September 11, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Attention: CMS–9904–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Submitted via regulations.gov.

RE: "Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program"

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit comments in support of the proposed rule by the Centers for Medicare & Medicaid Services (CMS) entitled "Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program."

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels. Where possible, we uplift the voices of real people engaging with the health care system at the patient level whose perspectives have shaped our advocacy work.

Overall, USofCare supports the provisions in the proposed rule, which will expand access to care and further health equity. As we articulate how the rule will positively impact people's access to health care, we focus our comments on the following topics:

I. Investments in Primary Care
II. Telehealth
III. Dental Care
IV. Integration of Behavioral Health & Primary Care
V. Caregiving Supports
VI. Services Addressing Health-Related Social Needs
VII. Basic Health Plan

I. Investments in Primary Care

USofCare has long advocated in favor of investments in primary care, which is the foundation of our care delivery system and often the gateway to other care needs. We have supported efforts in states to increase access, such as requiring free primary care visits in Colorado. When properly funded, a system grounded in primary care delivers value and demonstrates improved care outcomes. Any people-centered approach to health care reform must provide continued access to high-value services like primary care, center a system that rewards providers for delivering these high-value services, and incentivize a transition toward value-based care models.

We commend CMS's overall focus on primary care and support the proposed rule allowing for additional payment for evaluation and management (E/M) visits for primary care of complex patients. We know that people favor a "value-based" patient-first care model that compensates providers for improving overall health, delivering superior care, and coordinating patient care over the current fee-for-service (FFS) model by a 4:1 margin. These models help ensure patients' full scope of needs are met. **While we are supportive of increased payments for primary care, we encourage CMS to look beyond the FFS model of payment and incentivize transitions to alternative payment models (APMs).** Many states are leading the way; models such as Rhode Island's Patient-Centered Medical Homes (PCMHs) or Delaware's Primary Care Reform Collaborative show that these programs can be effective, sustainable, and equitable for patients and providers alike.

Telehealth

Expanding access to virtual health services allows for more people to receive timely, personalized, and understandable care. Even before the COVID-19 pandemic, virtual care was changing how health services are delivered, especially in communities disproportionately facing barriers to care. Through our listening work, we learned that people appreciate the convenience provided by virtual care, which has repeatedly been shown to be as effective as in-person care.

> *"I'm very comfortable [using technology to navigate the healthcare system.] I use apps on my phone to access my health records, send messages to my doctors…it is very helpful."*
> *~ White man, North Carolina*

USofCare is pleased to see CMS adopt provisions that we have previously advocated for in the CY2023 Medicare Physician Fee Schedule. **We are excited that CMS continues to prioritize telehealth access as part of the CY2024 Medicare Physician Fee Schedule.** Many of the telehealth flexibilities included in last year's Consolidated Appropriations Act, which USofCare supported, such as allowing people to receive care through audio-only modes, will be implemented as part of the CY2024 Fee Schedule. We strongly support extending pandemic-era telehealth flexibilities to allow people to receive telehealth services in a setting that works best for them – such as their homes, community centers, and schools – through the continued lifting of originating site and geographic restrictions through the end of CY2024. **We also support ensuring that providers retain the ability to bill through audio-only services.** Too many underserved and rural communities lack and have limited access to broadband services; maintaining access to audio-only services allows them to access care comfortably.

The CY2024 Fee Schedule also ensures access to the mental health and behavioral health specialists that people have come to rely on since the pandemic. USofCare is supportive of delaying the in-person visit requirement for telemental health services delivered in Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs), as well as maintaining access to

a wide range of telehealth practitioners, such as qualified occupational therapists and mental health counselors.

