



September 9, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: 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

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises more than 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC [defines serious illness](#) as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

Serious illness is also a health equity issue. A history of disenfranchisement has led to healthcare gaps across the country. Per a [2021 Commonwealth report](#) on racial and ethnic health equity, communities of color live fewer years, on average, than white people do, are more likely to die from treatable conditions, and are also at higher risk for many chronic health conditions. For serious illness, the lack of access to health insurance and [primary care](#) mean many are [diagnosed only at a late or end stage](#) of illness, when disease-modifying treatment is

typically no longer effective. Those from historically under-resourced communities who also have serious illness [experience poorer care](#) and access, making improving their care a health equity opportunity.

Here are our comments on the pertinent parts of the proposed rule:

Caregiver Training Services (CTS)

We support establishing new coding and payment for caregiver training for direct care services and supports, behavior management and modification training that could be furnished to an individual patient's caregiver(s) and allow the proposed CTS to be furnished via telehealth. Our additional suggestions are:

- Caregiver assessment- We appreciate that assessing the caregiver's knowledge or ability to provide the needed patient support is acknowledged here and is included when billing CPT code 96161. We suggest that the [Zarit Burden Interview](#), a validated self-reported tool, may also be useful for this purpose. Additionally, we suggest the final rule address what is to be done when the caregiver is found to be too depressed or burdened to fulfill their supportive role. Whenever an assessment is done, there needs to be a plan for what to do should that assessment reveal issues or concerns.
- Proposed Direct Care Caregiver Training Services- We support the addition of these new direct care training services as those living with serious may need caregiver help to manage direct care interventions, and their caregivers may need training to do so. We also suggest clarifying that medical assistants or aides should be able to provide caregiver training of such direct care services under the direction or supervision of the allowable providers.
- Contracting caregiver training- It is not clear in this year's or last year's rules whether or how such caregiver training might be able to be contracted out to other entities to deliver and, if so, who would be able to bill for such training. Please address this in this final rule or future rulemaking.

Request for Information (RFI) for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136))

We appreciate the opportunity to provide input to this RFI and have these responses:

- Auxiliary workforce- We confirm the importance of auxiliary personnel for these services, but we know that this is currently a limited workforce. We support the role of community health workers, for instance, yet know that their [workloads are already high](#) and that more need to be recruited and trained for these positions. The new payment is an incentive, but it will take some time for the needed workforce to grow to adequately support these new services. In the meantime, services will likely be limited as a result.

- Community-based organization (CBO) capacity- Many CBOs are also overwhelmed with service requests and will need infrastructure support to meet the increased demand coming from these new social needs assessments. CMS and the health system must recognize and address this going forward.
- Referring to actual service delivery- We also note that once assessed, any identified needs should be addressed with referrals to appropriate services and a mechanism in place to confirm that these referrals resulted in actual service delivery. Referring people to waiting lists is not the goal but instead to the actual services themselves. Our members continue to tell us that service waiting lists are long where services exist and that some communities may not have services to fill these needs at all. While that is not the health care provider's current responsibility, it is the responsibility of the overall health and social support systems, and CMS should continue to explore ways to promote the building of a robust infrastructure to truly meet identified social needs.
- Patient cost-sharing- We appreciate that the only mechanism available to CMS to establish new services is via the Physician Fee Schedule. Yet, these Medicare Part B services all come with patient cost-sharing. There is an irony in charging people to assess their SDOH risks or helping them navigate a challenging healthcare system for their illness. Many who could most benefit from these services, along with advance care planning, caregiver training, and chronic care management, come from under-resourced or low socioeconomic levels, and the 20% Part B cost sharing may make these helpful services unaffordable. We realize this falls outside of CMS' statutory authority but ask the agency to be sensitive to the realities of using the Physician Fee Schedule/Medicare Part B as the only way to add needed services. We look forward to a future when value-based payment may make such patient cost-sharing moot but, until then, it continues to be a barrier.

Evaluation and Management (E/M) Visits- Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

We support this complexity add-on as palliative care providers often see patients with high complexity, so paying for the additional time and attention these patients warrant is appropriate.

Telehealth Services

We support these proposed changes, especially the confirmation of two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site provider is technically capable of using an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology. During the pandemic, we observed that older patients often lacked access to video technology or were more comfortable discussing care over the phone. This is also true for communication interventions like advance care planning, where audio-only could help counter disparities as evidence shows [they already occur in advance care planning among minority](#)

[groups](#), so telehealth could help promote equity there.

