CHPA COMMUNITY HEALTH PROVIDER ALLIANCE
LEADERS IN INTEGRATED PRIMARY CARE

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1784-P

Submitted electronically to regulations.gov

RE: CY2024 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Brooks-LaSure:

Community Health Provider Alliance (CHPA) appreciates the opportunity to submit comments in response to CY2024 Medicare Physician Fee Schedule (MPFS) and Medicare Shared Savings Program (MSSP) proposed rule that expresses CHPA's interest as an Accountable Care Organization (ACO) and its member federally qualified health centers (referred to here as FQHCs, or "health centers").

CHPA is a nonprofit integrated network of 20 FQHCs throughout Colorado that participate in Medicare, Medicaid, and commercial quality improvement projects as an ACO. The network of providers CHPA supports includes 230 clinic locations, more than 1,000 medical and behavioral health providers, and 20 FQHCs serving over 832,000 community members. We are passionate about helping our members deliver quality patient-centered care. There are thousands of people who slip through the cracks of the health care system and CHPA provides guidance to CHCs to improve quality measures and care.

Members of CHPA must agree to work as an accountable care organization focused on adopting and implementing best practices to improve health and well-being for our patients. Our members agree to adopt and adhere to evidence-based clinical guidelines. CHPA provides resources to help physicians and clinics improve quality, efficiency, and coordination of patient care, including:

- Participating in clinical education, care coordination activities, and regular clinical and quality improvement meetings
- Critical review of FQHC performance data and testing and demonstrating improvements and progress toward CHPA goals
- Implementation of population health management strategies, including the implementation of health information technology to improve systems, care coordination, and population management
- Adherence to clinical guidelines, as demonstrated by performance on nationally endorsed measures and defined performance targets

In addition, CHPA supports the practices in:

- Establishing mechanisms to securely communicate PHI and developing claims-based patient meaningful reporting for members
- Providing clinical and operational staff with education, tools, and resources to be successful with the patient engagement and outreach efforts

- Consistent measuring of the quality improvement effort and aligning the measurement process with other payer initiatives to streamline internal clinic processes, such as billing and coding
- Regular and ongoing monthly communication and committee interaction with key operational, billing, and clinical staff to focus on the quality improvements

We appreciate that CMS has thoughtfully put a lot of consideration into improving and enhancing MSSP. In addition, we would like to thank CMS for having an invested interest in getting feedback and suggestions from other providers and ACOs. There are several physician payment policies that can be implemented to better support team-based care and to address patients with complex needs. We thank CMS for your attention to these issues and hope CMS will employ policies that will encourage more rapid adoption of ACOs and population health. Here are a few topics CHPA wishes CMS would consider:

- **Address the benchmark ratchet**. Over the next two years, the majority of MSSP participants will enter new contract agreements and have their benchmarks rebased and lowered due to achieving savings during the current contract cycle. While CMS has adopted policies to reduce the impact of the ratchet (i.e., prior savings adjustment, ACPT) these policies do not go far enough and many ACOs may face deep reductions to their benchmarks. It is critical that we ensure that ACOs have fair and accurate benchmarks. The savings achieved in these models have directly impacted patient care by expanding care teams, providing additional beneficiary services that are not billed to Medicare, ensuring provider retention with enhanced provider payment, and investing in technology or other services that enable care coordination and population health management. Lowering benchmarks because of the ratchet effect reduces providers' ability to improve care and reduces the ACO's opportunity to achieve success and reinvest shared savings into beneficiary care.
- **Remove burden from the program**. Beyond payment incentives, reduction of the fee-for-service (FFS) burden is a key recruitment tool to bring clinicians into the ACO model. We are concerned that certain policies (e.g., eCQM reporting, PI reporting for QPs, beneficiary notification) are increasing the burden of the program. Entering a population health program requires significant effort to redesign care processes. Clinicians in an ACO model should be rewarded with burden reduction. CMS should examine all policies and ensure that the ACO program is not introducing new regulatory burdens.
- **Support inclusion of all providers within the model.** ACOs are a unique opportunity to coordinate care across the continuum. While providers across the continuum participate in ACOs, more can be done to bring additional providers into the model. We encourage CMS to offer primary care population-based payments to increase primary care participation, encourage specialist engagement in ACOs and provide additional technical support for provider participants that are not paid under the PFS (e.g., FQHC, RHC, CAH).
- **Strengthen nonfinancial incentives within the model.** Despite the Innovation Center's testing of several waivers in ACO demonstrations, waivers available to MSSP ACOs have been limited. CMS must rapidly expand MSSP waivers and should create a process to accept public nominations for waivers in MSSP, like the process by which the public could annually request additions to the Medicare telehealth services list. Creating a transparent process for adding new waivers to MSSP would increase ACOs' flexibility to meet the needs of their populations and support CMS's goal to advance accountable care.

MEDICARE SHARED SAVINGS PROGRAM

Quality

Changes to the Quality Performance Standard

We continue to believe tying ACO quality performance thresholds to MIPS scores is inappropriate and makes unfair comparisons. However, in the context of what has been proposed CHPA supports CMS proposed changes to the MSSP Quality Performance Standard (QPS) calculations to move to a three-year average of historic performance data with a one-year lag for calculating the QPS. This proposal will provide ACOs with more certainty regarding what the quality targets are in advance of the performance period and mitigate the potential impact of annual program changes affecting the QPS scores. We request to have CMS publish MIPS quality performance category scores in the Public Use Files to bring greater transparency to these calculations.

Proposal to Apply a Shared Savings Program Scoring Policy for Excluded/Suppressed APP Measures

CHPA supports CMS proposals to apply an MSSP specific policy for measures suppressed from quality scoring, providing ACOs with the higher of their own score or the QPS if a measure is suppressed for a performance year. These changes will ensure ACOs are not negatively impacted by measure changes or benchmark issues that occur mid-year and are outside the ACO's control.

ACO Quality Measure Changes

CHPA supports CMS's efforts to align quality measures across its programs by using the new Universal Foundation measure set, however we caution CMS to balance alignment with efforts to reduce administrative burdens. Should CMS continue to refine the Universal Foundation measure set, it must ensure there is not significant growth in the number of measures ACOs must report. CMS started the MSSP with over 30 quality measures, and over time reduced the measure set to reduce burdens associated with reporting. This should continue to be a focus for CMS. We also urge CMS to first test measures before making them required and scored measures for ACOs. Finally, CHPA cautions CMS from implementing multiple major changes to the measure set in PY 2025 as this is the year the Web Interface is currently scheduled to sunset as a reporting option for ACOs, particularly as ACOs will now also be considering and preparing for a new reporting option (Medicare CQMs).

