whole-patient, comprehensive primary care.

Regarding the changes to determining beneficiary assignments, PCDC supports CMS' goal of creating an expanded class of assignable beneficiaries and generally supports the proposed changes that will help achieve that goal. PCDC specifically supports the decision to allow beneficiary assignments to be based not just on a patient having seen a primary care physician at the practice within the relevant time period but alternatively having seen either a NP or PA. PCDC's own research in New York State has found that many patients, particularly those in rural areas, likely see a NP or PA as their usual source of primary care and that NPs and PAs provide a significant amount of the primary care across the state.[xxxi] PCDC also supports the change to the Step-Wise program that would expand the window for assignable beneficiaries to 24 months. This would result in a greater number of beneficiaries in the assignable population, in particular beneficiaries who tend to come from underserved populations, whom we have seen over time are less likely to be assigned to ACOs than the overall Medicare FFS beneficiary population.

As CMS notes in the proposed rule, these proposals are expected to increase participation in the Shared Savings Program by roughly 10% to 20%, which will provide additional opportunities for beneficiaries to receive coordinated care from ACOs.

Finally, we would also like to thank CMS for acknowledging the value of prospective population-based primary care payment within MSSP. We urge the agency to move toward making this model available as soon as possible in order to reach its value and health equity goals. In addition, adopting a new hybrid approach to paying for primary care would greatly strengthen primary care, as we and many other stakeholder organizations led by the Primary Care Collaborative noted in a March 2023 letter to CMS Administrator Elizabeth Fowler.[xxxii]

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The letter advanced six principles for the design of this MSSP hybrid primary care payment option:[xxxiii]

- 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 with this proposal and urge the agency to move toward making this model available as soon as possible.

VIII. Conclusion

As described in the National Academies of Sciences, Engineering, and Medicine (NASEM) report, "[p]rimary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[xxxiv]

Because of these ongoing relationships with patients, community-based context, and integrated role, primary care saves lives, improves individual and community health, and is central to health equity. In fact, primary care is the only part of the health system that has been proven to lengthen lives and reduce health disparities while reducing costs.[xxxv]

PCDC wants to reiterate our support for the inclusion of billing codes that will allow providers greater ability to invest in their practices and serve their patients. We also continue to support any efforts to move CMS policy away from an FFS model. Given CMS' commitment to having 100% of Medicare beneficiaries in accountable care relationships by 2030, and the clear, critical role primary care will need to play in those relationships, PCDC encourages CMS to continue to consider other ways to ease the path to participation in value-based payment for primary care providers while reducing their administrative burden.

Once again, PCDC thanks CMS for the opportunity to provide these comments on the sections of the Proposed Rule that are within our expertise. We would be happy to follow up on any of these key points if more information would be useful and can be reached at jgoldberg@pcdc.org or (212) 437-3947.

Sincerely,

Louise Cohen
Chief Executive Officer
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