September 9, 2024

Meena Seshamani, MD PhD
Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Woodlawn, MD 21244

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments - CMS-1807-P

Dear Dr. Seshamani:

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (BHN), we appreciate this opportunity to offer comment on this Notice of Proposed Rulemaking (NPRM).

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 69 organizational Members ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high-value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships and "upstream" drivers for a better patient experience and better health outcomes. (See the Shared Principles of Primary Care). In March 2022, PCC launched the Better Health – NOW (BHN) campaign to realize bold policy change rooted in one simple principle: We need strong primary care in every community to achieve better health for all. A diverse set of organizations drive the BHN campaign.

Primary care is the one component of the health care delivery system where increased supply is consistently associated with improved population health, lower costs and more equitable outcomes.[1] [2] Yet despite growing chronic disease prevalence and persistent health disparities, the U.S. has devoted just 4.7% of health care dollars to primary care, a proportion that is trending down.[3] Today, after years of this erosion in investment in

[1] Sanjay Basu et al., "Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015," JAMA *Internal Medicine* 179, no. 4 (April 1, 2019): 506, https://doi.org/10.1001/jamainternmed.2018.7624.
[2] Leiyu Shi, "The Impact of Primary Care: A Focused Review," *Scientifica* 2012 (January 1, 2012): 1–22, https://doi.org/10.6064/2012/432892.
[3] Yalda Jabbarpour et al., "The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now | Milbank Memorial Fund," Milbank Memorial Fund, July 24, 2024, https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/.

primary care and challenges associated with the pandemic, primary care in the United States has reached a crisis point.[4]

Bold policy changes are urgently needed - changes capable of transforming both how much health care payers invest in primary care and the payment models through which those resources flow. We are encouraged, therefore, that CMS is acknowledging the imperative of changing both how and how much Medicare invests in primary care.

We have seen this acknowledgement reflected in past regulatory action to revalue Evaluation and Management service and establish G2211 payment for complex care; It is clearly visible in this year's Advanced Primary Care Management proposal and RFI on hybrid primary care payment. In the detailed comments below, PCC and our Better Health – NOW partners:

- Call on CMS to finalize payment for Advanced Primary Care Management (APCM) services in the CY 2025 rule along with suggested improvements to CMS' proposal.
- Articulate PCC/BHN's principles for a widely available hybrid payment and respond to key design questions raised by CMS' Request for Information (RFI) on Advanced Primary Care Hybrid Payment. Our responses stress the need for permanent hybrid payment options in Part B, support behavioral health integration, and emphasize cost-sharing relief.
- Call on CMS to move forward with key MSSP improvements, including the Health Equity Benchmark Adjustment and Prepaid Shared Savings.
- Respond to CMS' request for comments on greater risk/reward in MSSP's ENHANCED track.
- Express appreciation for and offer comments on specific CMS proposals that:
    - Improve MPFS Primary Care Payment, including removal of restrictions on G2211 in conjunction with preventive care, new payment to support ASCVD risk assessments and management, caregiver training services and expanded Part B vaccine coverage and payment;
    - Secure Telehealth, including permanent policy regarding audio-only services and distant site requirements;
    - Support Behavioral Health Integration, including payment changes that will reimburse for safety planning interventions, interprofessional consultation and innovative digital mental health tools; and
    - Bolster FQHCs and RHCs, including provisions that allow for separate billing of care management services, remove restrictions on specialty care in Rural Health Clinics (RHCs) and suspension of in-person visit requirements for telemental health in Federally Qualified Health Centers (FQHCs.)

Unfortunately, at present, the reality for Medicare beneficiaries and their families at the point of care is one of declining access due to primary care workforce shortages. **Faced with the challenging reality of the front door of the US healthcare closing, we call on the agency to continue pursuing access and payment improvements within its authority, while working aggressively with the broader administration and Congress to fully address these barriers.**

[4] Larry A. Green Center and Primary Care Collaborative, "Quick COVID-19 Survey Series 37, Fielded March 13-19, 2023," *The Larry A. Green Center*, C19+Series+37+National+Executive+Summary+vF.pdf (squarespace.com)

DETAILED COMMENTS

Advanced Primary Care Management

BHN Supports Finalization of APCM Payment in the Final Rule

We applaud CMS for acknowledging the value of advanced primary care and providing greater financial stability for primary care. We encourage the agency to finalize payment for APCM services in this year's final rule.

At the conceptual level, we are very pleased the proposal reflects perspectives from the primary care research and advocacy community. CMS has rooted its proposal in the National Academies of Sciences, Engineering, and Medicine (NASEM)'s definition of primary care: "whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."[5] We also acknowledge and appreciate that the APCM proposal seeks to realize the goals of the U.S. Department of Health and Human Services' (HHS) Initiative to Strengthen Primary Care.[6]

Turning to the details of the proposal, we applaud CMS' attention to more accurately and appropriately compensating the practitioner "who is also responsible for all primary care services AND the focal point for all needed care." Continuity of primary care is consistently associated with lower costs and fewer hospitalizations, including among the Traditional Medicare population.[7] [8] Key elements of the proposal are helpful to expanding access to continuous primary care and should be incorporated into any final rule:

- Making Advanced Primary Care Management services available to Part B beneficiaries – whether their source of ongoing primary care is a practice billing under the PFS, an FQHC or an RHC.
- Allowing APCM services to be billed by practices participating in MSSP, certain population-based CMS Innovation Center models as well as practices billing under the PFS.
- Removing the time-based requirements characteristic of other care management codes.
- Eliminating timeframe restrictions for CTBS (7 days after the e/m visit for certain virtual check-ins).

We appreciate CMS' acknowledgement that not all elements may be necessary for every patient during each month.

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[5] The National Academies of Sciences, Engineering and Medicine, "*Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*," *Nationalacademies.Org*, May 2021, https://doi.org/10.17226/25983.

[6] Rachel L. Levine et al., "The U.S. Department of Health and Human Services Is Taking Action to Strengthen Primary Care," *HHS.Gov* (blog), November 7, 2023, https://www.hhs.gov/blog/2023/11/07/us-department-health-and-human-services-taking-action-strengthen-primary-care.html.

[7] Dilara Sonmez, George Weyer, and Daniel Adelman, "Primary Care Continuity, Frequency, and Regularity Associated With Medicare Savings," *JAMA Network Open* 6, no. 8 (August 21, 2023): e2329991, https://doi.org/10.1001/jamanetworkopen.2023.29991.

