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AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

September 9, 2024

Re: Payment Policies Under Medicare Physician Fee Schedule; CMS-1807-P

Electronic Submission: CMS-1807-P

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services (HHS)
Attention: CMS-1807-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov.

Dear Administrator Brooks-LaSure:

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

Our comments address the following topics/issues:

1. Advanced Primary Care Payments, Including Effective Behavioral Health Integration and LTSS-Primary Care Linkages
2. ACO Quality Measures (SUD and SDOH)
3. Principal Illness Navigation and Community Health Initiatives – Focus on Group-Based Interventions and Wider Array of Providers
4. Caregiver Training
5. Telehealth Flexibilities

Partner Organizations – Submitted comments:

Details on many of these topics/issues are available in partner organization coalition submissions joined by AAHD and the Lakeshore Foundation:

1. CPR – Coalition To Preserve Rehabilitation
2. FUSA – Families USA
3. MHLG – Mental Health Liaison Group workgroup on bi-directional integration
4. NHC – National Health Council [not a sign-on; AAHD is a NHC member]
5. Partnership To Align Social Care

Advanced Primary Care Payments, Including Effective Behavioral Health Integration and LTSS-Primary Care Linkages

AAHD and the Lakeshore Foundation join the submitted comments of FUSA and MHLG on advanced primary care payments including proposals for more effective behavioral health integration. The NHC submission describes the importance of behavioral health services across the Medicare population. We fully support the CMS proposed rule to establish new coding and payment for the delivery of advanced primary care management (APCM) services under the Medicare Physician Fee Schedule (PFS). These new codes and payments recognize the value of, and the additional costs associated with, the delivery of advanced primary care, which CMS defines as the "delivery of 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."

The MHLG submission included recommendations for strengthening the proposal to improve mental health and substance use outcomes and promote behavioral health integration in primary care.

Advanced Primary Care - NCQA HEDIS Measure
Long-Term Services and Supports: Shared Care Plan with Primary Care Provider

We ask that CMS consider use of a NCQA HEDIS measure in the advanced primary care program – sharing the individual's LTSS plan of care with the primary care provider. And, we ask that CMS expand the quality measure so the primary care provider shares with the LTSS provider, including behavioral health providers, the individual's primary care plan. This NCQA HEDIS measure was considered by the Mathematica for CMS Medicaid and CHIP Core Quality Measures Committee in 2022. This is a NCQA HEDIS measure still used, but not yet recommended for Medicaid or Medicare use.

Advanced Primary Care and More Adequate/Effective Behavioral Health Services

CMS should clarify that APCM participants can bill separately for behavioral health integration (BHI) codes and allow MH/SUD providers to bill BHI, Health and Behavior Assessment/Intervention (HBAI) services, and the new and existing interprofessional consultation codes for the same patients receiving APCM services billed by the participating primary care provider.

Behavioral Health quality measures are discussed in the before-mentioned coalition comments. We join coalition requests that CMS track APCM

participants' spending on BHI, HBAI, and other MH/SUD services to inform revisions to APCM codes in the future and advance the goal of promoting integrated MH/SUD care, as well as documenting and publicly reporting primary care practice quality measures.

The Advanced Primary Care Hybrid Payment RFI

CMS should engage in a process of stakeholder input that results in clear articulation of how CMS will include MH/SUD integration going forward with its primary care models and how it will accurately value the services to encourage practices to participate and achieve greater integration. CMS should implement a set of future codes that specifically recognize the importance of delivering integrated and longitudinal MH/SUD care, and require specific evidence-based models of staffing, workflows, and quality measurements.

CMS should require primary care providers to report quality measures for both screening and outcomes focusing on MH/SUD, health-related social needs, and patient experience. It is critical that CMS establish that these models are improving patient experience and outcomes. Uniform quality measurement is essential to being able to establish the benefit of investments in primary care to policymakers and Medicare beneficiaries. We applauded the inclusion of MH/SUD measures as the first set of adult Medicaid core quality measures for required reporting and the inclusion of several relevant measures for MH/SUD, patient experience and equity in the CMS Universal Foundation announcement set of measures. CMS should build on these efforts in future proposals.

CMS should track spending on BHI, HBAI, and other MH/SUD services across models of advanced primary care, and target QPP and APM incentives to meet goals for integration, including either waiving MH/SUD integration spending from counting against shared savings or including expected spending through administrative benchmarking in APMs. Also track number of practices providing various levels of MH/SUD integration through claims data and MH/SUD quality measures where they are currently required to report and provide a dashboard on progress to date in advancing MH/SUD integration in primary care.