CMS should not require reporting on substance use disorder (SUD) treatment, until they are able to share SUD information with ACOs, as this is currently suppressed from data shared with ACOs for care coordination activities. Regarding the screening for social determinants of health (SDOH) measure, we caution this measure must be tested before making this a required measure. CHPA supports CMS efforts to improve health inequities and incentivize screenings for social drivers of health. However, CMS must recognize the current state of this work and first start with efforts around data standardization before any such measures are required in performance-based programs like the MSSP. This work is iterative, and we are still in the early phases, therefore CMS should limit any measures on social drivers of health screening to optional measures, or if required, provide pay-for-reporting for these measures within ACOs to allow more learning to happen in this space. CMS should also allow for more standardization to occur and to gather data and learn about workflow issues that occur with screenings during a testing/pilot phase where any screening measure would be pay-for-reporting and would not dictate

which screening tool was used, or how it was implemented. As an example, some ACOs may choose to do the screening as part of an office visit while others may instead find more value in providing an online screening tool that is completed outside an office visit. Regardless, screening measures should be used as one tool in a larger plan to address health inequities and provide high value care to underserved communities. Further, CMS is currently requiring collection of this data across multiple setting-specific programs, which could result in duplicative efforts and patients potentially having to share this information numerous times. CMS should explore how this data can be shared across providers. NAACOS has provided detailed recommendations on this topic, including more impactful ways CMS could engage with ACOs on this issue. Lastly, we point out that these measures are currently only available for one reporting type and question the feasibility of adding them to the measure set for ACOs.

Beneficiary Assignment

Modifications to Assignment Methodology and Identification of Assignable Beneficiary Population

CHPA appreciates CMS's efforts to eliminate barriers for beneficiaries to be assigned to ACOs. CMS proposes several changes to the assignment methodology, including revising the physician pre-step, implementing an expanded window for assignment, adding a third step to the claims-based assignment methodology, and revising the definition of assignable beneficiary. We support the overall goal to expand access to accountable care, particularly for beneficiaries in rural and other areas experiencing primary care physician shortages. Given the numerous program operations that rely on the assignable and assigned beneficiary populations, **we urge CMS to conduct additional analyses including more years of data to ensure the changes do not have unintended consequences** for certain types of ACOs or those operating regions such as rural ACOs.

Use of an Expanded Window for Assignment

CHPA supports the proposal to define "expanded window for assignment" as the 24-month period that includes the applicable 12-month assignment window and the preceding 12 months, as this appropriately aligns the expanded window for assignment with the different 12-month assignment windows used by ACOs operating under prospective assignment versus preliminary prospective assignment with retrospective reconciliation.

CHPA supports efforts to better account for beneficiaries who primarily receive primary care services from non-physician practitioners (NPPs) during the assignment window and who received a primary care service from a physician during the expanded window for assignment. However, we believe CMS needs to establish a more refined approach for defining primary care delivered by these provider types before moving forward. We agree with CMS that the current approaches create challenges for NPPs, including nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), to drive assignment in MSSP ACOs. This can be particularly challenging for ACOs that rely heavily on NPPs to deliver coordinated, team-based primary care and struggle to attribute patients as a result. However, we are concerned that the lack of specialty designation for NPPs will lead to more specialty-driven assignment from these provider types. While the majority of NPPs practice in primary care settings, we increasingly see more NPPs working in specialty practices, often providing follow up care after an acute event such as a transplant. Because CMS does not have specialty designations for NPPs and classifies

them all as primary care clinicians, this type of follow up care delivered by NPPs in specialty practices can lead to beneficiaries being attributed to an ACO with which they have no primary care relationship. ACOs report that beneficiaries aligning through specialists in this way tend to be those who are receiving a high-cost procedure in the performance year and do not align to the ACO again in future performance years, making it challenging for ACOs to meet their benchmarks.

CMS should investigate the impacts of specialty-driven assignment, including differences in risk scores and costs for beneficiaries attributed via specialists to inform future policy solutions. For example, if data show that these beneficiaries have higher risk scores and higher costs, there could be opportunities to address these challenges through benchmarking and risk adjustment policies. Attribution churn is another area with opportunity for improvement. ACOs struggle to maintain attribution for beneficiaries attributed through specialists because they do not have a primary care relationship with the ACO. CMS should explore strategies to support ACOs in leveraging specialty-driven assignment through NPPs to develop longitudinal primary care relationships with these beneficiaries and advance the goal of having all beneficiaries in an accountable care relationship by 2030.

While these proposals mitigate some of these concerns by retaining the requirement for a physician visit in the 12 months preceding the assignment window, the fundamental issue of not identifying NPPs as primary care clinicians or specialists remains. ACOs are differentially impacted by this depending on the ACO's composition. ACOs including large multispecialty practices or academic medical centers experience more specialist-driven attribution related to care delivered by NPPs in these settings. As our health care system continues to shift to value-based payment and accountable care, it's important to understand the care that's being provided so that we can better manage and appropriately pay for that care.

Solutions include updating the *Provider Enrollment, Chain, and Ownership System* (PECOS) to include specialty designations for NPPs. CMS could begin by collecting this information as an optional field in the Medicare enrollment application, which already includes this field for physicians. This would provide more information about the type of care being provided by NPPs and enable CMS to align beneficiaries more accurately with their primary care clinicians. Allowing participation at the TIN-National Provider Identifier (NPI) level in MSSP, as opposed to full-TIN participation, would also alleviate these concerns. ACOs in Innovation Center models, like ACO REACH and the Next Generation ACO Model, define participation at the TIN-NPI level and as such, can exclude specialty-focused NPPs from driving assignment. We believe NPPs that deliver primary care, as opposed to specialty care, should play a prominent role in ACO assignment. **In the absence of CMS's ability to distinguish between NPPs who practice primary care and those who practice specialty care, we continue to advocate that ACOs be permitted to remove specialty focused NPPs from assignment**.

Addition of a Step Three to the Assignment Methodology

CHPA supports CMS's proposals to add a new step three to the claims-based assignment methodology utilizing the expanded window for assignment to identify beneficiaries currently excluded from assignment under the existing pre-step. We appreciate CMS applying this step after the current methodology to ensure that all beneficiaries who are assigned to an ACO under the current methodology would continue to be assigned to an ACO. CMS notes in its proposals that there may be a share of beneficiaries who would be prospectively assigned to an ACO under the proposed step three

that differs from the retrospective ACO the beneficiary is assigned to under the current methodology. While this will likely affect a small number of beneficiaries, we encourage CMS to monitor these shifts to ensure ACOs operating under retrospective assignment, particularly small and rural ACOs, are not unduly disadvantaged by these policies.