Once again, states are leading the way in implementing permanent and long-term extensions of pandemic-era telehealth flexibilities. As of May 2023, 43 states and the District of Columbia have made telehealth reimbursable through private insurance and 20 states have authorized Medicaid reimbursement for all four telehealth modalities: live video, store-and-forward, remote patient monitoring, and audio-only. **We encourage the federal government to follow the lead of states in extending telehealth flexibilities beyond CY2024 to promote certainty around access to this kind of care for people to ensure it is available when they need it most.**

Dental Care

Although access to affordable, comprehensive dental care is a critical component of people's health needs, nearly half of people with Medicare do not have dental coverage. Oral health disparities disproportionately affect low-income older adults and communities of color, including Black and Hispanic populations. This is perpetuated by lack of access, which can increase the risk of a range of negative health outcomes, including cardiovascular disease and diabetes. Expanded access to comprehensive dental coverage under Medicare has the opportunity to address these disparities and improve health equity more generally.

> *"It's just astonishing to me that you can't just go to a government website and type [it] in…[People need assistance] on where to find a low-cost dentist."*
> *~ White man, Illinois*

While more can be done to ensure people have adequate access to oral health care, we are pleased to see Medicare adopt the USofCare-supported provision of the CY2023 Medicare Physician Fee Schedule that covers dental services deemed integral to the treatment of a person's primary medical condition and other "medically necessary" dental services. We appreciate CMS's continued expansion of the number of dental services that providers can bill to Medicare to allow for those services "inextricably linked" to treat people with cancer and encourage the agency to take more steps to make dental care accessible to people.

Integration of Behavioral Health & Primary Care

Despite an increase in the number of adults experiencing some form of mental illness, the mental health and behavioral health workforce remains ill-equipped to address the scope of this crisis. For many communities that lack dedicated mental and behavioral health care providers, primary care providers, such as nurse practitioners, often serve as the sole source of behavioral health treatment. Access to psychiatrists and mental health professionals remains low and is only exacerbated amongst underserved populations. Black, American Indian, and Alaska Native people have been found to use mental health services at significantly lower rates than white people, due in part to lower rates of insurance coverage and geographic barriers that limit access to behavioral health providers. **We were pleased that the CY2023 Fee Schedule relaxed supervision requirements to allow certain behavioral health providers, such as marriage and family therapists and licensed professional counselors, to practice at the top of licenses without direct supervision.** This provision aims to address the mounting behavioral health workforce shortage, especially in rural areas and amongst communities of color.

As emphasized in the 2022 CMS Behavioral Health Strategy, integration of primary care and behavioral health care is essential. USofCare is supportive of changes to behavioral health

integration codes to allow marriage and family therapists and mental health counselors the ability to provide behavioral health care services in the primary care setting. **We encourage CMS to deepen behavioral health and primary care integration further by referencing innovative payment models such as the Collaborative Care Model as it considers ways to expand access to needed behavioral health care services.**

Caregiving Supports

Earlier this year, USofCare applauded CMS's proposals to update payment for the Home and Community-Based Services (HCBS) direct care workforce in its Medicaid Access and Medicaid Managed Care Organization rules. In our comments, we emphasized the importance of adequately compensating the direct care workforce, which is disproportionately composed of immigrants and women of color. We also urged the agency to make further investments into "informal" caregivers, which we defined as people who provide unpaid care for a family member or loved one. **We are pleased to see that the CY2024 Physician Fee Schedule proposes support for these caregivers and tackles how payment is made for provider training of caregivers under Medicare.**

We support CMS's definition of caregiver ("a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition") in this context and agree with the agency's rationale that it would allow for holistic patient care. We appreciate the continued emphasis on person-centered care while discussing how Caregiving Training Services (CTS) are provided outside of the patient's presence, including obtaining documentation and the patient's consent for the caregiver to be trained. Caregivers play an essential role in supporting their care recipient's health care needs, and caregiver training can equip them to provide personalized care and help their care recipient achieve better health outcomes. It is important to iterate that the patient's choices and consent are paramount in their care plan, especially considering how marginalized communities, such as people of color and people with disabilities, have historically been deprived of their medical autonomy.

Services Addressing Health-Related Social Needs

We appreciate CMS's emphasis on health equity within the proposed rule by addressing health-related social needs. We encourage the agency to continue implementing programs that improve coordination and continuity of care while promoting care networks that are responsive to patients' cultural identities and needs.