ACO Quality Measures (SUD and SDOH)

We fully support CMS proposed ACO quality measures for the initiation and engagement of substance use disorder treatment (QM #305) and the screening for social determinants of health (QM #487). The SUD measure ensures that patients 13 years of age and older with a new SUD episode have the initiation of intervention or medication within 14 days of a new SUD episode or engage in

ongoing treatment. As CMS cited 2023 commenters – recognizing the impact of SDOH is crucial to promoting health and wellness. CMS proposed rules excerpts on the SUD and SDOH measures are pages 1232-1237.

We applaud CMS for recognizing the impact of health-related social needs (HRSNs) on health outcomes for the Medicare population through the inclusion of a HRSN screen quality measure for ACOs. There is a growing evidence-based documenting the real impact of HRSNs on health outcomes and total cost of care. While we applaud CMS for including screening for HRSNs in the quality measures, we encourage CMS to consider also including a measure related to addressing identified HRSNs in the quality measures. It is inappropriate to identify HRSNs that impact health outcomes and not deploy community-based interventions to address identified needs. [1] The evidence is overwhelming that screening and addressing HRSNs is an essential element of whole-person care. Therefore, we support adopting an HRSN screening measure, but also urge CMS to consider a measure documenting HRSN intervention deployment. The Partnership To Align Social Care submission discusses the importance of HRSNs screening and interventions.

Principal Illness Navigation and Community Health Initiatives – Focus on Group-Based Interventions and Wider Array of Providers

CHI/PIN/PIN-PS: Time-based billing:
The current minimum billing threshold for CHI/PIN/PIN-PS is 60 minutes per calendar month. The 60-minute minimum threshold is a barrier to adoption and implementation. When CHI/PIN/PIN-PS services are performed on behalf of a beneficiary and the time per calendar month is below the minimum 60-minute threshold, the organization cannot receive reimbursement for the work performed. It is well documented that persons with multiple HRSNs will require assistance over an extended period to resolve their HRSNs.[2] While the duration of the interventions may extend over time, the intensity of the labor, each calendar month, will vary. The HCPCS billing codes should accommodate months where the time required will be less than the minimum threshold of 60 minutes. The data from the accountable health community, second evaluation report, validates the contention that interventions to address HRSNs will occur over an extended period

[1] The Accountable Health Community (AHC) Model, Second Evaluation report documented statistically significant results demonstrating the impact on reducing total cost of care for beneficiaries that received navigation assistance to address identified HRSNs. RTI International. Accountable Health Communities (AHC) Model Evaluation: Second evaluation report. May 2023. Available online.
[2] *Supra* at 1

to meet all identified needs. Most beneficiaries in the AHC model did not have all their HRSNs resolved after a year of receiving navigation services.

We urge CMS to consider lowering the 60-minute minimum threshold to bill CHI/PIN/PIN-PS labor to 20 minutes per calendar month, with an additional HCPCS code unit for each additional 20 minutes, up until the first hour. After the first hour, then there would be a HCPCS code for each additional 30 minutes. There is precedence for using a time-based allocation which has a minimum base of 20 minutes, with additional HCPCS codes for each additional 20 minutes for the first hour. The current billing structure for Chronic Care Management (CCM) has a similar time allocation process:

99490 – First 20 minutes of chronic care management services, per calendar month

99439 – each additional 20 minutes, after the first 20 minutes, per calendar month

CHI/PIN/PIN-PS are authorized only when billed by the same provider that conducted the initiating visit:

The requirement for the provider conducting the initiating visit to be the same provider to bill for the ongoing CHI/PIN/PIN-PS presents a barrier to implementing CHI/PIN/PIN-PS for group practices that use non-physician providers (NPPs) and physicians to manage a population of patients under the medical home model. Under a medical home model, a group practice may have encounters that are billed as an "incident to" visit that is conducted by the NPP. We urge CMS to allow CHI/PIN/PIN-PS to be billed by any provider in a group practice, when an eligible provider in the group practice conducted the initiating visit.

Group-Based Interventions for Principal Illness Navigation:

The Principal Illness Navigation benefit should include an option for group-based interventions, which are not currently allowed under the HCPCS PIN codes. Principal Illness Navigation (PIN) is a benefit that provides health navigation, health education, and other supports for persons with serious, high-risk conditions that are expected to last at-least three months and without intervention could lead to further deterioration. Research demonstrates that patients with chronic conditions can improve their health outcomes through the application of improved disease self-management skills. The Centers for Disease Control and Prevention (CDC) has a website that provides information and links to evidence-based training

programs that are appropriate for persons managing chronic conditions.[3] The CDC Living with a Chronic Condition webpage recommends persons with chronic conditions learn more about their conditions and how to manage these conditions.

