AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 9, 2024

VIA ELECTRONIC MAIL
regulations.gov

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Agency's CY 2025 Payment Policies Under the Physician Fee Schedule (PFS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include nearly 100 hospitals and more than 600 other health care facilities across the nation.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole.

Daily, we observe the unique benefits that the Medicare and Medicaid programs offer to patients, their families and health care systems. AHPA seeks to provide an informed policy voice that reflects our experience delivering whole person care to these communities. Specifically, we offer comments to CMS on the following issue areas within the CY 2025 PFS proposed rule:

- Payment Update
- Telehealth
- Opioid Use Disorder (OUD) Treatment
- Code Update
- RFI: Primary Care Payments

- Medicare Shared Savings Program
- RFI: Health-Related Social Needs
- Medicare Overpayment

Payment Update

CMS proposes to reduce the PFS conversion factor by 2.8 percent (to $32.36), compared to $33.29 in CY 2024. The update includes the removal of the temporary 2.93 percent payment increase for services furnished between March 9 and December 31, 2024, a zero-adjustment factor and a positive 0.05% budget neutrality adjustment.

AHPA would like to stress that from 2020 to 2024, the conversion factor has been reduced by $2.80 (a 7.7 percent reduction). While we understand that this payment reduction can only be stopped through Congressional action, **we do ask that CMS take into consideration the increased strain that health providers are facing and avoid making further payment reductions through the decrease of Relative Value Units (RVUs).**

We fear that further payment reductions will negatively impact patients' access to care and providers' viability, making it harder to also invest in additional initiatives such as addressing the Health-Related Social Needs (HRSN) of our communities. For example, in the Outpatient Prospective Payment System (OPPS) proposed rule, CMS proposes to create a new Medicare Condition of Participation (CoP) for obstetric services with the goal of improving maternal care nationwide. However, CMS proposes in this rule to reduce the RVUs for obstetrics and gynecology services, which CMS estimates would result in a 1 percent payment reduction. While a 1 percent payment reduction may not seem high, when paired with the other payment reductions, these specialties are experiencing a significant financial impact. Is important for the Agency to at least retain current payment levels for these critical services, particularly if they are aligned with broader agency goals, such as improving maternal care and addressing chronic disease.

Telehealth

<u>Telehealth Service List</u>

CMS discusses the many requests it received to move codes from the provisional list to the permanent list, as well as the addition of new codes (not previously on either list) to the permanent list. To address this, CMS proposes to complete a comprehensive analysis of all

provisional codes currently on the Medicare Telehealth Services List before determining which codes should be made permanent or removed from the list.

AHPA applauds the Agency's efforts to ensure that the appropriate provisional codes are moved to the permanent list and that potential new codes are added. If feasible, we request that CMS release details on the process and timeframe for this analysis in the final rule.

Frequency Limitations

CMS proposes to remove telehealth frequency limitations for the same services until the end of CY 2025, including subsequent inpatient visits,[1] subsequent nursing facility visits,[2] and critical care consultation services.[3]

AHPA appreciates this extension but urges CMS to eliminate frequency limitations permanently as these are arbitrary barriers that limit access to care. Ultimately, we want the practitioner to be able to practice at the top of their license and allow them to use their clinical judgment to determine the type of visit, how many visits, and the type of treatment that is best fit for the patient so long as the standard of care is met. CMS, as with in-person visits, could conduct regular audits to determine any irregularities in billing. Instead of adopting frequency limitations, we support adopting the program integrity recommendations shared by the Office of Inspector General (OIG), which focus on how to identify high risk providers.[4] According to the OIG, CMS could focus on targeting providers that:

1. Bill telehealth services at the highest, most-expensive level for a high proportion of services.
2. Bill a high number of hours of telehealth services. For example, those that billed for an average of more than two hours of telehealth services per visit.
3. Billing telehealth services for a high number of patients. This measure seeks to identify providers who bill for a high number of unique patients, which OIG indicates may suggest that the provider is billing for services not rendered.
4. Billing for a telehealth service and then ordering medical equipment for a high percentage of patients.

[1] CPT codes 99231, 99232, 99233
[2] CPT codes 99307, 99308, 99309, 99310
[3] HCPCS codes G0508, G0509
[4] Office of Inspector General. Analyzing Telehealth Claims to Assess Program Integrity Risks, 2023.

5. Billing for both a telehealth service and facility fee for most visits.

Audio-only Services

CMS proposes to revise the definition of interactive telecommunications system to include audio-only communications for other services furnished to beneficiaries in their home in circumstances when the patient is not capable or does not consent to video technology. Claims for such services would need to be appended with appropriate "93" and/or "FQ" modifiers.