[8] Andrew Bazemore et al., "Higher Primary Care Physician Continuity Is Associated With Lower Costs and Hospitalizations," *The Annals of Family Medicine* 16, no. 6 (November 1, 2018): 492–97, https://doi.org/10.1370/afm.2308.

Finally, Better Health – NOW is particularly encouraged by inclusion of payment adjustment for both clinical and social risk.

APCM's Success Hinges on Sound Design and Implementation

To support broader availability of advanced primary care to Medicare beneficiaries, and promote comprehensive care, we encourage CMS to consider the following additional steps:

- As noted above, BHN appreciates CMS' proposal to reimburse for APCM codes using a mix of clinical and social risk. The highest level of reimbursement would be available to patients with Qualified Medicare Beneficiary status, which would be used as a proxy for social risk. **CMS should broaden the definition of social risk used to trigger the level 3 codes, by using all available data on social risk.** Overall, CMS should consider both the number of chronic conditions and social risk measures used by CMS and CMMI elsewhere: dual eligibility, low-income subsidy status, eligibility for Medicare due to disability, and national and regional ADI.
- Medicare's existing behavioral health integration codes (e.g. Psychiatric Collaborative Care Model and General Behavioral Health Integration), community health integration, and Remote Therapeutic Monitoring/Remote Patient Monitoring services each can contribute to comprehensive primary care but are not included in APCM as proposed. We note that practices or clinics not yet delivering these services may require additional substantial financial resources to build the teams, relationships and workflows necessary to deploy these services in accordance with best medical evidence. **We agree with CMS that these services "complement APCM services rather than substantially overlap or duplicate services" and that additional payment is needed to support their regular utilization. These identified services should remain outside of the proposed APCM service.** Below, in the section of this letter responsive to CMS' RFI, we provide more detailed comments with respect to behavioral health integration in the context of a more comprehensive, evolved hybrid payment.

Medicare Primary Care Payment Policy Must Continue to Evolve

Finalization of APCM services represents one step, albeit an important one, towards the primary care that Medicare beneficiaries, all individuals and their communities need. To realize the promise of primary care, the agency must go further, working with the broader administration and Congress to fully address these barriers. To ensure that Medicare can successfully build on this step, adequate primary care payment policy must surmount major barriers. These include statutory cost-sharing requirements, siloed physical and behavioral health delivery systems, the Physician Fee Schedule's budget neutrality requirements and the persistent, systematic undervaluing of primary care.

PCC and Better Health – NOW is particularly concerned that cost-sharing requirements could undermine the sustained, comprehensive primary care relationships the APCM service purports to support. The Kaiser Family Foundation estimates that 3.2 million beneficiaries lack any supplemental coverage and would be responsible for coinsurance

equal to 20% of the charges.[9] In addition, of the 12.5 million beneficiaries with Medigap, a substantial portion are enrolled in plans that retain cost-sharing for Part B services.[10] To allow for optimal implementation of APCM, CMS must take those steps that do lie within its authority to mitigate the cost-sharing barriers. We therefore call on CMS leadership to:

- Provide robust educational materials to Medicare PFS providers and beneficiaries that clearly address options for covering costs and specifically communicate the value of APCM and a primary care relationship, alongside similar educational materials for other care management services (e.g., behavioral health integration).
- Provide stakeholders and the public with further detailed analysis of the characteristics and extent of the population exposed to cost-sharing requirements associated with these services.
- Finalize a Prepaid Shared Savings provision that would enable ACOs use of prepaid savings to provide cost-sharing support for non-face-to-face services including APCM, behavioral health integration services, and other care management services and highlight the opportunity to use this option to cover APCM, BHI and other care management services.
- Work with stakeholders, other executive agencies and bipartisan leaders in Congress to craft legislative measures to address cost-sharing requirements for APCM and, where appropriate, other care management services in primary care.

Request for Information: Advanced Primary Care Hybrid Payment

In our comments regarding the CY 2023 MPFS proposed rule, PCC and our Better Health – NOW partners called on CMS to seek public comment on pathways to population-based, prospective payment. We thank CMS for responding with this RFI. Below, we share our broad principles for a broadly available hybrid payment option in Medicare Part B, followed by responses to key questions included in the RFI.

Better Health – NOW supports efforts to rapidly transition primary care payment from a predominantly fee-for-service (FFS) approach to one based upon prospective population-based payment (hybrid) models. These new models should include upfront and ongoing investments, as well as guardrails to assure quality and access in both rural and underserved communities. Within such a hybrid payment approach, payment for a defined set of primary care services would be provided upfront to practices each month, when furnished by primary care clinicians and teams to patients within a primary care setting. This would be coupled with FFS payment for other services not paid for in the population-based payment.

However, as we noted in recent correspondence to Congress, movement toward hybrid payment in Medicare should proceed alongside reforms addressing budget neutrality

[9] Clerveau, Gabrielle, Nancy Ochieng, and 2023. 2023. "A Snapshot of Sources of Coverage among Medicare Beneficiaries." KFF. December 13, 2023. https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/.

[10] Statistica estimates that 10% of Medigap enrollees choose Plan N, which replaces coinsurance with copays for some services. See: https://www.statista.com/statistics/413074/medigap-enrollment-by-plan-type/ and https://www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits

and integration of behavioral and social care.[11] We encourage CMS leadership to work in coordination with other federal agencies and Congress to maximize progress. It is critical that the establishment of a broadly available hybrid payment option in Medicare Part B not be offset through reductions in reimbursement for primary care and other cognitive services elsewhere in Medicare. The zero-sum budget neutrality requirements applicable to the Physician Fee Schedule should not be allowed to undermine the scope and viability of advanced primary care hybrid payment or other substantial reforms to Part B payment.

Principles for Broadly Available Hybrid Payment Options

The design and implementation of hybrid payment should invest in primary care capacity, support personalized, team-based care, and pay for services tailored to the needs of the patient and the community. Better Health – NOW has identified six principles which primary care hybrid payment options within Medicare Part B should reflect:

1. Tier the value of payment based on the scope of services provided.

2. Allow payment adjustments for clinical and social risk sufficient to support multidisciplinary primary care teams reflecting and meeting the needs of diverse populations. Overall payment should reflect beneficiaries' social risk and avoid reinforcing historical patterns of underutilization driven by poor access to care in both rural and underserved communities.

3. Make a higher tier payment available to practices that deliver greater levels of integration of behavioral health and social care (e.g., community health integration).