Advanced Primary Care Management Services (APCM)

We support the addition of these new codes with one major change on behalf of our members and partners who provide primary care to those with serious or complex illness: We recommend that the codes be revised so that one focuses on those with many chronic illnesses, as opposed to GPCM3 for beneficiaries with just 2+ chronic conditions who are Qualified Medicare Beneficiary (QMB) program enrollees. While many primary care providers see relatively healthy Medicare beneficiaries, home-based geriatric and palliative care programs see patients who are very ill, compromised, or homebound. They have 7, 8, or 9+ chronic illnesses for which they take many medications and see multiple specialists. An APCM program needs to acknowledge such complexity and pay for it accordingly.

Cardiovascular Risk Assessment and Management

We support this proposed addition with one additional change: the inclusion of palliative care services as part of cardiovascular care management. C-TAC recently participated in a grant from the American Heart Association (AHA), the [*“Improving Quality of Life for People with Heart Failure through Integration of Palliative Care Services”*](#) initiative. This brought together a national clinical advisory council, state coalitions, health systems, and health plans in 4 states to develop a standardized palliative care referral pathway for people with heart failure. The AHA has included palliative care in its [clinical guidelines for heart failure](#) based on [a systematic review](#) that showed such patients could benefit from it. Therefore, although palliative care was not included in the Million Hearts Model, we recommend it be added now based on more recent evidence. We would be happy to discuss this further if desired.

Behavioral Health Services

We support the proposed changes and agree that safety planning is important with the addition of an add-on G-code that would be billed along with an E/M visit or psychotherapy service when safety planning interventions are personally performed by the billing practitioner in a variety of settings. We also hope that such safety planning acknowledges the unfortunate reality that access to emergency behavioral services can be limited and that safety plans address that situation should such services not be available.

We also support Medicare payment to billing practitioners for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. We agree they should be FDA-approved and have demonstrated a reasonable assurance of safety and effectiveness. Such devices can also help with access to needed services.

Finally, we support the proposed “Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions” and agree these interprofessional consultations performed via communications technology such as telephone or Internet (including videoconference) should be reimbursed. Our only comment is that such

interprofessional collaboration should be promoted across the Medicare program and not just for behavioral health conditions.

Opioid Treatment Programs (OTPs)

We support the several proposed telecommunication technology flexibilities for opioid use disorder (OUD) treatment services furnished by OTPs and agree they should be allowed as long as the use of these technologies are permitted under the applicable SAMHSA and DEA requirements at the time the services are furnished, and all other applicable requirements are met. Access to OUD treatment is also challenging depending on beneficiary location or transportation, so making them available remotely can help address these access issues.

Dental and Oral Health Services

We commend CMS for continuing to recognize the importance of oral health on overall health. For too long, these two areas have been artificially siloed, and evidence increasingly confirms how dental and oral health contribute to general health. We appreciate that in making the proposed additions, the agency was guided by the strength of the evidence. We therefore support these additions to the list of clinical scenarios under which FFS Medicare payment may be made for dental services inextricably linked to covered services. We also recommend that the agency continue to monitor the evidence for additional conditions such as dementia, diabetes, and the risk of sepsis from untreated dental or oral conditions. There are likely many more medical situations that could be improved or prevented by Medicare payment for dental/oral care, and we look forward to the barriers between these areas eventually being worn down.

Improving Ambulatory Specialty Care

We appreciate this Request for Information and CMS's interest in soliciting feedback on the design of a potential ambulatory specialty care model that would leverage the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) to increase the engagement of specialists in value-based care and expand incentives for primary and specialty care coordination. We agree that this could help hasten the shift to value-based payment (VBP) and that specialists have not been engaged in enough VBP efforts to date. We are intrigued by the idea of making such arrangements mandatory for relevant specialty care providers to overcome challenges such as selection bias and participant attrition and to ensure the model reaches a representative group of providers and beneficiaries to facilitate the scaling of the model test. We also suspect that such providers will need strong incentives to take on risk and forego fee-for-service. Our only suggestion is that you consider palliative care providers as possible specialists for such a program. Fee-for-service billing currently does not support the full range of palliative care services nor the interdisciplinary team to deliver them, and we see VBP as one solution to that. We look forward to future rulemaking and the opportunity to comment on the specific details of such future plans.

Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood

It is gratifying to see that our consistent recommendation to expand the use of this palliative care-developed measure is bearing fruit. Thank you for now adding it to the cardiology, nephrology, family medicine, geriatrics, internal medicines, and oncology/hematology measure sets. We believe it would be appropriate in all Medicare measures sets and for all Medicare programs and will continue to advocate for that.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant

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