The list of evidence-based Chronic Disease Self-Management Education Programs are primarily group-based interventions. The absence of a PIN group benefit prevents persons with chronic conditions from participating in CDC-recommended evidence-based disease self-management education programs.

The PIN benefit should include a group intervention to allow persons with serious high-risk conditions to participate in evidence-based chronic disease self-management education programs, and we urge CMS to establish HCPCS codes for group interventions under the PIN benefit to allow persons to participate in evidence-based chronic disease self-management education programs.

Group-Based Interventions for Community Health Integration:
Persons that are negatively impacted by HRSN often require support for enacting behavior change. The current CHI benefit recognizes the need for addressing behavior change through the inclusion of the following services in the allowable intervention categories for CHI:

- Facilitating behavior change
- Building patient self-advocacy skills
- Facilitating and providing social and emotional support
- Leveraging lived experience when applicable

There are numerous CMS benefits that allow for group interventions to support necessary behavior change. The evidence is overwhelming that persons obtain tremendous benefit from participating in facilitated group-based interventions aimed at achieving behavior change. The benefits that currently support group-based benefits to support behavior change include the following:

- Medicare Diabetes Prevention Program (MDPP)
- Diabetes Self-Management Training (DSMT)
- Medical Nutrition Therapy (MNT)
- Health Behavior Assessment and Intervention (HBAI)

[3] CDC, 2024. Available Online: https://www.cdc.gov/chronic-disease/living-with/index.html and https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs/

Group interventions, facilitated by trained auxiliary personnel, provide the appropriate model to solicit and maintain the required behavior change elements in the CHI benefit. However, the current CHI benefit does not include a provision to allow for group-based interventions. The CHI benefit should be modified to include a group HCPCS code to allow for CHI interventions to be provided in a group-based intervention provided the goals of the group intervention align with the objectives in the person-centered CHI plan of care.

We urge CMS to create a HCPCS code for group-based CHI interventions that align with the person-centered plan of care for individuals that require the services to address identified HRSNs.

Caregiver Training Services (CTS) & Direct Caregiver Training Services
In the CY2024 Physician Fee Schedule Final Rule, CMS created a set of HCPCS codes for Caregiver Training Services (CTS). The CTS benefit is part of a broader set of HRSNs services that were created to promote health equity (CTS CPT codes implemented in 2024: 96202, 96203, 97550, 97551, and 97552). In the CY2025 Physician Fee Schedule Proposed Rule, CMS proposes to create a new set of codes to support Direct Caregiver Training Services (DCTS), which would include caregiver training services for clinical skills required to effectuate hands-on treatment needed to reduce complications and monitoring the patient. Both the Partnership To Align Social Care and the National Health Council submissions discuss the importance of caregiver training.

We applaud CMS for addressing the need for caregiver training services in the Medicare fee schedule. However, both the original CTS benefit and the proposed Direct CTS are difficult to implement because of structural barriers in the policy, which do not allow for the use of appropriately trained auxiliary personnel to provide CTS under general supervision as an incident to service. The current benefit requires a provider to fit expanded caregiver training services into clinical settings that are established to complete E/M encounters, which requires clinicians to have fixed appointments in small exam rooms. The fixed 15–30-minute E/M encounter in a small exam room are not conducive to the completion of extensive training required of caregivers. In addition, there are multiple evidence-based or evidence-informed caregiver training programs that are funded by the U.S. Administration for Community Living (ACL), which could be leveraged to meet the growing need for caregiver training including:

- Powerful Tools for Caregivers (https://www.powerfultoolsforcaregivers.org)

- Savvy Caregiver® (https://savvycaregiver.com)

We urge CMS to change the Caregiver Training Service benefit and the proposed Direct Caregiver Training Services benefit to allow a qualified healthcare provider to bill for all caregiver training services when rendered by trained auxiliary personnel as an incident to benefit, under general supervision.

Telehealth Flexibilities

We support to Coalition To Preserve Rehabilitation (CPR), National Health Council (NHC), and Partnership To Align Social Care submissions on the importance of telehealth flexibilities, consistent with patient preferences and clinical need.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,

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And
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