> *"You talk to one doctor, they talk about one thing. You go to a different doctor, totally different symptom. They're prescribing medicine that don't even work together and one medicine make you sick because you took the other… That is what is fragmented and complicated, nobody talking to each other, nobody getting their records. You're responsible for carrying your records around. It's not a good look."*
> *~ Black focus group participant*

From our recent research, we know that people are frustrated with the fragmentation of the health care system. People – especially people of color, low-income people, and people in rural areas – were less likely to rate their experiences as 'excellent' when it comes to their providers taking a whole-health approach to their treatment and coordinating care with their other providers. In fact, multiple participants compared their experiences receiving medical care to that of an "assembly line" experience, craving for their providers to treat them as whole people instead of just body parts.

USofCare supports the proposed rule's changes to allow separate coding and payment for community health integration (CHI) services to account for the work of community health workers, peer support workers, and care navigators to address social determinants of health (SDOH). Working together alongside other members of the primary care team, such as physicians, nurses, and auxiliary personnel, these workers play a critical role to advance health equity by bridging gaps in patient care and providing wrap-around services, especially to marginalized populations who may lack access to or trust in the health care system, while also lowering health care costs overall. Hallmark to USofCare's advocacy is the belief that people should have access to personalized care. It is critical that every person feels certain that they will receive quality medical care regardless of their identity. We believe that the proposed updates will further health equity by establishing culturally responsive care, which is an effort by medical providers to acknowledge and recognize all aspects of their patients' identities when providing care.

We appreciate the agency's efforts to address how the SDOH may impact a patient's ability to be diagnosed and treated for a condition. We are supportive of the addition of a SDOH risk assessment to the annual wellness assessment. **In doing so, we encourage CMS to facilitate meaningful collaboration between providers and community-based organizations, who may be more trusted to provide this assessment.** We echo the recommendation of the National Alliance to Impact the Social Determinants of Health (NASDOH) for CMS to consider further incentives and supports for providers and community organizations addressing health-related social needs.

> *"Probably everyone in this room has been, in some way, re-traumatized by a medical professional… I think the result of that is that communities are addressing their own social determinants of health, collectively, as a community. Because of this, those things are often ignored by the health care industry and traditional health care… It's like chasing a unicorn that doesn't exist, especially in rural areas. In some ways, we create spaces and do things to… supplement the trauma that comes from [a lack of culturally responsive care.]"*
> *~ White man, Colorado*

Moving forward and more broadly, we encourage CMS to continue to prioritize patients' SDOH when considering how best to work with physicians, nurses, and other personnel to address their medical care needs. Our listening work with underserved populations in Colorado has shown that providers, while willing to address social determinants of health, require additional resources and training to further respond to the needs of their patients.

Basic Health Plan

USofCare is supportive of innovative solutions pursued by states to increase access to affordable, comprehensive health care coverage. The Basic Health Plan, as authorized by the Affordable Care Act, has provided a low- or no-cost additional coverage option for people in New York and Minnesota. USofCare has been deeply involved in the creation and implementation of Oregon's BHP – known as the "Bridge Plan" – which is estimated to provide coverage to approximately 102,000 Oregonians.

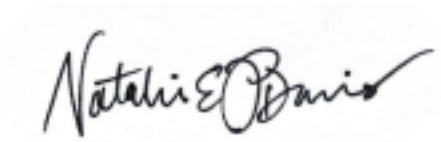
We commend language in the proposed rule to introduce additional flexibility to the Basic Health Plan blueprint process, which will allow states to pursue solutions that further expand access to affordable, comprehensive health care. **In particular, we support CMS's proposal to allow states to suspend their BHP for a limited amount of time to shift**

enrollees into comparable coverage options with similar benefits and cost-sharing. In addition, we appreciate CMS clarifying the instances in which a state must submit a revised blueprint to CMS for review. These proposed provisions allow states flexibility while ensuring proper federal oversight that states' proposals meet coverage and affordability metrics.

Conclusion

If finalized, this rule will build towards our mission of ensuring that everyone can access high-quality, affordable, personalizable, and understandable health care. Please reach out to Lisa Hunter, Senior Director for Policy & External Affairs, at LHunter@usofcare.org with any questions.

Sincerely,



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