ADVOCATES FOR
COMMUNITY
HEALTH

September 06, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016.

RE: File Code CMS-1770-P

Dear Administrator Brooks-LaSure:

Advocates for Community Health (ACH) is comprised of leading federally qualified health centers (FQHCs) focused on health equity and innovation to drive health care systems, policies, and health programs. Our members serve over two million people and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need.

Below, we provide our comments to the proposed changes outlined in CMS-1770-P Medicare Physician Fee Schedule CY 2023. In summary, our comments specifically address the following:

- **Behavioral Health Services**: ACH recommends considering “incident to” revisions to FQHCs, not just for physician professional services
- **New Coding and Payment for General Behavioral Health Integration (BHI)**: ACH supports
- **Community Health Workers**: ACH provides recommendations for the request for information
- **Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order**: ACH generally supports, but recommends considering audiologists’ clinical expertise for the best billing practices
- **Care Management Services in RHCs and FQHCs**: ACH supports
- **Conforming Technical Changes to 42 CFR 405.2463**: ACH provides further recommendations that would support FQHCs and their patients
- **Medicare Shared Savings Program**: ACH provides comments and elevates the need to consider the unique populations of FQHCs

Subsections:

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

Proposal: CMS proposes that licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) have an exception to the direct supervision requirement under the "incident to" regulation at 42 CFR 410.26. This would allow behavioral health services provided under the general supervision of a physician or non-physician practitioner, rather than under direct supervision, when these services or supplies are provided by auxiliary personnel incident to the services of a physician or non-physician practitioner.

ACH Comment: While ACH supports allowing LMFTs and LPCs to bill "incident to" physicians or non-physicians for behavioral health services, CMS does not address this change for FQHCs. The proposal is meant to increase access to behavioral health and advance health equity as part of the CMS Behavioral Health Strategy[1]. However, according to the 2021 Uniform Data System,health centers serve more than 30 million people, and health centers are experiencing an increase of 138,000 patients seeking behavioral health services (as in mental health and substance use disorder services). 54% and 31% of virtual visits were mental health and substance use disorder related, respectively[2].

In order to reduce disparities in behavioral health, ACH encourages CMS to allow LMFTs and LPCs bill "incident to" physicians and non-physicians under the FQHC Prospective Payment System.

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

Proposal: CMS proposes creating a new G code (GBHI1) describing General BHI performed by CPs or CSWs to account for monthly care integration where the mental health services furnished by a CP or CSW are serving as the focal point of care integration. CMS requests feedback on the proposed work value of 0.61 based on a direct crosswalk to CPT code 99484.

ACH Comment: ACH supports this new G code as a way for CMS to integrate behavioral health into primary care. CMS also seeks comments about "incident to" requirements. Therefore, similar to our comments for Section II.E.34, we strongly encourage CMS to apply flexibilities to general physicians as well as to FQHCs.

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

[1] https://www.cms.gov/cms-behavioral-health-strategy
[2] https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trends-speakers.pdf

RFI: CMS is interested in learning whether and how CHWs, as auxiliary personnel of physicians and hospitals, may provide reasonable and necessary services to Medicare beneficiaries under the appropriate supervision of health care professionals that are responsible more broadly for medical care, including behavioral health care.

ACH Comment: ACH strongly encourages CMS to perform services “incident to” eligible providers, particularly at FQHCs, which could include care coordination, social determinants of health screening, coaching, and advocating for the individuals and communities. As the American Public Health Association CHW definition describe, CHWs serve best when they share a common background with patients and the community being served, and have intrinsic trust-building qualities (e.g., listening, empathy). CHWs are a way to address the workforce challenges across healthcare. We suggest the following:

- CMS should work with Managed Care Organizations (MCOs) and review Medicaid state amendment plans that can shed light on CHW best practices
- CMS should address barriers to CHW certification
- CMS and HHS should provide flexibility for funding mechanisms for CHWs, their scopes of work, and realizing that CHWs reach patients “outside the 4 walls”
- CMS should consider that CHWs may have other titles that may or may not fall under the CHW category
- CMS should consider reimbursing CHWs for certain services under Medicare, especially at FQHCs.
    - For example, FQHCs and CHWs have been vital for COVID-19 vaccination efforts. CMS could consider CHW reimbursement for Medicare and Medicaid for CPT code 99401 (15 min-Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual) and allow Modifier 93 and 95 so that services be offered via telehealth or audio-only services, possibly incident to physicians and non-physician practitioners.

