The Commonwealth Fund
Affordable, quality health care. For everyone.

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September 9, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

VIA ELECTRONIC SUBMISSION

Re: CMS CY 2025 Medicare Physician Fee Schedule

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the Calendar Year 2025 Medicare Physician Fee Schedule (CY 2025 Medicare PFS) Proposed Rule. The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable—including people of color, people with low income, and those who are uninsured.

We offer comment on the following sections of the proposed rule, informed by Fund and grantee expertise and research:[1]

- Section II.G.2: Advanced Primary Care Management (APCM) Services
- Section II.G.3: Request for Information: Advanced Primary Care Hybrid Payment
- Section II.I.2: Digital Mental Health Treatment (DMHT)

Section II.G.2: Advanced Primary Care Management Services

Primary care is the only health service associated with improved life expectancy and reduced health care disparities. Evidence is clear that improving the capacity and quality of primary care so that it can improve the health and wellbeing of persons and whole populations is essential to successfully addressing the nation's most pressing health crises. Patients with a usual source of care are more likely to receive recommended preventative screenings and services and primary care has been found to

[1] The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

improve detection, management, and outcomes for people with diabetes, cardiovascular disease, and hypertension.

But in the U.S., several indicators suggest that the sustainability and future of primary care is at risk. Three in ten people report not having a usual source of care – a declining number, despite increased access to insurance. Compared to other high-income countries, U.S. patients are among the least likely to have a usual source of care or a longstanding relationship with a primary care provider. This trend is only likely to worsen as the supply of primary care providers shrinks, particularly in communities with historically few primary care clinicians, such as rural areas.

There is growing consensus that changing *how* and *how much* we pay for primary care is a critical next step for policymakers to reverse these trends and strengthen primary care in the U.S. As the National Academies for Sciences, Engineering, and Medicine (NASEM) identified in their 2021 landmark report "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care", which the Commonwealth Fund co-funded, the growing issues facing primary care — including workforce shortages and poor access — are in large part due to the continued dominance of fee-for-service (FFS) payment, which discourages team-based, coordinated care, and decades-long underinvestment.

As one of the largest insurers in the U.S., Medicare plays a critical role in leading the charge by increasing our nation's investment in primary care services and changing the way we pay for them, moving towards more population-based approaches.

We appreciate the opportunity to address steps CMS can take to further advance primary care hybrid payment in the Medicare Physician Fee Schedule (MPFS) and to act on the evidence and expert opinion from the NASEM report. **Finalization of the new Advanced Primary Care Management (APCM) codes proposed for FY 2025 would represent a critical step towards streamlined and heightened compensation for high-value services primary care clinicians provide—including coordinating care, managing chronic illness, and communicating with patients and caregivers—but are often under-reimbursed, overly complex to bill, or not reimbursed at all.**

We applaud several provisions of the proposed APCM codes including nurse practitioners (NPs) and physician assistants (PAs) being eligible to bill for APCM services; accounting for social risk of patients through Qualified Medicare Beneficiary status in the highest tier of reimbursement; inclusion of Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs); removal of burdensome time-based documentation requirements associated with other care management codes; and primary care clinicians being able to bill APCM services on a monthly basis regardless of services rendered in a given month, giving them predictable revenue to not only manage patient care but invest in care delivery improvements and staffing.

The APCM codes are a major step towards realizing the NASEM report's goal of paying more and differently for primary care. Below we provide comments on how the Administration can build on this progress and create more transformative change by implementing a hybrid payment model for primary care.

Section II.G.3: Request for Information: Advanced Primary Care Hybrid Payment

1. **Streamlined Value-Based Care Opportunities**

- **How can CMS better support primary care clinicians and practices who may be new to population-based and longitudinal care management?**

  Recent research found that only 46% of primary care physicians participate in value-based payment, and those in smaller practices, in rural areas, or not part of larger, integrated health system are even less likely to participate. The Commonwealth Fund sought to learn about the barriers to engaging in advanced primary care payment directly from primary care clinicians that have not yet engaged in models. This qualitative research found that enthusiasm for payment reform is tempered by financial barriers and imperfect performance measures. Primary care clinicians offered many solutions that would help them successfully engage in advanced primary care payment and the population health management that comes with it, including:
  - Offering upfront payments to help new practices, particularly those that are smaller and independent, make the transition to payment reform by hiring necessary staff and investing in data and IT systems, as the new Making Care Primary model will do.
  - Ensuring the amount of prospective, population-based payments is sufficient for primary care clinicians to sustainably and comprehensively deliver needed services. This perspective was shared by those already engaging in payment reform; participants in Primary Care First, for instance, noted that even when payments were higher than FFS, they were still not adequate.
  - Prioritizing performance measures that reflect the value of primary care (i.e. comprehensiveness, continuity of care) rather than the condition-specific metrics currently employed by most models (see Section #5 "Quality Improvement and Accountability").
  - For providers that are part of larger health systems, creating accountability mechanisms to ensure prospective, population-based payments reach frontline primary care clinicians.