Revision of the Definition of Assignable Beneficiary

CHPA strongly urges CMS to conduct further analyses using additional years of data prior to revising the definition of an assignable beneficiary to align with the proposed expanded window for assignment. We appreciate that under CMS's proposals, all beneficiaries who are currently assignable would continue to be assignable and that beneficiaries who do not receive any primary care services during the assignment window would continue to be excluded from the assignable population. However, due to the numerous program operations that rely on the national and regional assignable populations and the potential impacts to financial calculations, more information is needed to determine whether this is good policy.

The simulation of changes to the national assignable population provided in Table 30 only relies on one year of data, PY 2021, which was impacted by anomalies related to the COVID-19 pandemic. CMS should expand this simulation to include additional data years (e.g., 2019, 2020, 2021, and 2022). While CMS estimates that the overall growth in the national assignable population will be small (about 2.9 percent), it does not examine changes to regional assignable populations, which are used in calculations to adjust ACOs' financial benchmarks. We are concerned that rural ACOs could see more significant changes to regional adjustment factors due to smaller population sizes. Because CMS proposes to adjust benchmarks for all ACOs, regardless of agreement start date, based on the new assignment methodology and definition of assignable beneficiary, the agency risks harming current ACOs that may be disadvantaged under the new policies.

CHPA recommends that CMS expand on the simulation and provide additional analyses to assess:

- Impacts to individual ACO benchmarks to ensure the policies do not harm performance and create artificial winners and losers,
- Potential changes to regional factors calculated with the new regional assignable population to ensure there are not unintended consequences for rural ACOs and ACOs in underserved communities,
- Changes to PBPY expenditures and average risk scores under the new assignable definition, and
- Differential impacts based on geography, ACO size and composition, and between retrospective ACOs and prospective ACOs.

Benchmarking Methodology

CHPA appreciates CMS's commitment to ensuring ACOs are granted fairer, more accurate financial benchmarks. Overall, proposals in this rule, if finalized, will help entice more providers to join the MSSP and keep others in the program. These proposed changes will not help all ACOs but will help level the playing field for those who serve more at-risk, medically complex, or high-cost populations.

However, CHPA cautions CMS that nothing in this proposed rule will solve the ratchet effect, where ACO benchmarks will continue to be lower over time as they reduce spending in their populations and future benchmarks are rebased on lower historic spending. **CHPA implores CMS to consider future changes to mitigate this rebasing problem, which we believe threatens future participation for ACOs working to create a higher quality, more efficient, and more cost-effective health system.** More innovative benchmarking policies are needed to both attract new participants while keeping existing ACOs in the model.

Additionally, CMS's high-low revenue distinction is continuing to hurt providers who serve vulnerable populations, including rural and safety-net providers. Evaluations show that ACOs with federally qualified health centers (FQHCs), rural health clinics (RHCs), and critical access hospitals (CAHs) as participants are more likely to be classified as high revenue and therefore would be disqualified from receiving some program benefits such as the Advance Investment Payments. In 2020, 71 percent of low-revenue ACOs did not include a FQHC, RHC or CAH. Conversely, 46 percent of high revenue ACOs included 5 or more FQHCs, RHCs, or CAHs. CMS should instead consider alternative approaches, such as evaluating the demographics of the population served by an ACO. The high/low revenue status is arbitrary and leaves out the very ACOs CMS is trying to attract to the program.

Lastly, CMS needs to take action to correct an impending issue around drugs in the 340B program. Since a Supreme Court decision last year, CMS has not addressed the disparity between ACOs who paid for 340B drugs at lower prices during their benchmark years and at higher prices during their performance years. This will continue to hurt ACOs that have 2018-2022 in any of their baseline years for benchmarks. **We urge CMS to correct this disparity by adjusting its calculation of ACOs' performance year expenditures to correct for this difference in 340B drugs without ACOs having to early renew.** This adjustment would help ACOs with 340B providers, who help under-served patients and address the health disparities CMS wants to eliminate.

Capping Regional Risk Score Growth

CMS proposes to cap an ACO region's growth in risk scores at 3 percent, like how it caps the ACO's own risk score growth. CMS proposes to apply the cap on the region independently, meaning the region could be subject to a cap in its risk scores even if the ACO is not. ACOs in regions with risk score growth below the cap would not be affected. The cap for both the ACO and region is applied separately for each enrollment type. If finalized, the change would apply to new agreements starting in 2024. CHPA supports this change, and we encourage CMS to apply this change to all ACOs, not just new agreements.

Eliminating the Negative Regional Adjustment

CMS proposes to prevent any ACO from receiving a regional adjustment that would cause its benchmark to be lower than it would have been without the regional adjustment, effectively eliminating the negative regional adjustment. ACOs eligible for a prior savings adjustment would not have those savings offset by a negative regional adjustment. If finalized, this change would take effect for new agreements starting in 2024.

CHPA supports this change as it would remove the disincentive for ACOs with spending higher than their region to participate in MSSP. However, we urge CMS to apply this change to all ACOs, not just those starting new agreements in 2024. While CHPA understands the reasoning behind the negative regional adjustment, it harms ACOs whose patients are costlier and can work against CMS's health equity goals by shunning providers who serve sicker, possibility more medically complex populations. As CMS notes in the rule, ACOs who receive a negative adjustment are twice as likely to drop out of MSSP.
While there is no proposed change for ACOs with a positive regional adjustment, CHPA supports the provision of additional help to ACOs who have already lowered costs in their communities. This includes ACOs who receive the full positive regional adjustment or max out their prior savings adjustment. There is effectively a cap on ACOs' savings under these current policies, which should be addressed if CMS wishes to have successful ACOs remain in MSSP. A cap on savings does not exist in other Medicare programs, including Medicare Advantage.

Modifying the Prior Savings Adjustment

CMS proposes to recalculate an ACO's prior savings adjustment if shared saving amounts are retroactively adjusted to account for either 1) compliance actions to address an avoidance of at-risk beneficiaries or 2) a redetermination of shared savings or losses. CHPA supports this change as it increases program integrity without implementing undue burden on ACOS.

Introduction of New Risk Adjustment Model Version

For new agreements beginning in 2024, CMS proposes to use the same hierarchical condition code (HCC) risk adjustment model for a performance year and the relevant benchmark years. This means that as CMS introduces new risk models, including the forthcoming V28, risk scores would be calculated using a consistent model and any impacts a shift in the model version could create should be balanced. Importantly, these changes will only apply for agreement periods beginning in 2024 with CMS saying it historically incorporates changes to the benchmarking methodology at the start of an ACO's agreement period. ACOs not starting new agreements in 2024 will have risk scores for their benchmark years calculated using different HCC model versions.

