CIVITAS
Networks for Health

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1807-P
PO Box 8016
Baltimore, MD 21224-1816

RE: CMS-1807-P; 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

Dear Administrator Brooks-LaSure:

Civitas Networks for Health ("Civitas") appreciates the opportunity to provide input on CMS 1807-P; Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Free 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 ("Proposed Rule"). Civitas is a national nonprofit collaborative comprised of more than 175 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), quality improvement organizations (QIOs), All-Payer Claims Databases (APCDs), and providers of services to meet their needs—working to use data frameworks, information infrastructure, and multi-stakeholder, cross-sector approaches to improve health for individuals and communities. We educate, promote, and influence both the private sector and policymakers on matters of interoperability, quality, coordination, and cost-effectiveness within the health system.

As CMS knows well, health data management is inseparable from the theory and practice of value-based care. Accelerating connectivity, coupled with the recognition and increasing integration of health-related social needs (HRSNs) into the care pipeline puts an even greater premium on the effective use of data as part of the drive toward patient-centered, outcomes-based, and performance-benchmarked delivery. For Civitas members serving communities at the state, regional, and local levels, squeezing the greatest possible utility out of multi-directional information flows from points of care to teams of clinicians and non-clinician service providers, and then to public and private payers, public health agencies, and other stakeholders represents one of the central challenges—and opportunities—of the present moment.

Critical Local Infrastructure

To meet this challenge, systems of care are emerging around the country which integrate the transmission infrastructure of HIEs with the local depth and community leadership of RHICs and the analytic strengths of QIOs and APCDs, backed by state authorities. Various iterations of the Community Care Hub model recently endorsed by HHS as a promising approach to clinical and social care coordination (and supported with grant dollars from the Administration for Community Living and the Centers for Disease Control and Prevention) represent one such system of care—and one that is becoming an important part of the delivery landscape for Civitas members. The most developed and effective versions of the hub model involve a parent organization (often a RHIC) contracting with multiple

care coordination organizations in a given region who oversee networks of clinical and social care providers, anchored by primary care practices but staffed on the front lines by non-physician professionals (like trained and certified community health workers, or CHWs) who lead the initial outreach and oversee "closed loop" referrals for the highest-risk, highest-need patients across nontraditional care settings.

At intervals during the contract cycle, the hub parent organization sets performance targets for the care coordination organizations that include both provider implementation metrics and patient outcomes, and compensates the care coordinators, clinicians and service providers on that basis. Financing for the arrangement is provided by hub agreements with payers, often Medicare Advantage plans or Medicaid Managed Care Organizations (MCOs) (the latter sometimes fulfilling state mandates) and occasionally grants from state and local public health authorities. At the same time, the hub works closely with the area HIE or subsidiary community information exchanges (CIEs) to ensure that the data on patients, providers, and payments is standardized, secure, and readily accessible by all network participants.

The results have been more consistent, responsive, and generally cost-effective care delivery for patients who previously slipped through the cracks between crisis hospitalizations, alongside measurable improvements among subpopulations flagged by the hub organization and care coordination organizations for specific health indicators (such as maternal mortality in communities of color, or diabetes management among non-English speakers). Nearly as important, from a systemic perspective, is the enhanced level of coordination and operational alignment between the various clinical and social service providers and payers that iterations of the hub model have catalyzed in Ohio, California, Texas, Virginia, Alabama and elsewhere. Further deepening and institutionalizing these care management partnerships in the long term is a core interest of Civitas, and we applaud CMS' latest policymaking in the CY25 PFS as critical support toward that goal. Two components of the Proposed Rule stand out as particularly significant for our members: the new advanced primary care management codes introduced this year, and questions about the codes for services addressing health-related social needs now in effect after being introduced last year.

Advanced Primary Care Management Codes

In the Proposed Rule, CMS has rolled out its first-ever set of HCPCS billing codes for general use by providers delivering Advanced Primary Care Management (APCM) services to beneficiaries along a graduated scale of clinical need and practitioner resource investment—time and effort by physicians, nurse practitioners (NP) physician assistants (PAs) certified nurse-midwives (CNMs), and certified nurse-specialists (CNSs) that remains largely unsupported outside participation in select CMS Innovation Center (CMMI) demonstrations. Building on the lessons from those programs (specifically the Comprehensive Primary Care and Primary Care Plus models that ran between 2012 and 2021, as well as the ongoing Primary Care First Model), CMS has developed three new codes that combine elements of existing standalone CPT-coded activities ("service elements") into a bundle for monthly capitated billing. GPCM1 is the baseline for primary care coordination services by or under the general supervision of a physician, including needs assessment, preventative services, medication management, follow-ups, enhanced communication, and referrals to specialty providers in accordance with a comprehensive care plan. GPCM2 is the "stepped-up" version of these services for patients with two or more high-risk chronic conditions expected to last at least 12 months, while GPCM3 is similarly adjusted for QMB patients with complex conditions.