- **Newly finalized HCPCS codes are eligible for use by other payers, including commercial insurers, state Medicaid agencies, and others. We note that value-based alignment is a key goal of CMS. If the APCM codes are finalized, they would be eligible for use by these other payers as well. To what extent are other payers interested in adopting the APCM codes? Are there any other changes that would be necessary for other payers to adopt the codes?**

  We envision that other payers would be eager to adopt the APCM codes, as they are offering generous payment for high-value services primary care clinicians provide, but are either not compensated for, undercompensated for, or unable to bill due to burdensome time-based requirements.

  A range of payers are aware of the benefits of population-based, prospective payments like the APCM code, which have been tested in several large-scale primary care reforms by the Centers for Medicare and Medicaid Innovation (CMMI) including Comprehensive Primary Care, Comprehensive Primary Care Plus (CPC+), and Primary Care First. In evaluations of these models, participating practices emphasized that reliable prospective payments were invaluable for budgeting, hiring staff, and providing services otherwise not paid for. Interviews with practices in these models revealed that prospective payments were particularly important during the COVID-19 pandemic. By giving practices stable, consistent revenue, they protected against staff layoffs and allowed practices to

maintain critical service delivery, like care management and care coordination for high-need patients, with minimal financial losses.

Recognizing the benefits of prospective, population-based payments for primary care, a variety of payers have engaged in developing and launching such models. Over 20 private payers participated in CPC+ and there are many examples of commercial payers successfully launching their own models and initiatives. In California, purchasers, employers, and health plans have joined forces in an Advanced Primary Care Initiative to transform primary care payment and measurement. Several state Medicaid agencies have designed and launched prospective, population-based payment models for primary care.

There is clear interest and momentum for population-based payment in primary care across payers. However, uptake of the APCM codes could be hampered by the cost-sharing requirements (see Section #2 "Billing Requirements"). CMS could consider seeking feedback from commercial plans and State Medicaid Agencies to ensure the proposed APCM codes are additive to and aligned with payment reforms across payers and to address barriers to uptake.

- **CMS has historically used information presented by the Relative Value Scale Update Committee to determine PFS payment rates. Are there other sources of data on the relative value of primary care services that CMS should consider when setting hybrid payment rates?**

The Relative Value Scale Update Committee (RUC), which makes recommendations to CMS on updates to Relative Value Units (RVUs) in the MPFS, is dominated by specialists with few primary care clinicians represented. In addition, the current process the RUC employs to inform its RVU recommendations relies heavily on flawed estimates of practice expenses and clinician time and work compiled through burdensome surveys completed by clinicians as opposed to empirical, reliable data. These surveys have been criticized by the Government Accountability Office for low response rates, biased survey samples, and concerns about conflicts of interest, as those completing the surveys could benefit from inflating estimates of the time and work required for procedures they deliver.

Experts have suggested CMS establish a new process to more accurately and empirically determine RVUs, including the identification and development of data collection and valuation tools to identify over- and underpriced services. For example, to obtain empirical data on physician time and work, CMS could establish a rotating panel of practices to source timely and objective information for determining RVUs. This could be collected through administrative data extracted from electronic health records for some services and through direct observation of practice or physician staff to document the time needed to provide services to patients. A 2016 CMS commissioned study tested such empirical approaches with health systems and practices, and determined they are feasible alternatives for determining physician time and work, and ultimately RVUs. Recently introduced bipartisan legislation has proposed creating a technical expert panel within CMS to provide guidance on modernizing the fee schedule, including by establishing new processes to more accurately and empirically determine RVUs.

2. Billing Requirements

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

- **What is the best reporting structure to ensure that targeted services are delivered without causing undue or excessive documentation?**

  As proposed with the APCM codes, eliminating time-based documentation requirements, which were barriers to uptake of previous care management codes, would significantly reduce provider burden. In addition to relaxed time-based requirements, CMS can address another major source of burden for primary care clinicians in future advanced primary care payment models: reporting requirements. Recent evidence indicates that primary care physicians participating in value-based contracts report an average of 57 unique quality metrics. CMS can reduce reporting and administrative burden of primary care clinicians while improving the delivery of care for patients by applying a parsimonious set of billing requirements and quality measures that capture the core tenets of primary care (see below response under Section #5 "Quality Improvement and Accountability").