Mirroring risk model between benchmark years and performance years

CHPA supports CMS using a consistent risk model in both the performance and all benchmark years. We urge CMS in the final rule to apply a consistent risk model for all ACOs, not just those starting new agreement periods next year. Using a consistent risk model creates a fair, apples-to-apples comparison in MSSP's risk adjustment methodology, which compares patient populations' risk scores between a baseline period and the relevant performance year. Using different HCC model versions between these two sets of years creates a fundamentally flawed comparison. This is especially true given the changes seen between V28 and V24, which collapses many codes and revalues many others. Even if ACOs have the same patient populations with the same level of sickness, HCC scores will be lower under the new V28 model. Additionally:

- CMS noted in its proposed rule, ACOs would be hurt by using inconsistent risk models between benchmark and performance years. ACO shared saving payments would have been 11 percent lower in 2021 with inconsistent models. This compares to shared savings

payments being 2 percent higher that year if V28 were used in both the performance and benchmark years.
- Similarly, a NAACOS' analysis demonstrated that dual eligible and disabled beneficiaries would be disproportionately harmed by using the V28 model when the V24 model is used in the benchmark.
- ACOs were not aware of the impact of risk model changes prior to the deadline for new agreements—the proposed rule was published on July 13 and the deadline to submit application for new agreements was June 15.
- There's precedence for CMS to apply adjustments to all ACOs, not just those starting new agreements. CMS does this annually with billing codes used in assignment and previously all policies for risk adjustment were not codified in regulations, allowing the agency to make sub regulatory changes.

Blending of New Risk Model Versions

CMS proposes to phase in the new V28 risk model over a three-year period, similar to how it will for Medicare Advantage plans starting next year. This will apply to all MSSP ACOs, not just those starting new agreement periods.

CHPA supports this change believing that introducing the new V28 risk model over a blended, three-year period is a fair way to incorporate the model into MSSP. Furthermore, it matches how CMS is implementing the model in other Medicare programs. CHPA also appreciates that this blended introduction is done for all ACOs. We hope CMS will similarly apply other risk adjustment and benchmarking policies to all ACOs, not just those who are starting new agreements.

Codifying Risk Adjustment Policies

CMS will also codify its risk adjustment approach, which currently is missing from the regulations that govern the MSSP. CHPA supports this and urges CMS to consider additional changes to MSSP risk adjustment policy. This includes raising the 3 percent cap on ACOs' risk scores but also alternatives that eliminate providers' emphasis on collecting patient diagnoses for the purpose of increasing risk scores. The burden of collecting codes for risk adjustment is onerous and has become a burden on ACOs. It is time to consider a new paradigm that moves away from this risk-coding game. If an ACO is only successful by increasing risk capture, then we are losing our principles of improving care and reducing unnecessary utilization.

Alternatives include replacing the current 3 percent cap on scores with the possibility of risk adjustment audits, which are currently in place for Medicare Advantage plans. Additionally, CMS should monitor if the move to the V28 model will modify incentives to collect patient risk. CMS could install a cap on risk scores decreasing, which currently does not exist. Relatedly, we ask CMS to conduct analysis on the effect of the cap on years later in a five-year agreement period.

Eligibility Requirements

Shared Governance Requirement

CMS proposes to remove the option under § 425.106(c)(5) for ACOs to request an exception to the requirement that 75 percent control of the ACO's governing body must be held by ACO participants. CMS notes that since the start of MSSP, the agency has not denied participation to any ACO applicants based solely on failure to comply with this requirement and no exceptions to the requirement have been granted and therefore, it is not necessary to continue to offer the exception. We agree that the current 75 percent threshold is appropriate and attainable for ACOs. CHPA supports this proposal and the associated regulatory text revisions under § 425.106(c) and § 425.204(c)(3).

Identifying ACOs Experienced with Risk Based on TINs' Prior Participation

CMS proposes to codify the agency's current operational approach for determining whether an ACO participant TIN has "participated" in a performance-based risk Medicare ACO initiative. CMS proposes to modify the existing definitions for "experienced with performance-based risk Medicare ACO initiatives" and "inexperienced with performance-based risk Medicare ACO initiatives" to include the language, "An ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for a performance year under such initiative during any of the 5 most recent performance years."

CHPA supports this proposal, and we appreciate CMS's transparency with program operations**.** To define participation accurately and fairly, we encourage CMS to establish a process whereby ACOs may request reconsideration review if an ACO participant TIN is considered to have participated in an Innovation Center ACO model when only a small proportion of NPIs billing under the TIN participated in the model demonstration. Given MSSP is a full-TIN model and many CMMI models are under "split-TIN" or TIN-NPI participation, it is reasonable to utilize a threshold to determine participation for a TIN which had a portion of NPIs participating in a CMMI ACO model. CMS could use the threshold that is currently in place for the ACO-level experience criteria and consider a TIN to have participated if forty percent or more of the NPIs billing under the TIN were included in the model participant list.

Technical Changes

CHPA supports the following proposals to make technical changes to references in MSSP regulations, which will eliminate existing errors and inconsistencies and improve clarity in the regulatory text:

1. Revise references to an ACO's assignment methodology selection to eliminate inconsistencies between the use of § 425.226 (which describes actions for which an ACO is responsible in selecting and changing its selection of assignment methodology) and § 425.400 (which outlines how CMS employs the assignment methodology for program operations).
2. Correct the definition of "RHC" by replacing the word "center" with the word "clinic" and clarify that all uses of the acronym "RHC(s)" have been interpreted to refer to "rural health clinic(s)."
3. Correct typographical errors in the definition of "at-risk beneficiary" by replacing the word "Medicaid" in paragraph (7) with the word "Medicare."

4. Update terminology in regulations on data sharing with ACOs by replacing references to "Health Insurance Claim Number (HICN)," which was discontinued in 2019, with the term "beneficiary identifier," and revising the list of purposes for which an ACO may request certain beneficiary-identifiable data to replace the term "process development" with "protocol development."

Future Developments for Shared Savings Program

CHPA has advocated that CMS leverage MSSP as an innovation platform and applaud CMS for seeking input on ways to bring more innovation into the program. Additionally, CHPA is pleased to see CMS mention an option to provide prospective payment for primary care within MSSP as a strategy to support care delivery transformation, strengthen primary care, and increase participation in ACO initiatives. CHPA and others have called on CMS to implement such an option and outlined payment approaches that accommodate the differing needs and capabilities of various primary care practice types. **We encourage CMS to move forward swiftly and begin offering this option in MSSP to coincide with the start of the Innovation Center's Making Care Primary Model.**

Increasing the Amount of the Prior Savings Adjustment

Regarding its calculation of the prior savings adjustment, CMS seeks comments on increasing the 50 percent scaling factor or other alternatives for measuring savings generated in a way that does not overly inflate ACOs' benchmarks while still reducing the ratchet effect. For contracts beginning in 2024, CMS previously finalized adding back half of ACOs' prior savings to its benchmark, which cannot exceed 5 percent of national FFS spending, the same cap applied to an ACO's positive regional adjustment. CHPA appreciates CMS's openness to modifying prior savings adjustment. In comments on last year's fee schedule, several ways to strengthen the prior savings adjustment were outlined.