4. Incorporate and provide payment sufficient to support evidence-based behavioral health screening and referral and screening for the social determinants of health (SDOH).

5. Provide for an accountability framework that:
    - Stresses comprehensiveness, first contact access, coordination, and continuity.
    - Supports improvement of care for patient subpopulations facing greater social or economic vulnerabilities, (for example: by tracking utilization and quality by subpopulation).
    - Streamlines metrics and avoids duplication or unnecessary measurement burden.
    - Tracks utilization of services (e.g., in-person evaluation and management visits, behavioral health integration services, SDoH screening, and referral, etc.).
6. Allow for cost-sharing waivers applicable to primary care services reimbursed through a population-based hybrid payment. (see below for more detailed discussion)

[11] Primary Care Collaborative, "Better Health - NOW Replies to RFI on Pay PCPs Act," *Thepcc.Org*, July 16, 2024, https://thepcc.org/2024/07/16/better-health-now-replies-rfi-pay-pcps-act.

Hybrid Primary Care Payment: CMS' 2030 Goals and Accountable Care

CMS Question: How can CMS ensure that potential future advanced primary care payment will not induce clinicians to leave effective accountable care relationships and clinician networks that already produce positive results? Additionally, how can CMS support growth over time in existing effective accountable care relationships and clinician networks?

PCC/BHN Response: Overwhelming evidence indicates a primary care relationship is core to improved population health. Success of CMS National Quality Strategy and achievement of certain HHS Healthy People 2030 objectives depend on strengthening those relationships. "**Evolving and creating over time advanced primary care hybrid payments," as envisioned in this RFI, can help connect Medicare beneficiaries to that ongoing primary care relationship.**

At the same time, CMS' experience with MSSP, Innovation Center advanced primary care and other total cost of care (TCOC) models have led the agency to conclude that every Medicare beneficiary should have a relationship with a provider accountable for cost and quality of care by 2030.[12]

Better Health – NOW encourages CMS to <u>both</u> continue its work to make hybrid payment broadly available within Traditional Medicare <u>and</u> expand participation in TCOC approaches like MSSP and ACO REACH.

When available on a broad and permanent basis in MSSP and other TCOC models, properly designed and implemented hybrid payment has the potential to bolster cost savings and quality improvement for those practices engaged in TCOC accountability. For those not participating in TCOC models, hybrid primary care payment may have the potential to strengthen the capacities needed for success in such models.

However, wider hybrid payment availability and wider participation in TCOC models are conceptually distinct; confusing these aims could lead to unintended consequences which CMS must seek to avoid.

On the one hand, at the level of individual practices or clinics billing under MPFS, TCOC accountability or downside risk could hold primary care practices financially responsible for costs beyond their influence, e.g. unplanned hospitalizations or surgical complications.[13] This could force some practices to choose between shuttering their doors or consolidation as part of a larger system.

On the other hand, foregoing accountability for total cost of care and overall beneficiary outcomes at the larger ACO level could undermine the positive impacts ACO-based models produce for patients' health and the Medicare program.

Therefore, mindful of the relationship between these two worthwhile goals, CMS should pursue both wider availability of hybrid and broader access to TCOC models – working

[12] CMS Innovation Center, "Strategic Direction," CMS.gov, n.d., https://www.cms.gov/priorities/innovation/about/strategic-direction.
[13] Notably, CPC+ a CMMI advanced primary care model have yielded improvements in ED utilization and overall acute care hospitalizations. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10777250/

carefully and frequently with stakeholders, frontline clinicians and patient voices to assure the agency's efforts are mutually reinforcing.

Hybrid Primary Care Payment: Evolving Permanent Options in Part B

CMS Question: How can CMS better support primary care clinicians and practices who may be new to population-based and longitudinal care management?
CMS Question: Should CMS evolve the proposed APCM services into an advanced primary care payment that includes E/M and other relevant services, or maintain a separate code set for APCM?

PCC/Better Health – NOW Response: As noted above, Better Health – NOW supports rapidly transitioning primary care payment from a predominantly fee-for-service (FFS) approach to one based upon prospective population-based payment (hybrid) models. This transition will require broad availability of hybrid payment in Medicare Part B – to expand the opportunities for participation to all Medicare primary care. To send a clear signal to the delivery system, hybrid models must also be evolved into a secure part of the permanent Medicare program, not solely confined to time-limited models or demonstrations. It is therefore necessary that CMS evolve a population-based, prospective primary care payment through rulemaking, in close consultation with primary care clinicians, patient voices and the broad range of primary care stakeholders.

If CMS evolves an advanced primary care inclusive of E/M services, APCM services are likely to remain useful to practices that may not wish to participate in the envisioned hybrid payment and should remain available as a separate code set. For example, new primary care practices, small or rural practices or practices with a limited number of attributable Part B patients may wish to employ separate APCM code set or time-based care management services. Both options should remain available. Practices utilizing APCM should retain the ability to provide and file claims under the fee schedule – either to support specific services not included in the PMPM (e.g. inpatient E & M services, and other services that are not commonly provided across primary care clinicians) or to furnish appropriate care for beneficiaries who have not been attributed to the practice. Additionally, CMS should plan to regularly refine the model, designating additional services for inclusion in the PMPM, drawing on experience of the Medicare program and other evidence.

Across payment models within Medicare and the CMS Innovation Center, we recognize that the most common method employed is to calculate prospective payment levels based on historical FFS claims data, considering both levels of utilization and prices – as set in the PFS – to inform the base rate of a monthly payment amount. However, basing prospective payment on historic FFS spending and prices has a number of significant downsides. First, reliance on historical spend alone risks entrenching existing disparities in health care payments between primary care and specialty care into a hybrid primary care payment. Second, using historical utilization and spending as the basis for setting hybrid primary care payments could inadvertently reinforce existing patterns of underinvestment in and underspending on health care for historically marginalized communities thus exacerbating existing health inequities and widening disparities in health outcomes. Third, relying solely on historic utilization would deny needed financing to all those practices and communities, which have yet to bring behavioral health integration and community health integration to scale.

Hybrid Primary Care Payment: Behavioral Health Integration

CMS Question: Should CMS consider incorporating other services that involve comprehensive care management and care coordination, such as Behavioral Health Integration, End-Stage Renal Disease Monthly Capitation Payment (ESRD MCP), Assessment/Care Planning for Cognitive Impairment, and/or Advance Care Planning?

PCC/Better Health – NOW Response: CMS should work closely with stakeholders to define services included in the population-based payment as part of hybrid primary care payments. In addition, CMS should avoid capitating services where it is beneficial to increase volume, such as vaccinations and other preventive care services.