- **Care management coding and payment have historically required an initiating visit prior to starting monthly billing, to ensure that the services are medically reasonable and necessary and consistent with the plan of care. Are there other ways that CMS could ensure the clinician billing APCM is responsible for the primary care of the Medicare beneficiary?**

  We are supportive of the proposed APCM code process of an initiating visit and patient consent, particularly given the proposed cost sharing implications. If CMS seeks to evolve the APCM codes and further explore advanced primary care hybrid payment, it could consider voluntary patient attribution, which would be consistent with the goals of advanced primary care by engaging patients and centering their preferences. As experts have called for, CMS could develop approaches for collecting information from beneficiaries about who they consider to be their primary care provider. However, this approach comes with challenges, including the difficulty of getting the majority of patients to attribute a provider as their primary care clinician, particularly among those that face systemic barriers to care or those who lack the capacity to choose due to illness or another issue.

  Alternately, CMS could ensure attribution through claims-data, a common approach used in a number of federal health care programs including the Medicare Shared Savings Program. Under a claims-based approach, CMS could assign patients to a primary care clinician based on past annual wellness visits. This similarly could have health equity implications, as it could miss patients that have not been seen for an annual wellness visit due to systematic barriers to care, and it could incentivize providers to avoid seeing sicker, more costly patients to prevent them being attributed to their practice. If CMS uses a claims-based attribution approach, they could consider taking steps through risk adjustment and other efforts to reduce these perverse incentives.

  Given the limitations of each approach on their own, the Health Care Payment Learning and Action Network (HCP-LAN) and other experts have recommended a blended approach of voluntary attribution followed by claims-based attribution for patients that did not designate a primary care clinician.

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

  Cost-sharing requirements associated with care management codes pose significant barriers to uptake of services, while placing greater administrative burden on primary care clinicians

themselves. Even cost-sharing of just $1 to $5 has been linked to reductions in utilization of critical preventative care services – which can result in subsequent increases in costly forms of care like emergency department visits. It is for this reason over a dozen national provider associations called for the elimination of co-insurance requirements in Chronic Care Management (CCM) codes, as it was why "only 684,000 patients out of 35 million Medicare beneficiaries with two or more chronic conditions benefitted from CCM services over the first two years of the payment policy". Congress is currently considering legislation which would reduce beneficiary cost-sharing as part of a hybrid payment model for primary care.

- **Should CMS limit the types of non-physician clinicians that can bill for an advanced primary care bundle that is larger in scale and scope than APCM? If so, include evidence to support the restriction.**

  Advanced primary care practitioners, including NPs and PAs, are increasingly filling gaps in primary care access, particularly in rural areas. The number of primary care physicians per capita is falling, whereas the number of NPs and PAs is rising. To ensure the benefits of advanced primary care hybrid payment are available to a range of primary care clinicians and the patients they serve, and to prevent exacerbating geographic and other disparities in access to and quality of primary care, CMS could consider allowing advanced practitioners to participate as they have with the proposed APCM code.

3. **Person-Centered Care**

- **What activities that support the delivery of care that is coordinated across clinicians, support systems, and time should be considered for payment in an advanced primary care bundle that are not currently captured in the PFS?**
- **How can CMS structure advanced primary care hybrid payments to improve patient experience and outcomes?**
- **How can CMS structure advanced primary care hybrid payments to ensure appropriate access to telephonic and messaging primary care services?**

  Many of the high-value services primary care clinicians deliver which improve patient experience and outcomes – like care management, coordinating care across providers, following up with and checking in on patients, and addressing comprehensive needs – are either undercompensated, overly burdensome to bill for, or not paid for at all. As a result, to improve patient outcomes while giving providers greater flexibility, experts have suggested that population-based payments could cover:

  - Primary care services not necessarily linked to office visits which currently carry high documentation burden, such as care management and coordination.
  - Services that most primary care providers deliver that would benefit from reduced volume-based incentives and increased delivery flexibility, such as minor office procedures and common labs and tests.
  - Services primary care providers need greater resources and flexibility to provide, like communicating with patients and caregivers and addressing social needs of patients.
  - Telehealth services as well as electronic communication with patients, which cannot be accurately or effectively paid FFS. This would further simplify administrative burden while mitigating volume-based incentives and fraud.

Services that could be excluded from the population-based payment and which could continue to be paid FFS include those which are preventative and clinically essential services where volume-based incentives are appropriate, such as immunizations, and those that are underprovided but essential, such as home visits.