On the whole, Civitas considers the APCM proposal a major step forward in the long-running efforts to improve provider uptake of care coordination incentives. CMS notes in the text of the Proposed Rule that most practitioners still use the blanket Evaluation & Management (E/M) visit codes to bill for care coordination, patient navigation, and associated activities rather than the standalone fee-for-service codes like Chronic Care Management (CCM), which its own records show only 4% of all enrolled practitioners billed last year. We share CMS' hopes that the new APCM codes' capitated payment structure, stratification by patient risk and complexity, and greater overall flexibility will make them more attractive to a wider set of eligible clinicians, and especially to practices that are part of community care hub networks. Critically, the new codes eliminate the need for constant timekeeping that is difficult in a busy physician's office and even harder outside it, while maintaining the "incident to" billing allowance for auxiliary personnel to perform many of the slated coordination activities under general supervision and extending CCM's "initiating visit" exemption for "established patients" of the practice from one to three years. Collectively, these changes make GPCM1-3 better fits for the hub model and a meaningful source of funding to help sustain the positions of CHWs and other key members of the care team. The prospect of State Medicaid Agencies adopting these codes, once finalized, makes the revenue proposition for many regional networks even stronger.

In reviewing the 13 service elements attached to the APCM codes, we understand the rationale for transplanting as many of the preexisting CCM and Principal Care Management (PCM) requirements as feasible (and we support most of them). Nonetheless, Civitas members' experience with care management through the hub model and the expansion of interoperability more broadly informs our perspective that CMS should build upon the earlier fee-for-service codes' framework by placing more emphasis on HRSN data standardization. The proposed APCM service elements already require the use of electronic health record (EHR) tools, and by extension (in most cases) service area HIE systems: these include the stipulation that practices meet criteria for "comprehensive" meaningful use of ASTP/ONC-certified electronic health record technology (CEHRT) products and adhere to the merit-based incentive payment system (MIPS) promoting interoperability metrics (assuming the clinicians are MIPS-eligible). Such requirements ensure that practitioners will be sufficiently digitized to participate in the APCM model, but not that the data itself will be reflective of social determinants among beneficiaries most in need of coordinated care. Neither the "Value in Primary Care" MIPS value pathway, nor the APM Performance Pathway (APP) MIPS quality measures, nor the Accountable Care Organization Electronic Clinical Quality Measures (ACO eCQM measures) that are offered as APCM-compliant options for various categories of providers mandate the use of any specific measures related to food, housing, utility, transportation, and other insecurities that CMS has recognized as major drivers of patient distress.

To fill this gap, we would suggest that the proposed service elements explicitly recognize one or more of the many methodologies to quantify and evaluate social determinant impacts that are now in use across the health sector. CMS can start with its own standardized screening tool for HRSNs at the point of care that was pioneered during the Accountable Health Communities Model (AHC) from 2017-2022 for five "core domains of instability" (housing, food, transportation, and utilities, plus interpersonal safety); the AHC HRSN tool has since been made part of the ongoing ACO Realizing Equality, Access, and Community Health REACH CMMI demonstration and special needs Medicare Advantage plans. Following the lead of the new HRSN-billable services for community health integration (CHI), principal illness navigation (PIN), and social determinations of health risk assessment (SDOH-RA) that CMS introduced in the CY2024 PFS, the APCM service elements could also make use CMS' existing Z-codes for social determinants of health (Z55-65) as standard identifiers. Other candidate standards for the

"home and community-based care coordination," "patient population-level management" and "performance measurement" elements might be the Protocol for Responding to & Assessing Patients' Assets, Risks and Experiences (PRAPARE) tool developed by the National Association of Community Health Centers and used by many Civitas members; the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (NCQA HEDIS) Social Needs Screening and Intervention (SNS-e) measures used by commercial payers; and the Gravity Project data standards for social needs currently piloted in four states (for which Civitas has been an implementation partner).

Services Addressing Health-Related Social Needs

For many Civitas members, the highlight from CMS' CY2024 PFS was a set of three new billable activities designed to facilitate HRSN assessment and care coordination among Medicare practitioners: the aforementioned community health integration (CHI), principal illness navigation (PIN), and social determinations of health risk assessment (SDOH-RA), with seven new G-codes between them. All three activities are structured as "incident-to" services allowing auxiliaries to deliver the services themselves, so long as they operate under the general supervision of a billing practitioner who has conducted an "initiating visit" with the patients in question. CHI services are the most expansive and oriented around evaluations and follow up with high-need patients in accordance with individualized care plans that emphasize goal setting, patient-provider communication, and provider collaboration with community-based organizations (CBOs). PIN services (including separately coded PIN peer support services) are more narrowly tailored to patients with least one health condition that carries serious risk of hospitalization or residential placement (cancer, SOPD, serious mental illness) and consequently becomes the focus of the practitioner or staff care management efforts. The SDOH-RA service is intended to operate as a more limited add-on to E/M visits, the annual wellness visit (AWV) or psychiatric evaluations for infrequent patients.