Regarding behavioral health integration specifically, we applaud CMS's commitment to developing new hybrid payment models to create financially sustainable pathways to support primary care and its stated goal of fully integrating behavioral health care in primary care. As CMS further develops its strategy and options to support primary care, we urge CMS to develop a pathway to advanced primary care models that best achieve these complementary aims and produce the best outcomes and experience for patients.

These advanced primary care practices should include interdisciplinary team-based primary care, with behavioral health integration. As noted in its landmark report on *Implementing High-Quality Primary Care*, the National Academies of Science Engineering and Medicine stated:

> *The evidence for primary care integration is strongest for a behavioral health-primary care model. Mental health is a growing, costly global priority that has been exacerbated by the COVID-19 pandemic. Primary care has historically been the de facto mental health system for many individuals in the United States. Behavioral health concerns are often identified and managed within primary care, and integrating mental and physical health through innovative screening, diagnosis, and team management in primary care increases the likelihood that whole-person care—including behavioral health needs—can be addressed equitably, efficiently, and effectively. Individuals and families prefer to address their emotional and physical concerns through trusted primary care relationships and to be treated as a whole person, not just a disease. (p. 150-151)*

While behavioral health integration occurs on a spectrum, a wealth of research shows that the form of behavioral health integration into primary care that yields the best outcomes consists of far more than simply providing screening for depression or other behavioral disorders. Rather, it involves establishing a team-based approach to care in which primary care clinicians, care managers, and mental health specialists work seamlessly together to identify and help address not only behavioral health conditions, but also the behavioral factors affecting outcomes for physical and chronic health conditions across a broad swath of the patient population. It is vital that CMS provide reimbursement structures—both as part of hybrid payments or as parallel adjuncts to such payments—that provide support to primary care practices moving from traditional practice patterns to a more fully integrated, team-based tier of payment and performance.

As it evolves primary care payment approaches, CMS should track progress in achieving its behavioral health integration strategy by examining and reporting on resources, processes, and outcomes through claims data, as well as closer analysis of existing models and currently required outcome and process measures in order to inform a pathway to achieving greater behavioral health integration. We are pleased that CMS has incorporated behavioral health measures in the Universal Foundation (e.g., 'Preventive Care and Screening: Screening for Depression and Follow-Up Plan' and 'Initiation and Engagement of Substance Use Disorder are reflected Treatment.) CMS' approach to quality measurement for advanced primary care should support primary care-behavioral health integration while minimizing reporting burden. We call on CMS to both utilize the best measures currently available and prioritize measure development that measure primary care-behavioral health integration.

Finally, CMS should clearly articulate how the agency's lines of effort to strengthen primary care and expand behavioral health can work synergistically and convene stakeholders to inform its strategy in this regard.

Hybrid Primary Care Payment: Valuing Primary Care

CMS Question: Are there other sources of data on the relative value of primary care services that CMS should consider when setting hybrid payment rates?

PCC/Better Health – NOW Response: PCC and our Better Health – NOW partners remain concerned that existing sources of information tend to value Medicare services primarily on the basis of physical skill or technology used, while undervaluing cognitive services necessary for the management of complex patients with multiple chronic illnesses (i.e., critical thinking involved in data gathering and analysis, including understanding patient needs and preferences, planning, managing, decision making, and exercising judgment in ambiguous or uncertain situations).

In fact, one study found that Medicare reimburses physicians 3 to 5 times more for common procedures than for cognitive care.[14] In that study, the authors demonstrated that two common specialty procedures, cataract extraction and screening colonoscopy, can generate more revenue in one to two hours of total time than primary care receives for an entire day's work. Although cognitive services are not procedure-intensive (e.g., the work involved in a spinal tap), such services are increasingly labor intensive due to technological innovations, substantial amounts of data to review, and the coordination of different services both across primary care teams and across settings of care, (e.g., care coordination for a high-risk patient). While clinicians who primarily provide procedural services also provide a degree of cognitive care, those who almost exclusively provide cognitive care are deprived of an appropriate reimbursement due to the reliance on the metrics of time, intensity, and practice expense alone.

At present, CMS most often relies on the Relative Value Update Committee's (RUC) recommendations on the "resources needed to provide medical services" including time, intensity, clinical staff time, medical supplies, and professional liability. However, a focus on inputs alone may be contributing to less of the outputs Medicare beneficiaries and the Medicare program need most. To illustrate, a discussion of vaccination or

[14] Sinsky, Christine A., and David C. Dugdale. 2013. "Medicare Payment for Cognitive vs Procedural Care." JAMA Internal Medicine, August. https://doi.org/10.1001/jamainternmed.2013.9257.

smoking cessation with a trusted primary care clinician can require fewer inputs than specialty procedures (i.e., no medical supplies or fewer ancillary staff), but have the potential to generate comparable or even greater outputs for patients.

Importantly, this emphasis on inputs undermines the critical role that primary care plays in maintaining and restoring health. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels.

As the National Academy of Science Engineering and Medicine (NASEM) report points out, the nation's health is directly linked to the strength of its primary care delivery system and workforce. Unfortunately, the systemic undervaluing of cognitive (including primary care) services is problematic and widespread. As the current payment system drives down the value of primary care, there has been an attrition in the number of physicians practicing primary care, with a greater proportion of trainees choosing to go into procedure-based specialties. PCC's latest evidence report, *Health is Primary*, finds that the impacts of this attrition are shrinking the overall supply of primary care clinicians, even when the growing Advanced Practice Nursing and Physician Associate workforce is considered. The primary care shortage will, and has had, a profound impact on the availability, access and quality of care and patient health outcomes, particularly for the nation's most vulnerable elderly patients with complex chronic conditions.

The undervaluing of cognitive work also impacts key specialties beyond primary care (e.g., behavioral health) and undercuts reimbursement for behavioral health integration services. The shortage of behavioral health providers in the Medicare program highlights the need for CMS to consider integration as part of its primary care strategy and reimburse for these services accordingly.

Better Health – NOW organizations have a variety of perspectives on these challenges and optimal solutions, and we encourage CMS to continue dialogue with the primary care stakeholders represented among our participating organizations as you seek to understand and craft solutions.

Hybrid Primary Care Payment: Cost-Sharing Barriers and Burden Reduction

CMS Question: Care management coding and payment require beneficiary cost sharing. Has beneficiary cost sharing been a barrier to practitioners providing such services?