- Use ACOs' maximum shared savings rate from their prior agreement period. This would increase the prior savings adjustment to 75 percent for Enhanced ACOs, for example.
- Allow the prior savings adjustment to be more than 5 percent of national FFS spending, at which it is currently capped. The cap on the adjustment effectively limits successful ACOs' or ACOs who serve high-costs population. For these ACOs, a cap of 5 percent may represent more than a 50 percent scaling factor of the prior contract's savings.
- Risk adjusts the 5 percent national FFS spending to make it a more accurate reflection of the complexity of the patient population.
- Allow ACOs to receive the greater of the 5 percent of national per capita FFS spending in BY3 for assignable beneficiaries or 50 percent of the pro-rated average per capita savings net of any negative regional adjustments.
- Use a quartile-based benchmark system, like Medicare Advantage, which would adjust the caps based on the ACOs' spending compared to the region. For example, an ACO whose spending is 10 percent below their region could be capped at 5 percent while an ACO that is 20 percent below their region's spending could be capped at 7.5 percent. Currently, CMS policy of ratcheting every ACO back to a 5 percent of national FFS spending prevents any long-term investments that would require greater than a 5 percent savings rate to generate a return.

CHPA supports CMS's efforts to account for prior savings when ACO benchmarks are rebased under a new agreement period as this will help CMS retain ACOs in the program long-term. CHPA appreciates policies that reward strong performance and further incent a transition away from FFS. We feel there are ways to strengthen this policy that are important to consider as we deal with the ratchet effect that comes from continual rebasing. It is important to remember that any move to administrative benchmarks will not solve this problem of benchmarks starting off at unachievably low levels because of ratcheting due to rebasing. This ratchet does not just cap savings, it caps investments in beneficiaries, and it caps how much an ACO can truly transition away from FFS and towards value.

As CMS looks to solve the ratchet effect, it is important to remember this could be solved by increasing both the regional adjustment and prior savings adjustment. The size of the ratchet depends on how efficient the region is, and ACOs in more efficient regions need a higher prior savings adjustment to offset the lack of help provided by the regional adjustment.

Expanding the ACPT Over Time and Addressing Overall Market-wide Ratchet Effects

CMS is seeking feedback on future refinements to its new Accountable Care Prospective Trend (ACPT), including replacing the national trend in the current two-way blended update with the ACPT, along with scaling the weight of the ACPT to account for ACOs' market share in its region. Because the ACPT is based on national Medicare spending, ACOs in regions whose spending growth was higher than the ACPT will be hurt. According to NAACOS' analysis, that is about a third of ACOs. For new agreements starting in 2024 and beyond, MSSP benchmarks will be a combination of two-thirds of the current national-regional blend rate and one-third of the ACPT.

CHPA appreciates CMS looking at future refinements to the ACPT. We support keeping the current two-way trend that uses a blend of national and regional spending but recommended two changes: CMS (1) use the ACPT as the national component of the trend adjustment, rather than observed national FFS spending and (2) remove ACO-assigned beneficiaries from the regional comparison group, negating the effect of ACOs' savings on the regional trend. This would still allow CMS to move toward its goal of an administratively set benchmark while minimizing the unintended consequences of harming nearly a third of ACOs.

Our concern with the ACPT hinges on the fact that national spending is not reflective of the spending trends in an ACO's region. When an ACO's regional trend is lower than national spending increases, the ACO would be negatively impacted. ACOs should not be punished if they operate in regions with spending growth below that of national inflation. Replacing the national trend in the current two-way blend with the ACPT is a step in the right direction. It creates a benchmark that is based less on national spending and more on regional spending, which is a policy CHPA supports.

CHPA asks that guardrails be put into place to protect ACOs who would see lower benchmarks because of the ACPT. These include:

- Setting ACOs' historic benchmark at the higher of the proposed three-way trend adjustment or the current two-way trend adjustment.
- Basing the ACPT on regional spending, rather than national. Because there is significant variation in regional spending growth, the use of a national trend will benefit ACOs in

regions with slower spending growth and reduce benchmarks for ACOs in regions with higher spending growth.

- Using a 3-year projection of the ACPT, which is the current projection used in the USPCC. It would be difficult to project five years out and reserving the right to make mid-agreement period adjustments simply introduces uncertainty.

Promoting ACO and CBO Collaboration

CMS seeks feedback on general approaches for encouraging or incentivizing increased collaboration between ACOs and CBOs and on potential changes to MSSP's patient-centeredness requirements to strengthen partnerships between ACOs and interested parties in the community, including CBOs, to address unmet HRSNs. CHPA shares CMS's commitment to whole-person care, and we appreciate the opportunity to highlight ways to support ACOs in collaborating with CBOs and addressing health equity and SDOH. CHPA supports policy changes that support ACOs in this work, including increasing financial benchmarks for beneficiaries with social risk factors, providing funding for community partnerships, allowing additional flexibility for ACOs to provide supplemental benefits, leveraging technology, and providing ACOs timely access to data.

Many ACOs are actively working with their communities, by partnering with CBOs or implementing initiatives in partnership with local schools and churches to meet patients' needs. A common barrier that ACOs encounter in this work is lack of funding and/or capacity of CBOs to meet the level of need in the community. Many CBOs across the country are small, underfunded, and lack connections to the health care system. While some ACOs use shared savings to fund partnerships with CBOs, more stable and predictable funding mechanisms are needed to create meaningful, sustained collaboration.

New codes for community health integration and SDOH risk assessment, proposed in this rule, will help support these efforts by providing payment for screening patients for SDOH and social risk factors, and for activities to address SDOH and HRSNs. We encourage CMS to do more to incorporate social risk into financial benchmarks to reflect the cost of improving outcomes more accurately for beneficiaries affected by SDOH and HRSNs. These beneficiaries may have significant unmet need due to historical lack of access, making risk scores based on historic utilization appear low. Combined with the cap on risk score growth in MSSP, these policies significantly underestimate the resources required to care for underserved beneficiaries and create financial challenges for ACOs providing this care.

Another challenge that ACOs frequently cite is the structure of the current Beneficiary Incentive Program (BIP), which lacks flexibility to tailor the program to the needs of an ACO's population. While this program was established by Congress and will require statutory changes, there are opportunities for CMS to improve the process for updating waivers available in MSSP.