AHPA supports the inclusion of two-way, real-time audio-only communication technology for any telehealth service provided in a beneficiary's home and applauds CMS for covering such services.

Distant Site and Provider Home Address for Telehealth Providers

In CY 2024, CMS extended flexibilities allowing providers to report/bill from their currently enrolled practice location instead of their home address when providing services from their home. In this rule, the agency proposes to extend these flexibilities.

AHPA appreciates CMS' recognition of the importance of ensuring provider safety and privacy and urges CMS to make this policy permanent.

Direct Supervision

CMS proposes to continue allowing virtual presence to satisfy the direct supervision requirements to be "immediately available" through the end of CY 2025, including for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

AHPA supports the proposal to extend this flexibility and encourages its permanent adoption given the clinician shortages that the nation continues to face, particularly in rural areas. We are also pleased that CMS proposes to permanently define this standard for a subset of low-risk, incident-to services typically performed entirely by auxiliary personnel.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment

Periodic Assessments to be Furnished via Audio-only Telecommunications on a Permanent Basis

CMS is proposing to allow Opioid Treatment Programs (OTPs) to furnish periodic assessments using audio-only communications technology when video is not available on a permanent basis

beginning January 1, 2025. Under this proposal, CMS would allow periodic assessments to be furnished via audio-only when video is not available to the extent that use of audio-only communications technology is permitted under the applicable SAMHSA and Drug Enforcement Administration (DEA) requirements at the time the service is furnished, and all other applicable requirements are met.

AHPA supports granting flexibility to OTPs to use audio-only communications technology and encourages CMS to finalize this policy.

<u>Allow OTPs to Use Audio-Visual Telecommunications for Initiation of Treatment with Methadone</u>

CMS is proposing to allow the OTP intake add-on code (G2076) to be furnished via two-way audio- video communications technology when billed for the initiation of treatment with methadone, to the extent that the use of audio-video telecommunications technology to initiate treatment with methadone is authorized by DEA and SAMHSA at the time the service is furnished.

AHPA supports allowing OTP's to initiate OUD treatment with methadone via two-way interactive audio-visual communication technology. Providing this flexibility to patients receiving treatment for opioid use disorder significantly expands access to care by removing the need to travel to and from appointments, which is a barrier experienced by many underserved patients and those living in rural communities.

Code Update

<u>Cardiovascular Risk Assessment</u>

Due to the success of CMMI's Million Hearts Cardiovascular Disease Model, CMS is proposing to establish new codes to describe a separately billable cardiovascular disease risk assessment. CMS proposes for the new GCDRA code to be assigned an RVU of 0.18 and allow for a five to 15-minute assessment for Social Determinants of Health (SDOH). The assessment is proposed to include Atherosclerotic Cardiovascular Disease (ASCVD) risk management of individual and lifestyle traits and ASCVD-specific, individualized electronic care plans.

AHPA supports the adoption of the GCDRA code but recommend assigning a higher RVU rate. We also support the elements proposed to be included in the risk assessment. We recommend that CMS consult with cardiovascular industry leaders to identify other metrics that could be used to identify individuals at risk of cardiovascular disease. For example, CMS

could look at adopting the Coronary Calcium Score as part of the assessment to better understand the adherent risk an individual is facing for cardiovascular disease.

Advanced Primary Care Management (APCM) Services

CMS is proposing to establish a new set of payment codes to better reimburse clinicians for advanced care management in primary care while reducing the administrative burden currently faced by clinicians trying to bill for the existing care management codes.

AHPA supports CMS' efforts to build a high-quality primary care system. For far too long, the U.S. has underinvested in high-quality primary care services, which are critical for both individual and population health. However, it is imperative that new payment mechanisms and models for primary care advance the Administration's goals in promoting behavioral health integration and addressing the ongoing mental health crisis. Unfortunately, uptake of integrated MH/SUD services in primary care has been limited to date, despite the increasing availability of Medicare payment options.

Request for Information on Primary Care

To strengthen the primary care infrastructure within FFS Medicare, CMS seeks to explore opportunities to create new sustainable pathways to reimburse providers, including the potential creation of hybrid payments consisting of monthly capitated payments.

AHPA commends CMS for seeking to modernize and improve Medicare's primary care system. The American Association of Medical Colleges projects a shortage of up to 48,000 primary care physicians over the next decade, which highlights the need for reform to incentivize more clinicians to go into primary care.