In conclusion for this RFI, ACH suggests Medicare and the Center for Medicaid and CHIP Services (CMCS) partnering with CHW organizations, MCOs, community-based organizations, and state Medicaid organizations to appropriately integrate and reimburse CHWs into beneficiary care.

(II.K) Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order

Proposal: CMS is proposing to allow beneficiaries to have direct access, when appropriate, to an audiologist without a physician referral by creating a new HCPCS code (GAUDX) for audiologists to use when billing for audiology services they already provide that are defined by other code(s). The service(s) encompassed by the new HCPCS code would be personally furnished by the audiologist and would allow beneficiaries to receive care for non-acute hearing or assessments unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. The proposal permits audiologists to bill for this direct access (without a referral) once every 12 months.

ACH Comment: ACH is supportive of allowing audiologists to furnish certain diagnostic tests without a physician order. However, we encourage CMS to consider audiologists' clinical feedback and expertise. For example, creating a new code to represent 36 existing codes could have unintended consequences including but not limited to lowering reimbursement of services, muddling data tracking of services, and may not distinguish what services need to be rendered via a physician versus an audiologist. A modifier may be a more suitable approach.

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

b. Care Management Services in RHCs and FQHCs

Proposal: CMS is proposing to add the new chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code, G0511, to align with the proposed changes made under the PFS for CY 2023. Since the requirements for the new chronic pain management and behavioral health integration services are similar to the requirements for the general care management services furnished by RHCs and FQHCs, the payment rate for HCPCS code G0511 would continue to be the average of the national non-facility PFS payment rates for the RHC and FQHC care management and general behavioral health codes (CPT codes 99484, 99487, 99490, and 99491) and PCM codes (CPT codes 99424 and 99425) and would be updated annually based on the PFS amounts for these codes.

ACH Comment: ACH is supportive of this proposal and appreciates the alignment of PFS proposals to apply to FQHCs.

3. Conforming Technical Changes to 42 CFR 405.2463

Proposal: CMS is proposing to make conforming regulatory text changes to the applicable RHC and FQHC regulations in 42 CFR part 405, subpart X, specifically, at §405.2463, ''What constitutes a visit,'' we propose to amend paragraph (b)(3) and at §405.2469 ''FQHC supplemental payments'' we proposed to amend paragraph (d) to include the delay of the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology under Medicare until the 152nd day after the PHE for COVID–19. In addition, several other provisions of the Consolidated Appropriations Act of 2022 (CAA, 2022) would apply to telehealth services (those that are not mental health visits) furnished by RHCs and FQHCs. Section 301 of the CAA, 2022 amended section 1834(m)(4)(C) of the Act to add a new clause (iii) expand the originating site requirements to include any site in the U.S. at which the beneficiary is located, including an individual's home, for a 151-day period beginning on the first day after the end of the PHE for COVID–19. It also prohibits an originating site facility fee from being paid unless the site is a setting included on the originating site list in section 1834(m)(4)(C)(ii) of the Act, excluding the home of an individual. Section 305 of division P, title III, subtitle A of the CAA, 2022 amended section 1834(m) to extend coverage and payment of telehealth services that are furnished via audio-only telecommunications system for the 151- day period beginning on the first day after the end of the PHE for COVID–19.