We urge CMS to avoid creating new requirements, which may limit ACOs' flexibility to tailor to their unique populations and increase burden, and instead focus on addressing existing barriers. Rather than making changes to the patient-centeredness criteria, CMS could, for example, provide additional guidance and resources to ACOs looking to establish new partnerships with community stakeholders, and conduct outreach and provide support to CBOs interested in ACO partnerships. CHPA looks forward to advancing this important work.

Beneficiary Notification Requirements

While CMS does not propose any changes to the MSSP beneficiary notification requirements in this rule, CHPA would like to reiterate concerns with the requirements as currently written and highlight key challenges ACOs face in implementing and complying with these requirements. Beneficiary notifications were required in the early years of MSSP, and the requirement was later removed due to the administrative burden, beneficiary confusion, and operational complexity caused by the notifications. CMS later reintroduced the requirement and made changes to the policies but has not addressed the fundamental issues with the requirement.

In last year's rulemaking, CMS added a follow-up communication requirement in conjunction with the notice, which CHPA opposed due to concerns it would exacerbate beneficiary confusion and operational complexity. ACOs have struggled in implementing this new element of the requirement and CMS did not provide any guidance on the follow-up requirement until April 2023, nearly four months after the requirement went into effect, and the guidance and FAQs provided failed to answer numerous questions about compliance or CMS's expectations for ACOs. We have outlined four overarching issues with the beneficiary notification requirements as currently written, detailed below.

First, ACOs that have elected preliminary prospective assignment with retrospective reconciliation (retrospective assignment) struggle to identify the denominator of beneficiaries to which they are required to provide the notice and follow-up. While ACOs with prospective assignment are only required to provide these to prospectively assigned beneficiaries, ACOs with retrospective assignment are required to provide them to all Medicare FFS beneficiaries. CMS provides these ACOs with information on preliminarily assigned (ALR Table 1-1) and assignable (ALR Table 1-6) beneficiaries but does not provide a list of or contact information for all FFS beneficiaries, making it infeasible for ACOs to identify and contact these beneficiaries to comply with the requirements. While CMS attempted to alleviate some burden by reducing the frequency with which ACOs must provide the notice, many ACOs' compositions change significantly from year to year, with hundreds of new providers and thousands of new beneficiaries, making it incredibly challenging to identify all "new beneficiaries" each performance year.

Second, the timing requirements of the initial notice and follow-up are impractical and make it effectively impossible to be fully in compliance. Under current regulations, ACOs are required to provide the notice at or before the first primary care service visit of the performance year and provide the follow-up "no later than the earlier of the beneficiary's next primary care service visit or 180 days from the date the standardized written notice was provided." Some beneficiaries will inevitably have a primary care visit on January 2 and ACOs do not receive attribution lists for the upcoming performance year until December, leaving very little time to send notifications by January 1. Requiring clinic staff to furnish the notice at point of care adds significant administrative burden—including staff training, changing workflows, and documenting and tracking when beneficiaries receive the notice—to primary care practices, many of which are experiencing staffing shortages and high levels of burnout.
The timing of the follow-up communication poses even more challenges. Many ACOs do not have access to practice-level scheduling data to determine whether the beneficiary's next primary care visit takes place before the end of the 180-day period after the notice was provided. At a minimum, CMS should only require follow-up communication within 180 days, removing "the next primary care service visit" as it is a difficult and impractical standard for all ACOs to track.

Third, lack of appropriate guidance from CMS and contradictory information provided by ACO coordinators have caused significant confusion among ACOs about how to comply with the requirements. As previously mentioned, written guidance documents from CMS fail to answer questions about implementation, required documentation, and what CMS considers to constitute compliance with the requirements. Additionally, because this guidance was not published until the second quarter of the year, some ACOs had to re-do many of the notifications to comply with the guidelines, adding costs and administrative burden. ACOs that have contacted their ACO coordinators with questions about these requirements have received information that contradicts answers provided by other ACO coordinators or conflicts with guidance and statements made by CMS.

Finally, and perhaps most importantly, these requirements have caused confusion and frustration for Medicare beneficiaries, in direct contrast with the intention of the requirements. CHPA strongly supports efforts to improve beneficiary education and engagement, and we are concerned that the current beneficiary notifications are having the opposite effect.

CHPA is a strong supporter of CMS's goal to have all Medicare beneficiaries in a relationship with a provider accountable for their quality and total cost of care by 2030. Effectively communicating with and educating beneficiaries about accountable care will be essential to achieving this goal. CHPA is willing to engage with CMS and other stakeholders, including patients and consumer advocates, to improve beneficiary communications as they are critical to expanding the reach of accountable care and to the success of patient engagement activities.

Proposals to Align CEHRT Requirements for Shared Savings Program ACOs with MIPS

CHPA strongly opposes CMS proposals to align CEHRT requirements for MSSP ACOs with MIPS and we urge CMS to reconsider this policy. By requiring all ACOs to report Promoting Interoperability, regardless of track or qualifying APM participant (QP) status, CMS is creating yet another disincentive for ACOs to participate in an Advanced APM and obtain QP status. CMS notes their intention with this proposal is to reduce burdens for ACOs, however the result is the opposite. Instead, CMS is now creating a new reporting obligation for ACOs who participate in an Advanced APM and obtain QP status. Lastly, QPs are statutorily excluded from the MIPS program and this proposal would essentially subject QPs to MIPS as Promoting Interoperability is the only reporting obligation ACOs have in the program.

Further, it would be difficult for ACOs to comply with this new requirement in the timeline proposed. The final rule will not be published until November, and ACOs must report to CMS those practices they wish to eliminate from their ACO participation list in September. This leaves ACOs no recourse if there are practices not currently on CEHRT that will be unable to comply with the new requirement by 2024. CMS must ensure ACOs still could bring small practices who are not currently on CEHRT into the ACO. ACOs can provide resources and assistance for transitioning to CEHRT, however this can take time, the current 75% attestation approach allowed ACOs to bring these practices into value arrangements. We urge CMS to not finalize this proposal which would stifle growth in ACOs and take CMS further from their goal of having all patients in an accountable care relationship by 2030. Lastly, we urge CMS to provide additional information regarding the consequences of noncompliance with this requirement and how or whether the Promoting Interoperability score achieved will factor into compliance requirements.

FEDERALLY QUALIFIED HEALTH CENTER

CHPA strongly supports CMS' proposal to allow FQHCs to bill for Remote Patient Monitoring/Remote Therapeutic Monitoring (RPM/RTM), Community Health Integration (CHI) services, and Principal Illness Navigation (PIN).