PCC/Better Health – NOW Response:
As with the proposed APCM services, the success of a more comprehensive advanced primary care hybrid payment in Medicare will depend on the removal of existing financial barriers to comprehensive, whole-person primary care.

Primary care is the only component of the health system that consistently leads to better outcomes.[15] To remove barriers to this high-value care, PCC has called on Congress to include patient cost-sharing waivers of the full coinsurance and deductible for services

[15] The National Academies of Sciences, Engineering and Medicine, "*Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*," *Nationalacademies.Org*, May 2021, https://doi.org/10.17226/25983.

provided prospectively as part of any hybrid primary care payment. We know that cost-sharing relief reduces affordability barriers to primary care for individual Medicare beneficiaries – half of whom had incomes under $36,000 a year in 2023 and three in ten beneficiaries spent more than half their income on health care in 2022.[16] [17]

Studies have shown that patient cost sharing requirements are associated with lower utilization of important primary care and preventive services and increased hospitalizations, thus increasing overall health care spending while disincentivizing high value care.

Cost sharing also has been a significant barrier to expanded utilization of Medicare care management and behavioral health integration services. CMS should work with Congress to address these barriers to better meet the needs of patients.

CMS Question: How can CMS reduce the potential burden of billing for population-based and longitudinal care services?

PCC/Better Health – NOW Response: By reducing the incentive to maximize billing that is inherent in a fee-for-service system, hybrid payment strikes at one root cause of administrative burden. The documentation burden required for many PFS codes adds to systemic costs and consumes clinician time that could be better spent with patients. In the future, these documentation requirements ought to become less necessary and can be more easily alleviated to the extent the incentive to maximize volume of services delivered is reduced.

However, today's alternative payment models have yet to realize that promise. In fact, service code-based documentation requirements persist. Additionally, primary care clinician focus groups report additional sources of burden, including risk adjustment coding and model misalignment across payers, may deter participation in value-based care models.[18] Recent evidence indicates that primary care physicians participating in value-based contracts report an average of 57 unique quality metrics.[19] Ultimately, this pattern will undercut patient access.

As CMS evolves toward advanced primary care hybrid payment, we encourage the agency to engage with the stakeholder community, other payers and front-line clinicians (as described below) to mitigate burden while ensuring access and quality.

Hybrid Primary Care Payment: Person-Centered Care

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[16] Alex Cottrill et al., "Income and Assets of Medicare Beneficiaries in 2023 | KFF," KFF, February 9, 2024, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/.
[17] Nancy Ochieng, Juliette Cubanski, and Anthony Damico, "Medicare Households Spend More on Health Care Than Other Households | KFF," KFF, March 14, 2024, https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/.
[18] Ann S. O'Malley et al., "Why Primary Care Practitioners Aren't Joining Value-Based Payment Models: Reasons and Potential Solutions," *Commonwealth Fund*, July 17, 2024, https://doi.org/10.26099/2cxx-0z64.
[19] Claire Boone et al., "Value-Based Contracting in Clinical Care," *JAMA Health Forum* 5, no. 8 (August 23, 2024): e242020, https://doi.org/10.1001/jamahealthforum.2024.2020.

CMS Question: What activities that support the delivery of care coordinated across clinicians, support systems, and time should be considered for payment in an advanced primary care bundle not currently captured in the PFS?
CMS Question: How can CMS structure advanced primary care hybrid payments to improve patient experience and outcomes?

PCC/Better Health – NOW Response: **Deepening dialogue and clear communication between CMS and the stakeholder community is absolutely essential.** While this RFI is an important step, CMS should continue to seek broad stakeholder input as it evolves hybrid payment that is truly person- family- and community-centered. **In a letter regarding implementation of the Innovation Center's ACO PC Flex Model, we recommended identifying a regular group of front-line clinicians and patients to provide periodic, real-time feedback on the model. We invite CMS to work with PCC to convene such a group.** Such a process could also have benefits as CMS considers the shape of a potential hybrid payment and other improvements to primary care payment**.**

Hybrid Primary Care Payment: Health Equity, Social and Clinical Risk

CMS Question: What risk factors, including clinical or social, should be considered in developing payment for advanced primary care services?
CMS Question What risk adjustments should be made to proposed payments to account for higher costs of traditionally underserved populations?

PCC/Better Health – NOW Response: We thank CMS for recognizing the need for a simple payment structure that encourages "uptake of advanced primary care services while providing for better incorporation of costly chronic conditions, as well as social risk factors." BHN supports adjusting payment for clinical and social risk - sufficient to support multidisciplinary primary care teams reflecting and meeting the needs of diverse populations. Overall payment should reflect a beneficiaries' social risk but avoid reinforcing historical patterns of underutilization driven by poor access to care in both rural and underserved communities.

The 2021 landmark NASEM report, *Implementing High-Quality Primary Care*, notes that "primary care is the only health care component where an increased supply is associated with better population health and *more equitable outcomes*."[20] When beneficiaries become eligible for Medicare, their health status reflects inequities that often begin early in life and reflect structural factors rooted in years of systemic racism, economic hardships and other circumstances. For many beneficiaries, gaining Medicare eligibility helps them establish and maintain a regular source of care because their source of coverage stabilizes, yet disparities across race in the percentage of beneficiaries reporting a usual source of care persist in Medicare.[21] Unfortunately, Medicare's physician fee schedule undervalues the prevention, chronic care management, and care coordination activities that can mitigate health inequities compounded over the lives of

[20] The National Academies of Sciences, Engineering and Medicine, "*Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*," *Nationalacademies.Org*, May 2021, https://doi.org/10.17226/25983.
[21] Yalda Jabbarpour et al., "Relationships Matter: How Usual Is Usual Source of (Primary) Care?: 2022 PCC Evidence Report," *Primary Care Collaborative*, November 2022, https://thepcc.org/resource/evidence2022?utm_source=link&utm_medium=link&utm_campaign=2022-evidence.

many individuals and that are exhibited in many marginalized communities.[22] We look forward to working with the agency to address these gaps in current CMS policy.

CMS Question: What metrics should be used or monitored to adjust payment to ensure that health disparities are not worsened as an unintended consequence?