Because of the budget neutrality provisions in the statute for physician payments, we recommend that CMS work closely with Congress before adopting any reform that would trigger additional reductions to the conversion factor. AHPA supports the goals of the *Pay for PCPs Act,* which also seeks to adopt hybrid payments for primary care physicians across Medicare. CMS could partner with the sponsors of this legislation to inform the modernization of payments, sharing its own lessons from models adopted by the Center for Medicare and Medicaid Innovation (CMMI). We recommend adopting one of the primary care models that have already been tested by CMMI at a smaller scale. Since these models have already been tested and tweaked throughout the years to accommodate provider feedback and necessary improvements, they can serve as a good blueprint for a larger payment reform.

Below we offer our feedback on the questions raised by CMS:

1. *How can CMS better support primary care clinicians and practices who may be new to population-based and longitudinal care management?*

   Reducing the administrative burden currently experienced by clinicians in fee for service and permanently adopting the current CMMI waivers would be helpful. Primary care physicians want to spend more time with their patients and less time doing clerical work. They want to be able to refer patients to home-based and post-acute care services when needed without having to worry about regulatory hurdles. Adopting the CMMI waivers, which have proven to be helpful in coordinating care, would allow clinicians to provide better care to their patients. Providing technical assistance and educational webinars, similar to how is currently done for CMMI model participants would also be essential for supporting clinicians' success in value-based care. When establishing any regulatory requirements, we recommend not making any significant changes in a short period of time so that clinicians can have a sense of stability and enough time to learn and make needed adjustments. Finally, any changes need to result in increased primary care payments. Substantial disparities between what primary care physicians earn compared to specialists can weigh into medical students' decisions about which field to choose. If CMS wants to focus on preventing disease and promoting longitudinal care, it has to start by increasing payments for primary care. We encourage reimbursing primary care physicians at the same rate as specialists for at least specific functions or patients, such as when treating patients with chronic conditions. This would incentivize primary care physicians to work at the top of their license, allowing specialists to do the same.

2. *How can CMS ensure clinicians will remain engaged and accountable for their contributions to managing the beneficiary's care?*

   The adoption of both outcome-based and patient-reported quality measures that are informed by primary care physicians and quality endorsement organizations, along with adequate attribution models, would help promote engagement and accountability.

3. *How can CMS structure advanced primary care hybrid payments to improve patient experience and outcomes?*

   We recommend structuring them the same way as currently done in some of CMMI's existing hybrid primary care models, such as the Primary Care First model. There is no need to reinvent the wheel if these models, while not perfect, have already been tested for a while and proven successful. We also support adopting other elements of CMMI's models, such as

increased payments to capture the cost of treating more complex patients and advanced capital payments to help clinics invest in initiatives designed to address social determinants of health.

Medicare Shared Savings Program (MSSP)

Health Equity Benchmark Adjustment

CMS proposes a Health Equity Benchmark Adjustment (HEBA), which would be an upward adjustment to the historical benchmark intended to benefit ACOs that serve a larger proportion of beneficiaries from underserved communities and that receive a lower regional adjustment and/or lower prior savings adjustments. Under the policy, ACOs would receive the highest of the positive adjustments for which it is eligible.

CMS proposes to calculate the HEBA as the product of the HEBA scaler and the proportion of the ACO's assigned beneficiaries who are dually eligible for Medicare and Medicaid or enrolled Medicare Part D Low-Income Subsidy (LIS). The HEBA scaler is calculated as the difference between five percent of national per capita Parts A and B expenditures for assignable beneficiaries and the highest of regional adjustment, prior savings adjustment or no adjustment. ACOs with less than 20 percent of their aligned beneficiaries enrolled in LIS or dually eligible would be ineligible for a HEBA.

AHPA supports CMS' proposal to adopt a HEBA to the MSSP, which recognizes the critical need to modify current financial methodologies to account for the needs of undeserved patients. However, we are concerned that the policy as proposed will have minimal impact on ACOs. CMS notes in the rule that it estimates based on 2023 data that only 20 ACOs would have a HEBA greater than the other two adjustments and therefore would benefit from this policy.
AHPA recommends that CMS:

- Remove the requirement that ACOs have at least 20 percent of their aligned beneficiaries enrolled in LIS or be dually eligible, as this will significantly reduce the number of ACOs that qualify.
- Explore additional methodologies that would allow more ACOs to benefit from this policy, such as applying the HEBA in addition to the other adjustments.

Reopening ACO Payment Determinations

If CMS determines that shared savings or losses were calculated in error, it may reopen either the initial or final determination and issue a revised determination either:

- No later than four years after the initial determination of savings or losses for a relevant performance year; or
- at any time in the case of fraud or similar fault.