We appreciate CMS creating the opportunity for FQHCs to receive reimbursement for a range of services they consistently provide to their patients. Including these new services under the general care management code G0511 is a step in the right direction for FQHCs to have evidenced data on the type and intensity of services provided.

Remote Patient Monitoring (RPM)/Remote Therapeutic Monitoring (RTM)

CHPA supports CMS' proposal to allow FQHCs to bill for RPM/RTM under G0511, the general management care code. During the COVID-19 pandemic, health centers increased the use of RPM to provide care and monitor patients' health. Both health centers and their patients have reported positive experiences with RPM/RTM. It has helped increase patient self-sufficiency and allowed patients to gain confidence in using these self-measurement tools. Many health centers have shifted to incorporate this model and use remote monitoring technology in general to stream communication and access for patients. Furthermore, health centers have been able to reimagine preventive care and chronic disease management with at-home care utilizing remote patient monitoring. With many U.S. adults delaying preventive care, and with 6 in 10 having at least one chronic condition including heart disease, cancer, and diabetes, regular health management can be a matter of life and death. Community health centers serve a large population of high-risk patients who are more likely to suffer from a disproportionate array of chronic conditions. Being able to offer patients their own self-care tools and remote patient monitoring can help prevent unnecessary health problems. CHPA appreciates CMS permitting FQHCs to bill for this vital service under general care management.

However, we urge CMS to expand the definition of RPM/RTM devices to include devices that empower patients to monitor their own health data. During the pandemic, patients utilized devices that could self-report to the physicians or allowed them to monitor their own health. These devices could include blood glucose meters and pulse oximeters. Health center personnel have helped patients understand how to properly use the device and empower patients to take a more active role in their health care. Expanding coverage to self-reporting devices would minimize patient's out of pocket costs and increase accessibility for Medicare beneficiaries. Self-monitoring monitoring blood pressure devices (SMBPs) are a good example of why self-reporting devices need to be included in the definition, so that patients can fully utilize this useful tool to monitor their blood pressure and improve their health outcomes.

Cost and coverage should not be barriers to accessing a SMBP device especially given the unique patient population health centers serve. Forty-five percent of health center patients suffer from hypertension, compared to 32% of the general population. Furthermore, health centers serve some of the nation's most vulnerable patients; 67% of health center patients live under 100 percent of the Federal Poverty Level (FPL) and 90% live under 200 percent FPL. With the growing shift towards keeping individuals in their homes and communities as they age and receive care, health centers will need to utilize SMBP devices to better care for patients. Expanding Medicare coverage is also aligned with CMS' health equity goals as well. In CMS' 2022-2023 Framework for Health Equity, the fifth priority is to "Increase All Forms of

Accessibility to Health Care Services and Coverage." Coverage of SMBP devices would help meet this goal by increasing access to a crucial device that helps patients take better control of their own health. CHPA strongly urges CMS to allow SMBP devices, and other patient-monitored devices, to be covered and billable under Medicare as a critical patient care tool.

Community Health Integration (CHI) Services

CHPA supports CMS' proposal to allow FQHCs to bill for CHI services under the G0511 general management care code, which will allow auxiliary personnel like CHWs to furnish key SDOH interventions after an evaluation/management visit. CHPA appreciates the Administration's continued support of CHWs, especially the $225 million in American Rescue Plan funds to help train CHWs. CHWs serve as key care team members at health centers; in 2022, health centers employed over 2,300 CHWs. They are often members from the communities where they work, making them uniquely equipped to connect patients to community-based resources and help address barriers patients face in continually accessing the care they need. CHWs may be part of the FQHC multi-disciplinary care team, and their responsibilities can include the following:

- Determining resources available in the community and completing an action plan prior to the patient visit
- Facilitating referrals to community resources based on patient needs
- Case management and follow-up between patient visits
- Health education and translation services

CHW services have been historically supported by time-limited grants from private foundations or governmental organizations that help develop and grow capacity at the health center. However, these do not deliver long-term sustainability, so we are enthusiastic for the proposed CHI services to help cover more of these previously non-reimbursable CHW services.

CHPA recommends that the initial billing code for CHI services, GXXX1, be changed to the range of 20-60 minutes instead of just 60 minutes. We appreciate CMS' creation of two different codes – GXXX1, 60 minutes/month and GXXX2 – additional 30 minutes/month to document and bill for CHI services. However, if auxiliary personnel providing CHI services do not meet that 60-minute threshold for the visit, FQHCs are unable to bill for that visit. As previously mentioned, many health center patients have complex needs, and meeting these needs will take varying amounts of time depending on the level of services needed. Health centers need the flexibility to tailor visits to the patient's needs without health centers missing the opportunity to receive reimbursement for these eligible services. Therefore, we recommend that code GXXX1 be changed to 20-60 minutes, while maintaining GXXX2 as an additional 30 minutes/month.

As CHWs continue to be an important part of the health center care team, CHPA advocates making CHWs a billable Medicare provider. Over the last few years, more health centers have entered contractual agreements with managed care plans that provide reimbursement based on patient size or outcomes. A 2017 Kaiser Family Foundation survey of Medicaid managed care organizations found that 67% of plans used CHWs to address social determinants of health in the previous 12 months. While CHWs have traditionally not been reimbursed by public and private insurers, a growing number of states are using funding mechanisms such as Medicaid State Plan Amendments, Section 1115 Demonstration Waivers, and legislative statutes to reimburse for CHW services.

We are excited for Medicare Part B to cover CHI services, including CHW services. Reimbursement for responding to SDOH needs is crucial as more FQHCs seek to transition to alternative payment models (APMs), such as participating in the recently announced Making Care Primary model. Health centers need payment models that will provide adequate financial support and flexibility to deliver the kind of whole person care their patients deserve in new and innovative ways. In the end, every patient, practice, and community are different. There is no one-size-fits-all approach to addressing individuals' unique health-related social needs. Employing CHWs at the health center is one way to provide help and resources to patients, and getting reimbursement for CHI services, and hopefully coverage of CHWs as a billable Medicare provider, will help health centers continue to employ CHWs.

Furthermore, CHPA recommends that CMS not limit only one practitioner to furnish and bill the CHI initiating visit and the CHI services for a patient. At FQHCs, located in health professional shortage areas (HPSAs), physicians and non-physician practitioners operate as care teams. As a result, the patient may be seen by more than one provider in a group practice, with each provider following the shared care plan within the care team. When multiple providers, in a group practice, operate as a clinical care team, each provider in the group practice would be working in support of the same clinical care plan. This means the provider who conducts the CHI initiating visit may not always be the same provider providing the CHI services, in a group practice environment. Alternatively, one or more of the providers, in the same group practice, may conduct the initiating visit and a different provider in the group may oversee the subsequent CHI services. We feel strongly believe that limiting the CHI initiating visit and CHI services to the same individual provider, without recognition of group practices that employ other practitioners that may initiate the qualifying visit, would impair the ability of auxiliary personnel to provide CHI services to patients.