4. **Health Equity, Social and Clinical Risk**

- **What non-claims-based indicators could be used to improve payment accuracy and reduce health disparities, and how can CMS ensure that they are collected uniformly and documented consistently without unduly increasing administrative burden?**
- **What risk factors, including clinical or social, should be considered in developing payment for advanced primary care services?**
- **What risk adjustments should be made to proposed payments to account for higher costs of traditionally underserved populations?**
- **What metrics should be used or monitored to adjust payment to ensure that health disparities are not worsened as an unintended consequence?**

We support the proposed APCM code accounting for the physical and social risk of patients by creating tiers based on chronic conditions and low-income status. Future advanced primary care hybrid payment models can continue to account for the health and social complexity of primary care clinicians' attributed patients. CMS could leverage validated, readily available community-level measures of social risk or social deprivation, which have successfully been added to risk adjustment methodologies, including in Massachusetts' Medicaid program and Maryland's all-payer program, and which are currently being pilot tested in the ACO REACH model.

Evidence suggests that shifting from FFS to hybrid payment itself could help to promote racial equity. A recent study found that movement from FFS to population-based payment models that use current Medicare risk adjustment methodologies would result in sizable resource reallocations and incentives that would likely mitigate racial and ethnic disparities in care.

- **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?**

Per-member, per-month payments would incentivize primary care clinicians to proactively initiate visits for more patients and attribute them to their practice, which could help to improve access to primary care. But, shifting to advanced primary care hybrid payment on its own will not address the large and growing primary care physician 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 clinicians to deliver high-quality 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. To increase investment in primary care, as MedPAC has recommended, CMS can develop processes to more accurately and empirically determine RVUs, including the identification and development of data collection and valuation tools to identify over- and underpriced services, (see Section #1 "Streamlined Value-Based Care Opportunities"). CMS can also 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 clinicians sustainably and comprehensively deliver needed services.

- **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?**

  To support health equity goals and ensure advanced primary care hybrid payments are available to providers serving disproportionately low-income and underserved populations, it is important for CMS to consider how to effectively engage FQHCs. Recent focus groups supported by the Commonwealth Fund with FQHC leaders found that they see value-based payment as the future, and they feel 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 about the financial impact value-based care could have on their bottom line, models not sufficiently accounting for the complexity of their patient population, and having the resources to stand up the workflows, technology, and data systems needed to participate. 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 staffing they need to make the transition, and providing technical assistance and training opportunities.

5. <u>Quality Improvement and Accountability</u>

- **How can CMS ensure clinicians will remain engaged and accountable for their contributions to managing the beneficiary's care?**
- **What are key patient-centered measures of quality, outcomes and experience that would help ensure that hybrid payment enhances outcome and experience for patients?**
- **How could measures of quality, outcomes, and experience guard against and decrement in access or quality?**

  By blending FFS and population-based payment, advanced primary care hybrid payment models reduce the adverse effects of pure payment models - including excessive care in FFS and stinting in pure population-based payments. Therefore, CMS can prioritize a reduced, parsimonious set of quality measures that capture the core tenets of primary care, to achieve its goals of reducing administrative burden of providers while improving patient experience and outcomes. The quality measures selected can build on lessons learned from previously tested primary care demonstrations at CMMI and seek to be aligned with active models to reduce the burden of managing various program requirements among primary care clinicians participating in multiple models.

  CMS can consider improving the measures themselves to capture the core tenets and value of primary care delivery such as care coordination, comprehensiveness, accessibility, and patient experience – features which research has found to be associated with improvements in population health. This would serve to improve provider and patient experience simultaneously. Recent focus groups with primary care clinicians that have been hesitant to engage in payment reforms to date revealed that the burden of measurement alone is compounded by the disease- or procedure-specific measures themselves not capturing the true value of the care they provide.

CMS can leverage existing measures to achieve this goal, including the Person-Centered Primary Care Measure (PCPCM). PCPCM is a reliable, valid and patient-reported measure which captures the core tenets of primary care including longitudinal relationships, coordination, and comprehensiveness. Leveraging PCPCM would further serve to align with other programs, as it will be used in CMMI's new Making Care Primary Model, and is approved for use in Quality Payment Program of the Medicare Merit-Based Incentive Payment System.

- **Should CMS consider flexibilities for smaller practices to bill the advanced primary care bundle? Should CMS consider flexibilities for entities exempt from MIPS to bill the advanced primary care bundle?**

  Recent research found that primary care clinicians that are part of practices with less than five physicians, in rural areas, or that are not part of a large, integrated health system are less likely to participate in value-based payment models. This is likely due to these practices not having the financial or staffing resources to take on risk or manage the multiple reporting requirements to engage in models. In future advanced primary care hybrid payment models, to ensure greater participation and to enable practices serving a variety of patients to engage in new payment approaches that they could stand to benefit from, CMS could consider offering upfront financial assistance to small, independent, or rural practices, and offer flexibility in reporting requirements.