CMS proposes a process through which an ACO may request a reopening of an initial or final shared savings or losses determination. Upon receiving a request, CMS would evaluate it and ask for supplemental information if needed. CMS would also work with CPI and law enforcement agencies to identify, validate and quantify improper payments potentially impacting expenditures used in program calculations.

AHPA supports this proposal to codify a process for reopening payment determinations in instances where improper payments have been identified, including an option by which ACOs can request a reopening. We also recommend giving the option to ACOs to request reopening their determinations if any issues are found as well.

Beneficiary Notification Requirements

In prior rulemaking, CMS modified the frequency of required beneficiary notifications from a minimum of once per performance year to once per agreement period. As part of this, CMS finalized a new requirement that ACOs provide an additional follow-up notification with beneficiaries at either the beneficiary's next primary care service visit with an ACO professional or no later than 180 days after the initial beneficiary notice was provided. The follow-up communication, which can be delivered verbally or in writing, is intended to provide the beneficiary a meaningful opportunity to engage with an ACO representative and to ask questions. ACOs are required to track and document the follow-up engagement and make documentation available to CMS upon request.

CMS proposes modifications to its beneficiary notification policy to require ACOs to provide the follow-up communication within 180 days of the initial written notification – removing the requirement that it be the earlier of the next primary care visit or 180 days from initial notification. Additionally, CMS proposes changes to notification requirements for retrospective ACOs to require the written notification to only a subset of the Medicare fee-for-service beneficiary population that is more likely to be assigned to the ACO.

AHPA strongly supports the proposed changes to beneficiary notification requirements, which will reduce administrative burden and make the notification processes less confusing and onerous for ACOs and beneficiaries alike.

AHPA also recommends eliminating or modifying the "prior to or during first primary care service of the year" requirement to allow ACOs to own the process while also reducing the amount of beneficiary notices. Specifically, allowing retrospective ACOs to utilize the quarterly preliminary prospective attribution list as the notification list would accomplish this. It could also be appropriate to place a 90-day notification deadline after the release of each list to bring the notification as close as possible to the actual utilization of primary care services.

Option of Prepaid Shared Savings

CMS proposes to establish a prepaid shared savings option for certain ACOs with a history of earning shared savings while participating in MSSP. For each performance year, ACOs would be permitted to use up to 50 percent of their estimated annual prepaid shared savings on staffing and health care infrastructure and up to 100 percent on direct beneficiary services. In the proposed rule, CMS specifies the permitted uses for staffing, infrastructure and direct beneficiary services.

While AHPA supports establishing a prepaid shared savings option for ACOs, we are concerned that CMS is being too restrictive by limiting the types of activities that ACOs may use the upfront payment amount for, which will ultimately limit utilization. For example, many ACOs currently use a portion of their shared savings to pay for performance incentives. Over the last couple years, CMS has expressed interest in growing the engagement of specialists in value-based care models and we believe that performance incentives are a key tool to achieve that.

Request for Information: Health Related Social Needs

AHPA firmly believes that the host of circumstances that define HRSNs do not operate in an individual silo. Transportation, utilities, housing status, nutrition, safety and security are all intertwined with a person's well-being. Given that clinical care has been found to only impact 10-20 percent of patient outcomes, meaningful investments in SDOH will generate the long term returns to offset any initial monetary investments. **AHPA therefore recommends that the Agency provide reimbursement for additional z-codes for HRSNs, similar to how it did for**

homelessness. We are already seeing how the benefits of such a policy could assist in cost reduction.

When Care Managers perform discharge planning, the standard work is to document an "Avoidable Delay" in the Electronic Health Record when a patient stays an additional midnight that was avoidable due to services or care availability. For the last 12 months, AHPA member AdventHealth noted 1,551 additional days that were documented across its system due to homelessness, protective services delays and transportation delays. Every avoidable day costs a hospital a minimum of $800 in care provided – which is typically not reimbursed. Therefore, the 1,551 avoidable days would amount to an estimated $1.2 million in avoidable costs. Screening for SDOH has allowed us to identify this financial impact. While our systems continue to invest and seek community partnerships to support the availability of resources in our communities, some recognition of the additional costs incurred by providers treating patients that screen positive for an SDOH need would be helpful.

Below we provide additional comments on questions raised by CMS:

What barriers exist for furnishing the services addressing health-related social needs, and if the service described by the codes it established are allowing practitioners to better address unmet social needs that interfere with the practitioners' ability to diagnose and treat the patient?