ACH Comment: ACH agrees with these regulatory text changes. However, while some patients may not use telehealth, the option of telecommunications and telemonitoring has been vital to FQHC patients during the PHE. Therefore, ACH recommends the following:

- Allowance for telehealth and telemonitoring, particularly to be furnished in any geographic area and in any originating site setting, including the beneficiary's home 365 days after the PHE ends
- Allowance of certain services to be furnished via audio-only telecommunications systems, and adjusting in-person visit requirements 365 days after the PHE ends
- Revision of the regulations at § 405.2463 such that medical visits, medical nutrition therapy visits, and diabetes outpatient self-management training visits match the definition of FQHC mental health visits in which the visit can also include encounters furnished through interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio/video interaction for the purposes of diagnosis, evaluation or treatment of a mental health disorder

(III.G) Medicare Shared Savings Program

Option to receive advance investment payments (AIPs) (§425.630)
Proposal: CMS proposes AIPs intended to encourage low-revenue Accountable Care Organizations (ACOs) that are inexperienced with risk to participate in the Shared Savings Program and to provide additional resources to such ACOs in order to support care improvement for underserved beneficiaries. An ACO receives two types of advance investment payments: a one-time payment of $250,000 and quarterly payments for the first two years of the 5-year agreement period. Quarterly payments would be based on a score set to 100 if the beneficiary is dually eligible for Medicare and Medicaid or set to the ADI national percentile rank (an integer between 1 and 100) of the census block group in which the beneficiary resides if the beneficiary is not dually eligible, with higher payment amounts for assigned beneficiaries with a higher risk factors-based score.). The advance investment payments would be recouped once the ACO begins to achieve shared savings in their current agreement period and in their next agreement period, if a balance persists. If the ACO doesn't achieve shared savings, we would not recoup the funding, except if the ACO terminates during the agreement period in which it received the advance investment payments. Under the proposed approach, ACOs must use advance investment payments to improve health care provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries, which may include addressing social needs. ACOs would also publicly report on their website the amount of any advance investment payments and the actual amount spent in each of the spend plan categories.

ACH Comment: ACH appreciates the upfront AIPs to advance equity in the Shared Savings Program and ultimately advance health equity for beneficiaries. We support ACOs publicly reporting the amount of AIPs in order to increase transparency to the public and beneficiaries. The ACO Investment Model, which generated net savings, provided advanced payments to support infrastructure financial support[3].

[3] https://innovation.cms.gov/innovation-models/aco-investment-model

Recouping via shared savings lessens cash flow issues, especially since CMS will not recoup money if no savings are earned.

Nevertheless, ACH strongly recommends allowing FQHCs and other safety-net ACOs to receive the AIP even if the ACO has experience in shared saving initiatives. Additionally, we urge CMS to consider if $250,000 is enough money for infrastructure building, particularly to account for building information technology and strengthening data staff and resources. The proposed $250,000 AIP is the same amount given to Accountable Investment Model participants in 2016, but the proposed amount does not consider inflation.

Recent Innovation Center studies and a health equity analysis of people eligible for assignment to ACOs in the 2021 performance year demonstrated that lower income individuals or members of racial or ethnic communities appeared to represent a disproportionately smaller share of the Medicare population assigned to ACOs. Therefore, to advance health equity requires supporting safety net providers who reach the most vulnerable patients in often underserved areas. CMS must consider the unique underlying population of an ACO. For example, FQHCs are often low revenue ACOs who participate under no or low financial risk and use retrospective beneficiary alignment. Medicare is often small portion of the FQHC's population, which should be considered for alignment, quality measures, benchmarking, and the quarterly payments.

The proposed quarterly payment listed in Table 42 may not be sufficient and the methodology may need revision. The risk factors-based score will be set to the Area Deprivation Index national percentile rank matched to the beneficiary's mailing address if the beneficiary is not dually eligible for Medicare and Medicaid and sufficient data is available to match the beneficiary to an Area Deprivation Index (ADI) national percentile rank. ACH suggests considering both the Primary Care Health Professional Shortage Area (HPSA) and the ADI. The Accountable Care Organization Investment Model evaluated both ADI and HPSA[4], and HPSA may be a better indicator for FQHCs participating in SSP, particularly for understanding underserved communities at the local level.