Chronic Care Management Services – Beneficiary Consent & Virtual Communication Services

CHPA supports CMS' proposal to increase the ways providers can obtain patient consent for chronic care management (CCM) services.

Due to COVID-19 flexibilities permitted by CMS, health centers were able to obtain patient consent in a variety to ensure patients could continue receiving chronic care management services. We appreciate CMS clarifying that health centers can continue using these options, including verbally (if documented in the medical record), by auxiliary staff performing CCM service, or via virtual communication by auxiliary staff under general supervision. This flexibility will continue to allow health centers to enhance their efficiency by tailoring their operational processes and workflows to continue focusing on patient care. We also appreciate CMS allowing third-party vendors to obtain consent from patients. Utilizing technological third-party vendors helps decrease administrative burden, allowing health center personnel more time to focus on providing patient care while ensuring patients' understanding of services rendered.

Proposal to Create Reimbursement for SDOH Risk Assessment

CHPA supports CMS' proposal to reimburse for the screening of social drivers of health (SDOH) through the creation of a standalone G code but urges the agency to clarify language to ensure FQHCs can benefit from this proposal.

Health centers have long been at the forefront for screening for SDOH and subsequently connecting patients to these resources. Health centers were created to specialize in providing comprehensive primary care services. From the onset, health center practitioners have provided whole-person care when treating their patients, uncovering barriers patients face in accessing basic health care services. With their team approach to care, health centers saw the need to document and track these services to ensure that any provider treating the patient can fully understand their needs.

One of the tools that health centers use is the Protocol for Responding and Assessing Patients' Assets, Risks and Experiences (PRAPARE) tool. NACHC helped create this tool to enable health centers and other providers to collect the data they need to better understand and address their patients' social determinants of health. In 2022, 599 health centers used the PRAPARE tool, which was mentioned in this NPRM as an accepted tool to use when conducting an SDOH risk assessment. Furthermore, 28% of health centers have reported that they are in the planning stage of getting a tool to complete screening for SDOH health risk assessment.

CHPA recommends CMS amends the regulation to allow FQHCs to be reimbursed for this evaluation. Additionally, CHPA recommends that the number of minutes in the new stand-alone G code be increased from 5-15 minutes to 10-20 minutes to give staff adequate time to engage with their patients.

As currently proposed, this new stand-alone G code, GXXX5, would allow providers to bill 5-15 minutes every 6 months, for the administration of a standardized, evidence based SDOH Risk Assessment. The PRAPARE tool takes approximately 9 minutes to complete if the practitioner is quickly asking the questions and leaving little room for prolonged dialogue. More than 9 minutes are needed to have a truly bidirectional conversation with the patient. Talking about SDOH needs can be sensitive and health center care team members strive to make the patient feel comfortable talking about their lived experiences and needs. To best address patient SDOH needs, more time is needed for this risk assessment. Health centers serve some of the most medically complex patients. Given that 80-90% of health outcomes are due to SDOH, health centers prioritize screening and then connecting patients to services to help address SDOH.

CHPA strongly encourages CMS to adopt more flexible policies that reimburse health centers for follow-up visits after a patient has a positive screen for SDOH needs. Additionally, it is important the CHC has the discretion to determine how often a patient should be screened. We advocate for the development of billing codes that reflect the time and effort health center care team members invest in not only assessing patients but connecting those patients to crucial services. We also recommend CMS create billing codes that support care coordination efforts aimed at addressing SDOH. This could include reimbursement for activities like connecting patients with community resources, coordinating with social workers, and monitoring SDOH-related interventions.

We also support the proposal to add the new SDOH code to the Medicare Telehealth Services List. Until December 31, 2024, FQHCs will be able to bill for any service on the telehealth list under the G2025 code, including this SDOH code. We urge CMS to allow FQHCs to bill for telehealth services beyond the 2024 deadline. Telehealth has played a vital role for health centers during and after the pandemic. This would allow health centers that allow practitioners, or auxiliary personnel, to continue to complete the risk assessment in an interview format, depending on patient needs. Allowing health centers the flexibility in furnishing this risk assessment will help them better meet the needs of their patients. For example, a

health center may conduct this health risk assessment over the phone and then use their E/M visit to dive more deeply into the areas of concern flagged during the telephonic risk assessment.

Furthermore, CHPA advocates for more federal support of PRAPARE. There is currently a lack of federal funding to assist health centers in covering the cost of integrating PRAPARE into their EHRs, which could cost anywhere from $6,000 to over $49,000. Health centers operate on thin financial margins and while many health centers already screen for SDOH, there are other smaller health centers whose budgets cannot absorb the cost of integrating PRAPARE into EHRs. CHPA supports additional federal funding to help health centers cover the administrative costs of integrating PRAPARE into their clinics and the costs to cover the services needed for patients after they are identified by PRAPARE.

Proposal to Include an Optional, Additional, Social Determinants of Health Risk Assessment in the Annual Wellness Visit

CHPA supports CMS' proposal to reimburse for an SDOH Risk Assessment as part of the Annual Wellness Visit (AWV) but asks CMS to clarify language to ensure FQHCs can bill for this optional, additional service. As mentioned above, health centers are consistently screening and addressing patients' SDOH needs. Screening for SDOH can happen during a variety of times. For new patients, health centers complete an initial assessment for a patient and then it happens at least annually. Having the risk assessment be part of the AWV naturally fits with how many health centers already operate these visits. We also support the idea that like the AWV, the SDOH Risk Assessment will not cost patients anything when paired with the AWV. However, it is unclear how health centers would be getting paid for administering this additional, optional risk assessment.

CHPA seeks clarification that FQHCs would be eligible to bill for this; we propose being able to receive payment for the SDOH Risk Assessment as an additional adjuster, like how FQHCs currently get paid for conducting the AWV. Health centers are required under § 410.15 to conduct an AWV for Medicare patients and receive a 34.16% payment increase under Medicare's FQHC PPS G Codes for new patients. Allowing health centers to get paid for the SDOH risk assessment through an additional adjuster will help health centers continue to provide the assessments and further incentivize smaller health centers with smaller operating budgets to more formally assess and document SDOH needs of their patients.

CONCLUSION

Thank you for the opportunity to provide feedback on CY2024 Physician Fee Schedule and MSSP proposed rule. CHPA and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on improving and enhancing MSSP. If you have any questions, please contact Brandi Apodaca, Chief Operating Officer, at brandi@chpanetwork.com.

Sincerely,

MB Apodaca

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