A major barrier is the lack of sufficient community resources available to meet the needs of patients that screen positive for a health-related social need. Health providers want to help their patients with issues such as homelessness and food insecurity but as the volume of referrals grow, community-based organizations need to be well equipped to manage that increased volume. Unfortunately, many are already struggling financially. Additionally, as we strive to close those referral loops and determine whether a patient received a specific community service, organizations may need to hire additional staff that can input that information in community referral software. **CMS' efforts must therefore be paired with increased support to Federally Qualified Health Centers and community-based organizations. This could be done by working with the Administration and Congress to provide grants that could help grow the resources available to these organizations. This could involve grants to support investments in community referral software and any additional technology needed to support SDOH related work.**

While hospitals are a great starting point for addressing SDOH concerns within the community and improving health outcomes, it will take a societal effort to ensure that any identified needs

are met and sustained. Without community involvement, we risk patient backsliding, increased patient admissions, and momentary access to resources.

What are other types of auxiliary personnel, other certifications, and/or training requirements that are not adequately captured in current coding and payment for these services?

AHPA recommends adding inpatient ambulatory Care Management as well as Discharge Planning as billable services when incorporated into the discharge plan by an acute-care hospital. We believe this could help to significantly reduce readmissions.

Telehealth Usage

We also request that any community integration or SDOH screening services are reimbursed regardless of the modality used, whether virtual or in-person. For example, a practitioner may determine during an initiating Community Health Integration visit (virtual or in-person) that a beneficiary is experiencing food insecurity. The practitioner could connect the beneficiary to a community health worker, whether contracted or otherwise, familiar with local programs and able to help. Connecting to these local programs can be just as easily accomplished via virtual means and studies have shown that community health workers are as effective at addressing gaps in care when working remotely. [5]

Medicare Overpayments

Currently, overpayments must be reported no later than 60 days after the date on which the overpayment was *identified* or the date of any corresponding cost report is due. According to CMS an overpayment is deemed identified "when an individual has, through reasonable diligence, determined receipt of an overpayment and *quantified* the amount." This means that the 60-day clock under current standards does not start until after the qualification of the overpayment is complete.

CMS is proposing that the deadline to report and return an overpayment would be suspended if the criteria below is met and the statutory 60-day clock would start on either the date of the investigation's completion or 180 days from the date on which the initial overpayment was identified, whichever is earlier.

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8274676/

- An entity has identified an overpayment but has not yet completed a good-faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment.
- The entity conducts a timely, good-faith investigation to determine whether related overpayments exist.

Break from the Standard Operating Procedure

In the rule, CMS seems to indicate that providers would need to identify all potential overpayments related to the initially identified overpayment and quantify them, within 180 days. CMS provides the following example:

> **"**A person identifies an overpayment arising from a physician's failure to properly document the medical record to support the coding of a specific claim, and the person who identified the overpayment has reason to believe that this may be a common practice of the physician. Therefore, there may be more claims affected by the same issue. The person has up to 180 days to conduct and conclude a good faith investigation to determine whether related overpayments that arise from the same or similar cause or reason as the initially identified overpayment exist. The suspension ends when the investigation is concluded and the initial overpayment and related overpayments, if any, are calculated, or by day 180, whichever is earlier."

AHPA is concerned that the reporting requirement represents a significant break from the current standard and would be very difficult to implement. The proposed 180-day timeframe to [6]identify all potential overpayments is insufficient to conduct a robust investigation and accurately *quantify* the overpayment. When identifying an overpayment, this is usually treated as the first indication that a larger problem may exist. It is not the period in which it is reported but the actual event that triggers an entire investigation. Requiring health providers to identify and quantify all "related overpayments" is a complicated process that can take more than six months. The 180-day deadline could result in a provider self-reporting an overpayment without having an accurate quantification.

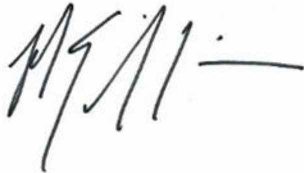
Additionally, providers sometimes run into situations in which when the calculations are finished, they determine that while the claims error rate may be high, the payment error rate is low enough that it does not require a self-report but a pay back to the Medicare Administrative Contractor

instead. **To mitigate all these issues, we recommend that CMS not set an arbitrary timeframe for conducting investigations needed to accurately identify an issue and quantify the overpayments.**

Conclusion

AHPA welcomes the opportunity to discuss further any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Susana Molina, Director of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,



Michael E. Griffin
President
The Adventist Health Policy Association