For the quarterly payment amount, we suggest looking at other Innovation Model payment amounts. For example, the Primary Care First Model pays a per-beneficiary per-month population-based payment that ranges from $28 to $175[5] based a practice's overall patient risk group. The Maryland Total Cost of Care (MTCOC) Model also provides a care management payment from $6 to $100[6] per-beneficiary per-month based on model track and risk adjustment. This model has reduced spending, doubled rates of follow-up after ED or hospital discharge, strengthened case management, support processes to screen patients for social needs, and progressed initial ways for practices to integrate behavioral health care.

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[4] https://innovation.cms.gov/data-and-reports/2020/aim-final-annrpt
[5] https://innovation.cms.gov/media/document/pcf-py22-payment-meth-vol1
[6] https://www.mathematica.org/download-media?MediaItemId=%7BB1224F74-0853-46EF-ADC0-2760A3090FC9%7D

Smoothing the Transition to Performance-Based Risk

Proposal: For agreement periods beginning on January 1, 2024, and in subsequent years, we are proposing to allow ACOs inexperienced with performance-based risk to participate in one 5-year agreement under a one-sided shared savings model only by entering the BASIC track's glide path and remaining in Level A for all 5 years. These ACOs may be eligible for a second agreement period within the BASIC track's glide path, with 2 additional years under a one-sided model for a total of 7 years before transitioning to two-sided risk. For performance years beginning January 1, 2023, and in subsequent years, we are proposing to allow ACOs currently participating in Level A or B the option to elect to continue in their current level of the BASIC track glide path for the remainder of their agreement. For agreement periods beginning on January 1, 2024, and in subsequent years, we are proposing to remove the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track; participation in the ENHANCED track would be optional.

ACH Comment: ACH supports these proposals to encourage participation in MSSP, and ease ACOs into risk-sharing. As stated previously, some low-revenue FQHC ACOs may want to stay in one-sided risk Level A for the entirety of their agreement.

However, we strongly urge CMS to give any needed data, such as revenue checks, in time and with ample notice before a decision on levels needs to be determined. As proposed, "If the ACO does not elect to remain under Level A or Level B, for performance year 2024, the ACO is automatically advanced to the next level of the BASIC track's glide path, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). A voluntary election by an ACO under this paragraph must be made in the form and manner and by a deadline established by CMS." Therefore, we recommend that such deadlines and the manner needed to notify is not burdensome and allows ample time for an ACO to decide their best course of action. Transparency and clear guidance can help ensure MSSP participation.

Smoothing the transition into risk also involves benchmark adjustments. Therefore, we also suggest that CMS reevaluates the cap of shared savings that cannot exceed 10% of updated benchmark for the basic tracks. The proposed Accountable Care Prospective Trend (ACPT) along with general benchmarking methodologies may not account for geographic differences, patient population, and different Medicare spending.

Proposal to Implement a Health Equity Adjustment and Reducing the Impact of the Negative Regional Adjustment

Proposal: CMS is proposing to implement a health equity adjustment of up to 10 bonus points to an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs and based on (1) high quality measure performance and (2) providing care for a higher proportion of underserved or dually eligible beneficiaries. We propose to use the area deprivation index (ADI) score and Medicare and Medicaid dually eligible status to assess underserved populations which would allow capturing of broader neighborhood level and individual beneficiary characteristics. The proposal would add bonus

points to the ACO's MIPS quality performance category score if the ACO scores in the top third or middle third of performance for each quality measure. This proposal would only positively impact ACOs and not penalize them.

CMS proposes to institute two policy changes designed to limit the impact of negative regional adjustments on ACO historical benchmarks and further incentivize program participation among ACOs serving high cost beneficiaries. CMS proposes to reduce the cap on negative regional adjustments from negative 5% of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3 for assignable beneficiaries to negative 1.5%. We also propose that after the cap is applied to the regional adjustment, to gradually decrease the negative regional adjustment amount as an ACO's proportion of dual eligible Medicare and Medicaid beneficiaries increases or its weighted-average prospective HCC risk score increases.