PCC/Better Health – NOW Response: One significant barrier to adequate social risk adjustment is a lack of reliable and consistent data on social needs, particularly on the individual level. To the extent social needs screenings have been implemented, the results are often not captured in discrete data fields sufficiently at this stage for this to be a reliable source of data for risk adjustment. Efforts to incorporate social risk factors into risk adjustment often do so on the community level through metrics such as Area Deprivation Index (ADI), which map the relative socioeconomic conditions of communities using census data. Community level data like ADI is integral to the allocation of resources to underserved communities. However, over the longer term, usable individual level data on social needs will be important to adequately account for a wide array of social needs, particularly in communities with large socioeconomic disparities.

CMS Question: How can CMS ensure that advanced primary care hybrid payment increases access to health care services for patients without a usual source of primary care?

PCC/Better Health – NOW Response: Upfront, per-member, per-month payments would encourage practices and clinics to proactively initiate visits for more patients and attribute them to their practice, thereby expanding access to primary care. However, shifting to advanced primary care hybrid payment on its own will not address the large and growing primary care workforce shortages across the U.S. which have contributed to fewer people having a usual source of care.

To address these shortages and properly resource primary care practices to deliver high-quality care, the United States will have to reorient its health spending to invest in primary care. Experts have suggested that total primary care payment would need to be substantially higher than the 3.9% of Medicare expenditures we currently spend on primary care.

PCC has previously recommended that CMS measure current primary care spending levels and establish targets to increase average revenues of primary care practices. These steps, combined with moving to an advanced primary care payment model in the MPFS, could improve access to care and help primary care sustainably and comprehensively deliver needed services to Medicare beneficiaries.

CMS Question: Are there steps CMS can take to ensure advanced primary care billing and coding is utilized for dually eligible beneficiaries, and by safety net providers?

PCC/Better Health – NOW Response: To support health equity goals and ensure advanced primary care hybrid payments are available to practices and clinics serving disproportionately low-income and underserved populations, it is important for CMS to

[22] Larry McNeely et al., "Primary Care: A Key Lever to Advance Health Equity," *Primary Care Collaborative*, May 2022, https://thepcc.org/health-equity-report.

consider how to effectively engage both pillars of the primary care safety net: community health centers and smaller community-based primary care practices.

Recent focus groups with FQHC leaders supported by the Commonwealth Fund found that they see value-based payment as the future.[23] These leaders reported feeling primed to join the movement because they have long been required by the federal government to do many of the activities that are core to payment reform – from providing comprehensive primary care to reporting on quality measures. However, FQHCs do have concerns including the impact value-based care could have on their financial sustainability, insufficient recognition of complexity of their patient population, and the workflows, technology, and data systems needed to participate in value-based models. FQHC leaders said they would benefit from CMS providing onramps to financial risk (as in the new Making Care Primary model), accounting for patient complexity in payment rates and risk-adjustment approaches, offering upfront financial support to help FQHCs invest in data infrastructure and the staffing they need to make the transition, and providing technical assistance and training opportunities.

CMS would be well advised to get a deeper understanding of what the shrinking number of independent primary care practices – recently estimated at 20% of practices[24] -- need to successfully participate in value-based payments given their outsize role in providing care to the safety net.

Hybrid Primary Care Payment: Quality Improvement and Accountability

CMS Question: How can CMS ensure clinicians will remain engaged and accountable for their contributions to managing the beneficiary's care?
CMS Question: How could measures of quality, outcomes, and experience guard against and decrement in access or quality?
CMS Question: What should CMS consider so that advanced primary care bundles could be used to promote accountable care across payers, both commercial and Medicaid?

PCC/BHN Response: Better Health – NOW believes hybrid payment must provide for an accountability framework that:

- Stresses comprehensiveness, first contact access, coordination, and continuity.
- Supports improvement of care for patient subpopulations facing greater social or economic vulnerabilities, (for example: by tracking utilization and quality by subpopulation).
- Streamlines metrics and avoids duplication or unnecessary measurement burden.
- Tracks utilization of services (e.g., in-person evaluation and management visits, behavioral health integration services, SDoH screening, and referral, etc.).

[23] Corinne Lewis, Alexandra Bryan, and Celli Horstman, "Federally Qualified Health Centers Can Make the Switch to Value-Based Payment, but Need Assistance," Commonwealth Fund, February 26, 2024, https://doi.org/10.26099/gzca-1217.
[24] Hayden Rooke-Ley, Zirui Song, and Jane M. Zhu, "Value-Based Payment and Vanishing Small Independent Practices," *JAMA*, August 22, 2024, https://doi.org/10.1001/jama.2024.12900.

Other Proposals:

Telehealth: Audio-Only Services
Description: CMS proposes to permanently add audio-only services to the Medicare Telehealth Services List, which could be billed if the provider has video capacity, but the patient does not have or chooses not to use video.

PCC/Better Health – NOW Comment: Better Health – NOW appreciates and supports permanent policy changes to support appropriate use of audio-only telehealth technology. Disruption of audio-only coverage could undercut both access to care and disparity reduction.

Telehealth: Distant Site Requirements
Description: CMS proposes to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

PCC/Better Health – NOW Comment: Better Health – NOW supports this proposal. Since 2020's onset of the COVID-19 pandemic, CMS has allowed providers furnishing services via telehealth from their homes to list a practice address rather than their home address. A further extension of this flexibility is needed to assure privacy of clinicians furnishing telehealth services Medicare patients need. Moreover, it supports primary care practices that choose to expand patient access beyond the typical 9-5 working day – an important component of advanced primary care.

Caregiver Training Services
Description: CMS proposes new coding and payment for caregiver training for direct care services and supports, as well as caregiver behavioral management and modification training.

PCC/Better Health – NOW Comment: Better Health - NOW supports the creation of coding and payment for caregiver training services. Caregivers are essential for patient health and so is their training. The work that primary care practices do to provide this training today is uncompensated. These new codes will allow clinicians to be reimbursed for this critical work.

Office/Outpatient Evaluation and Management Same Day Payment (G2211)
Description: CMS proposes allowing payment of the O/O E/M visit complexity add-on code G2211 when it is reported on the same day as an annual wellness visit, vaccine or Medicare Part B preventative service.

PCC/Better Health – NOW Comment: Better Health - NOW supports the use of G2211 when reported on the same day as an annual wellness visit, vaccine or Medicare Part B preventative service. This shift in the specifications for G2211 will remove barriers to delivering multiple services and improve access to care. Rural and underserved communities often face challenges receiving in-person care due to distance, scheduling and other barriers, but this new payment will help these communities receive more vital services without barriers.

Atherosclerotic Cardiovascular Disease Risk Assessment & Management

Description: CMS proposes coding and payment for ASCVD risk assessment and management services. This assessment would happen with an E/M visit prior to diagnosis.