CMS is seeking feedback on these services a year after their release in a request for information (RFI) section of the Proposed Rule that asks broad questions about their structure, content, and potential revisions to better align payment with provider experiences. Civitas continues to support the use of these codes because we appreciate their potential to meaningfully expand care coordination activities for beneficiaries in need—even if that potential has gone largely unrealized to date among Civitas members who manage or participate in the community care hub networks that stand to benefit from their widespread adoption. The CY24 HRSN codes' fee-for-service structure, and emphasis on assessing and standardizing social determinants in varying circumstances make them sufficiently different from the CY25 APCM codes as currently proposed to justify CMS maintaining both code sets. Consolidating them into a single version of the capitated APCM codes with a more robust HRSN focus and higher valuation of the work might make sense for Medicare in the future; but for the time being adjustments to the CHI, PIN, and SDOH-RA billing would be welcome.

As Civitas noted in our public comments last year, one of the most significant shortcomings of all three HRSN codes is the continuing requirement for an "initiating visit" with the enrolled practitioner before auxiliary personnel can begin billable service delivery. We understand that CMS must work within the parameters of the Medicare Benefits Manual that allow only so much leeway in interpretation. However, we were concerned that requiring an initiating visit on the front end would undermine the critical work of CHWs and other non-billing members of community care teams in conducting proactive outreach to the highest-need patients and establishing relationships that depend largely on connectivity and trust with those CHWs. In the care hub framework, experienced and state-certified CHWs are proactive in seeking

out new patients for “onboarding,” serving as the primary points of contact through frequent assessments, logging data into shared EHR and HIE systems, and building individualized care plans that form the backbone of comprehensive referral systems. A significant number of the highest-risk patients are only engaged because CHWs alone have engaged them at home or (effectively) “on the street”, and having those patients visit a doctor’s office visit before these efforts can be reimbursed was expected to be a major obstacle.

With the new codes now billable this year, Civitas members have seen this impact—or rather, lack of impact—firsthand. Uptake of the HRSN codes by hub model participants in Civitas members’ networks has been slow, driven by the initiating visit barrier as well as the specific time constraints for CHI and PHI (60 minutes initially, then 30 minutes additionally per month) and the need for more provider education. CHWs, CBOs, and practices that have started to bill with these codes have been forced to leave or at least delay services for beneficiaries and payment for themselves, diluting the intended provider incentive. Care transitions from hospital stays and emergency departments to outpatient settings have also emerged as a disruptive link in the coordination pipeline when the HRSN codes are involved, since the hospitals will have already performed their own required HRSN screenings which cannot be credited as “initiating visits” (thus adding extra steps for the care coordinators).

To remedy these issues and bolster the use of the HRSN codes for care networks and Medicare at large, we join several of our members and other stakeholders in suggesting changes that CMS could make. Borrowing from its APCM proposal in the current Proposed Rule, CMS could increase care networks’ operational flexibility by creating multi-year time widows that designate previous and sporadic patients as established patients for billing purposes, limiting initiating visits to new patients with zero record of clinical contact. Alternatively (or additionally), CMS could make initiating visits retroactive in some cases where sufficient documentation and risk assessment benchmarks have been met for the beneficiaries in question, with further exceptions for HRSN evaluations conducted before beneficiaries are discharged from the hospital. Given how CHWs at care coordinating agencies, contracted CBOs or in-house with billing practitioners are already doing much of that work ahead of time, patient care teams would not suffer for lack of capability. To improve flexibility within the fee-for-service framework, CMS may also want to consider redistributing the billable time for CHI and PIN services from single 60-minute monthly blocks per patient with 30 additional minutes to multiple 20 or 30-minute blocks per patient, bringing them closer in line with the current structure for standalone CCM billing.

On behalf of Civitas and our members, thank you again for the chance to comment on CMS-1807-P and for considering our recommendations. We would also like to draw your attention to comments from Civitas members Health Impact Ohio (HIO), Michigan Multipayer Initiatives (MMI), and Partnerships for Advancing Community Health (PACH), which have been submitted separately in response to this Proposed Rule, and which further articulate unique perspectives and priorities based on extensive experience in their respective service areas. The Civitas community is deeply engaged in multiple corners of the health data policy and regulation space, and we stand ready to collaborate to achieve our shared goal of creating a higher-value health system.

Please do not hesitate to reach out if you have any questions or comments for us.

Sincerely,

Lisa Bari
CEO, Civitas Networks for Health
lbari@civitasforhealth.org