ACH Comment: While we appreciate a health equity adjustment that would not penalize ACOs, the 10 bonus points are not enough to make up for regional benchmarks in which ACOs tend to compete with themselves. FQHCs who see all-payer patients or patients that cannot pay at all, meaning their attributed Medicare population is not representative of their overall patient or community population and so these adjustments may not account for an ACO's sub-population differences. The health equity adjustment as well as quality measures must consider local data, not just ADI national data. While in theory reducing the regional benchmark cap from negative 5% to negative 1.5%, this may have unintended consequences for FQHCs who want to participate in value-based care, but whose majority of the population may not have Medicare.

Proposal to Modify Marketing Material Review Requirements

Proposal: CMS proposing to remove the requirement for ACOs to submit marketing materials for CMS review prior to use. ACOs would continue to have to comply with marketing material requirements and CMS maintains its ability to review marketing materials upon request. We would also maintain our requirements regarding the content of marketing materials and our ability to issue a compliance action if a marketing material is out of compliance in the future.

ACH Comment: ACH supports this proposal, which will reduce administrative burden.

Proposal to Modify Beneficiary Notification Requirements

Proposal: CMS is proposing to modify the requirement for ACOs to provide a beneficiary notice prior to or at the first primary care service visit annually to providing the notice prior to or at the first primary care service visit once per agreement period, with a follow-up beneficiary communication taking place within 180 days after the beneficiary notice is provided. CMS is also proposing to further clarify our current policy that all ACO participant practices and facilities need to post signs notifying beneficiaries of

their participation in an ACO, what it means for their care, and their ability to decline claims data sharing and voluntary align to their primary clinicians.

ACH Comment: ACH supports beneficiary notification once per agreement period and posting signs notifying beneficiaries of their participation in an ACO. Per regulations, information is always available to a beneficiary upon request. However, ACH does not support follow-up with 180 days after the beneficiary notice is provided as this may add to administrative burden. Additionally, especially for FQHCs, beneficiary assignment is not stagnant, and constant follow up may further confuse a patient. Instead, similar to marketing activities, we suggest that an ACO provides follow-up in a form and manner that is appropriate for population the ACO serves.

Updates to ACO Beneficiary Assignment Methodology

Proposal: CMS is proposing to modify our approach for identifying facilities, such as Federally Qualified Health Centers, Rural Health Clinics, Electing Teaching Amendment hospitals, and Method II Critical Access Hospitals, identified by CMS Certification Numbers (CCNs) on ACO participant lists used to assign beneficiaries, to account for changes in CCN enrollment during the performance year.

ACH Comment: ACH supports this proposal, but we suggest clear guidance of beneficiary and provider overlaps rules with other Innovation Center initiatives well before participant lists are due. Understanding overlaps will help ACOs set up for success.

Social Determinants of Health Measure and Addition of New Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey Questions Requests for Information (RFIs)

RFI: In order to further address health equity as it relates to quality measurement, we also have a request for information on the use of two social determinants of health (SDOH) eCQM/MIPS CQM outcome-oriented measures for ACOs, which would assess providers on the percentage of individuals screened for social needs (done in conjunction with CCSQ), and inclusion of CAHPS for MIPS survey questions specific to discrimination and price transparency. These SDOH eCQM/MIPS CQMs are identical to those proposed as part of the Inpatient Prospective Payment System (IPPS) Proposed Rule for Hospital Inpatient Quality Reporting (IQR), demonstrating alignment across quality programs.

ACH Comment: ACH applauds adding in SDOH measures. Many MCOs require screening of SDOH, often via PRAPARE, and use of Z codes. Therefore, we suggest that the administration partner with MCOs and CBOs to understand best practices for SDOH screening and more importantly, follow up and referral. While screening is needed, the follow up is what drives health equity and improves patient outcomes.

Conclusion

ACH thanks the administration for proposing changes to the Physician Fee Schedule and to the Medicare Shared Savings Program that aim to advance health equity. For more information, please feel free to contact me at apearskelly@advocatesforcommunityhealth.org.

Sincerely,

Amanda Kelly
Chief Executive Officer
Advocates for Community Health