PCC/Better Health – NOW Comment: Better Health - NOW supports the creation of coding and payment for ASCVD risk assessment and management services, drawing on the clear findings of the CMS Innovation Center's Million Hearts Model. Cardiovascular disease is the leading cause of death in the US, so ASCVD prevention is critical to improving health, especially in vulnerable populations. Primary care clinicians provide vital preventative care and can do so effectively because of the strong relationship they build with patients. Properly resourcing primary care to perform this life-saving work is essential.

Medicare Part B Preventative Services (vaccinations)
Description: CMS proposes expanding coverage of hepatitis B vaccinations by covering individuals who have not previously received a completed hepatitis B vaccine series or whole vaccine history is unknown. CMS also proposes allowing RHCs and FQHCs to bill and be paid for part B preventative vaccines and administration at the time of service.

PCC/Better Health – NOW Comment: Better Health - NOW supports expanding coverage for vaccinations for Medicare Part B beneficiaries and for changes to billing and payment for these services at RHCs and FQHCs. We support making vaccines as accessible as possible, and these proposals reduce barriers for patients and create incentives for providers.

Behavioral Health: Safety Planning Intervention
Description: CMS proposes creating a Safety Planning Intervention add-on-G-code to be billed along with an E/M visit or psychotherapy service. CMS also proposes creating a monthly billing code supportive of Safety Planning Interventions that is a bundled service for specific protocols of post-discharge follow-up contacts in conjunction with discharge from an emergency department for a crisis encounter.

PCC/Better Health – NOW Comment: Better Health - NOW supports the creation of a Safety Planning Intervention add-on-G-code and bundle for post-discharge protocols. Suicide is an epidemic in this country, and primary care clinicians are often the only mental support patients have. This proposal will allow for reimbursement for work that clinicians perform to support mental health outside of in-person contact. We urge CMS to increase the time for the service or allow for time increments, insofar as safety planning can often take 45-60 minutes. CMS should also clarify that other staff can bill incident to the billing practitioner if they are doing the safety planning.

Behavioral Health: Expanded Interprofessional Consultation
Description: CMS proposes to establish a reimbursement mechanism for behavioral health clinicians engaging in interprofessional consultations for the treatment of their patients.

PCC/Better Health – NOW Comment: PCC/BHN supports this proposal. As primary care practices deepen the integration of behavioral health services, they may leverage clinical and non-clinical staff with a variety of backgrounds. This proposal ensures that Medicare supports direct consultations between members of the team and external professionals. For example, a beneficiaries' care may require an integrated primary care practice's clinical social worker to consult directly with a psychologist or addiction

counselor. This proposal will ensure that Medicare better supports the integration of behavioral health within primary care.

Behavioral Health: Digital Mental Health Treatment
Description: CMS is proposing to create three (3) new G codes for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care.

PCC/Better Health – NOW Comment: Digital behavioral health treatment devices deliver evidenced-based, clinically validated behavioral health interventions through legally marketed software approved by the FDA to treat or manage a broad spectrum of diseases and disorders. CMS' proposed framework mirrors existing codes with the added requirement of FDA approval of the device. Though evidence is still being developed on these treatments, PCC/BHN recognizes the need for a billing structure and thanks CMS for a proposal that should enable access to digital behavioral health treatment.

PCC/BHN particularly appreciates that the proposal includes reimbursement for both the supply of a digital product, and for the professional management of interventions furnished through the product. We encourage CMS to consider broadening the scope of devices to include medical and neurodevelopmental disorders to adequately cover the range of disorders treated by FDA-approved products. CMS should also consider adjusting the title of the proposed codes. Digital Behavioral Health Treatment better describes and captures the fact that behavioral health interventions are being used to treat and manage mental health, substance use, and medical conditions. We recommend CMS use the terminology Digital Behavioral Health Treatment (DBHT) instead of Digital Mental Health Treatment (DMHT).

FQHCs/RHCs: Billing and add-on codes for Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs)
Description: CMS proposes that RHCs and FQHCs report the individual CPT and HCPCS codes that describe care coordination services. CMS proposes to permit billing of the add-on codes associated with these care coordination services.

PCC/Better Health – NOW Comment: Better Health - NOW supports the use of individual CPT and HCPCS codes with add-on codes. Care coordination is a critical part of delivering comprehensive primary care, and these codes will allow clinicians to be reimbursed more accurately for care coordination.

FQHCs/RHCs: Conditions for Primary Care Coverage (CoCs) for Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs)
Description: CMS proposes adjusting COCs for RHCs and FQHCs to require provision of primary care services rather than requiring that RHCs be "primarily engaged" in these services.

PCC/Better Health – NOW Comment: Better Health - NOW supports the expansion of primary care access in RHCs and FQHCs. This proposal will ensure patients served by these clinics will receive access to primary care without inhibiting the delivery of specialty services. As rural communities continue to confront epidemics of mental health and substance use disorders, this change will remove a barrier to the provision of integrated behavioral health services in a primary care setting.

MSSP: Health Equity Benchmark Adjustment
CMS Proposal: CMS proposes a health equity benchmark adjustment based on proportion of Medicare Part-D Low-Income-Subsidy or dually eligible beneficiaries assigned to an ACO. CMS estimates that just twenty existing ACOs would benefit from the benchmark adjustment but goes on to share that it would bring between 500,000 and a million beneficiaries into MSSP by 2035.

PCC/Better Health – NOW Comment: Better Health - NOW strongly supports the fact that the HEBA would increase resources for ACOs serving underserved patients – to account for historic inequalities – without penalizing other ACOs by reducing their benchmarks. This policy aligns with CMS' health equity goals and with its goal to have all Medicare beneficiaries in accountable care relationships by 2030.

We encourage CMS to consider expanding the beneficiaries included in the HEBA calculation to include beneficiaries who obtained Medicare coverage due to disability, as well as beneficiaries that live in a high-risk ADI (based on either national or regional rankings). CMS should also eliminate the 20 percent threshold to maximize the impact of this adjustment. It is essential that VBC models do not penalize providers that care for higher-risk patients, including both clinical and social risk factors. While patient-level data is the gold standard, validated geographic indices such as the ADI are useful proxies. Using all available data elements on social risk and eliminating the threshold will expand the HEBA's ability to address these issues.

Establishing Higher Risk and Potential Reward under the ENHANCED Track
CMS Request for Comment: CMS seeks comments on financial arrangements that could allow for higher risk and potential reward under a revised ENHANCED track within MSSP.