Section II.I.2: Digital Mental Health Treatment (DMHT)

Over the last year, the Commonwealth Fund has supported the development of a federal policy landscape assessment, interviews with vendors and policymakers, and a multi sector stakeholder convening to develop recommendations on further strategies to provide regulatory certainty to digital mental health technology vendors and equitable access to patients. The multi-stakeholder listening session included vendors, plans, providers, employers, and mental health advocates. While this work is ongoing, there is initial feedback relevant to the proposed addition of billing codes for digital mental health treatment (DMHT) devices in the CY 2025 Medicare PFS.

We support the Centers for Medicare & Medicaid Services (CMS) "aim to both provide access to vital behavioral health services and gather further information about the delivery of digital behavioral health therapies, their effectiveness, their adoption by practitioners as complements in the care they furnish, and their use by patients for the treatment of behavioral health conditions."

In 2022, 23% of adult reported experiencing a mental illness, and many report receiving no treatment. Digital tools that deliver evidence-based treatments offer a pathway for expanding access to care for mental health conditions.

Our stakeholder input suggests that ensuring adequate reimbursement for both DMHT vendors and providers is central to increasing patient and consumer access to evidence-based DMHT. The proposed rule seeks to reimburse clinicians for their professional effort in introducing patients to the DMHT as well as their ongoing use of the tool in treatment management. Based on the stakeholder input we have received, we believe this reimbursement approach will support providers in educating patients about the tools and engaging with these tools.

Ensuring the availability of these tools to a broad set of billing practitioners is also important considering behavioral health workforce shortages. In many behavioral health clinics, the number of prescribing

providers is limited. This year, CMS added marriage and family therapists and mental health counselors as practitioners eligible to provide diagnosis and treatment of mental illness. The availability of reimbursable DMHT to support these providers is another important means to address the scarcity of behavioral health professionals.

We note that while this rule is focused on Medicare PFS payment, CMS decisions will have an impact across the health care landscape. We encourage CMS to use its full authority in Medicare, Medicaid, and other markets to support the development, access, reimbursement, and quality of DMHT. That includes clarifying existing financing pathways for reimbursing DMHT as part of clinical care, as well as highlighting examples of how states have used DMHT in their Medicaid programs to support care delivery and the existing workforce. CMS could uplift state strategies to coverage determination processes and support learning collaboratives for states to share ideas for scaling digital mental health solutions with each other.

As CMS reviews other detailed comments on the coding proposal, we suggest that CMS keep in mind the following key themes from our recent stakeholder engagement on this topic.

- ***Access and Equity –*** Prioritize policy options which support broader use of DMHT reimbursement codes across the country and which help to reduce disparities in access to mental health and substance use disorder care.
- ***Implementation –*** Monitor use of the new codes to better understand DMHT utilization and potential barriers to use of DMHT across different provider types, patient groups, or regions.
- ***Patient Privacy –*** Ensure implementation of privacy and security protections, particularly given the sensitive nature of information that may be shared or captured in these devices. This will require education and support for billing practitioners and vendors, as well as other stakeholders. Since many DMHT use some form of artificial intelligence, it is also imperative that CMS work with other agencies to ensure that consumers are protected and understand how their data may be used.
- ***Quality –*** As the number of DMHT on the market grow, providers, payers, and consumers may be confused about which tools best meet their needs. CMS should identify opportunities and encourage vendors and billing practitioners to join in efforts to leverage interoperable DMHT data to support CMS goals to measure quality.

We appreciate CMS' efforts to gain and respond to stakeholder input for this proposed rule and encourage CMS to continue to seek input from a broad set of stakeholders, including vendors, as well as advocates, payers, clinicians, researchers, and others involved in decision-making and implementation of these tools. We encourage CMS to work with other agencies across the government to develop and implement a strategic, coordinated approach to DMHT reimbursement and regulation.

For general questions about this response or inquiries for the Commonwealth Fund, please contact Christina Ramsay (cr@cmwf.org). Please contact Corinne Lewis (cl@cmwf.org) with any questions regarding our comments on the APCM services or Advanced Primary Care Hybrid Payment RFI. Please contact Rachel Nuzum (rn@cmwf.org) and Reggie Williams (rw@cmwf.org) with any questions regarding our comments on DMHT.

Sincerely,

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