PCC/Better Health – NOW Response: ACOs participating in ACO REACH are seeking new opportunities for more robust risk models when ACO REACH ends in 2026. The ENHANCED Plus track may also support former Next Generation ACOs with experience in full-risk models, as well as current ENHANCED participants who are ready to take on additional risk. For current ENHANCED track participant ACOs who have demonstrated an ability to take on full risk, an ENHANCED Plus track would provide them the opportunity to test care delivery innovations and advance in the program.

On the other hand, not all ACOs in the current ENHANCED track can take on the additional risk described in the NPRM. Requiring all ENHANCED ACOs to undertake a higher level of financial risk could limit participation in the ENHANCED track – particularly for those ACOs serving rural and underserved communities or composed largely of primary care practices. It is crucial to ensure that this new option is designed in a way that supports ACOs at all stages of their development, provides adequate safeguards to protect against excessive financial losses, and includes guardrails to ensure incentives are shared with the primary care clinicians and teams that contribute to their success.

If CMS moves forward with this approach, any ENHANCED Plus track should prioritize encouraging experienced ACOs to shift away from FFS payments by offering three things: (1) greater ACO opportunity for reward and accountability for risk based on costs and quality, (2) capitated payments for both low and high revenue ACOs, and (3) expanded benefit enhancements to allow ACOs flexibility in how they address

patient needs. CMS has repeatedly tested some of these concepts in earlier CMMI ACO and primary care models and has continued to incorporate these concepts into models like ACO REACH.

Specifically, we encourage CMS to incorporate the following into MSSP and any new ENHANCED Plus Track:

1. **Offer Greater Risk / Reward Opportunities**: CMS should create the option for MSSP advanced risk tracks above the existing ENHANCED Track that offers ACOs the option of having greater up- and downside risk.

2. **Support Capitated Payments:** Allow MSSP ACOs the option of:
    a. **Monthly primary care capitation** payments similar to those offered in the ACO Primary Care Flex (PC Flex) Model.
    b. **Total cost of care capitation** payments like the global track in ACO REACH. This option would support ACOs interested in stronger specialist engagement via mechanisms such as shadow bundles, in alignment with CMS' specialist integration goals. This would also provide ACO REACH participants with a clear option after the model concludes, creating greater predictability and encouraging the ongoing participation of these ACOs in CMS models.

3. **Increase Benefit Enhancements:** CMS should allow ACOs to improve care delivery and beneficiary affordability by expanding the MSSP benefit enhancement to match those in other models. Enhancements available to MSSP ACOs advanced risk tracks should include:
    a. **Beneficiary Affordability:** Implement lessons from value-based insurance design by allowing MSSP ACOs to waive patient copays and deductibles for visits to ACO providers in advanced risk models, similar to the ACO REACH program. This is particularly important for high-value services such as primary care and services to address patients' health-related social needs, such as the Community Health Integration services that became available in 2024.
    b. **Telehealth:** Broaden telehealth waivers to apply regardless of ACO assignment methodology to provide ACOs with a stable telehealth policy environment after the end of COVID-related telehealth policy exceptions. In addition, CMS should engage with stakeholders to identify additional services that can be safely and effectively provided via telehealth, leveraging ACOs to test and refine a modernized telehealth policy.
    c. **Simplify Skilled Nursing Facility (SNF) Three-Day Waiver:** Simplify the requirements for SNF waiver to make it easier for ACOs to implement by adopting flexibilities implemented during COVID as permanent waivers. This could include encouraging, but not requiring, ACOs to contract with SNFs.
    d. **Home-based services:** Explore adding additional waivers related to home-based services. CMS should adopt the post-discharge and care management home visits waivers in place under the ACO REACH model.

Action Needed to Improve Benchmarking in MSSP Overall

We appreciate that CMS acknowledges the downward ratchet effect created by benchmarking methodologies dependent on historical spending. The current approach threatens to make benchmarking strategies untenable in the long term. Left unchecked, this could create a race to the bottom, especially for ACOs with a long history of alternative payment model participation. Acknowledging this challenge, CMS has instituted a new five-year prospective cost growth trend factor known as the Accountable Care Prospective Trend (ACPT) based on U.S. per capita cost (USPCC) as one-third of a three-way blended trend incorporating the existing national-regional blend. The ACPT does not fully account for ratcheting within an agreement period, but it does reduce the weight of regional trends. F**urther action is needed to address the benchmark ratchet effect.**

Over the long-term, CMS must also move towards more foundational changes to benchmarking and risk adjustment that move the needle on addressing historic patterns of underinvestment, disinvestment and limited access to care. There remain significant equity concerns with today's approach. The foundation of MSSP benchmarking is an ACO's historical spending over the three previous benchmark years. While historical spending is an important data point for establishing benchmarks, this approach often inadvertently embeds and worsens existing health inequities and disparities in health care access and utilization.[25] Historic health care spending and utilization reflect long-term disparities in health care access and affordability experienced by rural and other marginalized communities.[26] For instance, Black and Hispanic families are more likely to skip or delay seeking care due to high health care costs, despite experiencing higher rates of diabetes, heart disease, and other chronic illnesses.[27] In turn, ACOs and other entities who serve rural or under-resourced communities may receive benchmarks that are set too low, especially when considering the greater health care needs often experienced by under-resourced communities.[28] It is critical that providers serving these communities not be penalized for addressing historic health inequities.

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[25] Families USA Submits Response to Request for Information on New Legislation to Improve Primary Care - Families USA," Families USA, July 16, 2024,
[26] Staci Lofton, "Do The Right Thing: Shifting Health Care Payment Systems to Value-Based Incentives to Achieve Health Equity and Promote Racial Justice," *Families USA*, December 2022, https://familiesusa.org/wp-content/uploads/2022/12/People-First-Care_Intersection-of-Payment-Reform-and-Equity.pdf.
[27] Ibid
[28] Douglas B. Jacobs, Michelle Schreiber, and Meena Seshamani, "The CMS Strategy to Promote Equity in Quality and Value Programs," JAMA Health Forum 4, no. 10 (October 20, 2023): e233557, https://doi.org/10.1001/jamahealthforum.2023.3557.

PCC and our Better Health-NOW campaign appreciate this opportunity to provide comments on the proposed rule and look forward to working with the CMS team to further strengthen primary care in Medicare. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at lmcneely@thepcc.org.

Sincerely,



Ann Greiner
President & CEO
Primary Care Collaborative