September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

SUBJECT: CMS-1770-P, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts (Vol 87, No 145), July 29, 2022

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2023 physician fee schedule (PFS) proposed rule. CHA provides comments on several provisions of the proposed rule that are significant to hospitals and the physicians who provide care in our member hospitals.

In summary, CHA:

- Urges CMS to work with Congress to address significant payment reductions to the proposed conversion factor and physician payments
- Supports policies that expand access to Medicare telehealth services and urges CMS to work with Congress to permanently remove barriers to access. We also urge CMS to ensure telehealth services are reimbursed at levels that recognize their important role in the health care delivery system while maintaining access to in-person care.
- Urges CMS to permanently expand virtual direct supervision policies when determined clinically appropriate by the supervising physician
- Supports the delay in the appropriate use criteria (AUC) penalty phase that CMS has provided via sub-regulatory guidance. CHA asks that CMS confirm the delay in the PFS final rule and discuss its future plans for the penalty phase.

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- Supports CMS' delay of the evaluation and management (E/M) "split billing" policy and urges the agency to allow for the determination of the "substantive portion" of a split visit based on who provided the preponderance of the medical decision-making, according to the provider's attestation
- Appreciates the multitude of changes proposed to the Medicare Shared Savings Program, which we believe are directionally correct

PFS Conversion Factor

The proposed conversion factor for 2023 is $33.0775, which reflects the expiration of the 3% increase for services furnished in 2022 provided by the Protecting Medicare and American Farmers from Sequester Cuts Act (PMAFSC), 0.00% update adjustment factor specified under section 1848(d)(19) of the Act, and a budget neutrality adjustment of -1.55%. CHA notes the proposed conversion factor is decreased from the CY 2022 conversion factor of $34.6062.

CHA is deeply concerned that this reduction in physician payments will reduce access to care not just for Medicare beneficiaries, but all residents in California. Prior to the pandemic, many physicians were already struggling financially due to conversion factor updates that failed to keep up with the cost of running a practice. Many of these costs are a direct result of increased regulatory requirements. CHA notes the proposed physician practice conversion factor in 1994 ($32.90) when properly adjusted for inflation using the Consumer Price Index would be worth $66.69 in today's dollars[1]. This implies that if finalized as proposed, the conversion factor over the last 29 years has lost 50% of its purchasing power.

Further, the ongoing pandemic has only exacerbated and accelerated the financial pressure, as it continues to increase practice expenses related to personal protective equipment and staffing, while causing patients to avoid receiving medically necessary care. A recent survey by the California Medical Association finds 70% of the state's physician practices are worried about their financial stability[2]. Practices have endured throughout two years of persistent revenue decreases of between 35%–64% — depending on the specialty — while having to bear a 15% increase in practice expenses. Due to the precarious nature of practice finances, one in three physicians has considered leaving private practice for employment in another model. Inadequate Medicare payment is a key driver of this phenomenon. **CHA asks CMS not to exacerbate this further by working with Congress to extend the 3% increase in the conversion factor provided by the PMAFSC indefinitely.**

Additionally, providers are at risk of a 4% reduction associated with the American Rescue Plan Act of 2021. When passing this bill, Congress failed to include a waiver of the statutory "PAYGO" requirement to offset the cost that the legislation adds to the federal budget deficit. As a result, statutory offsets were automatically set to take effect in 2022, including a 4% Medicare reduction. While Congress ultimately passed legislation that prevented this cut from taking effect in 2022, it did so by delaying the cut until 2023. CHA asks CMS to consider this looming significant reduction in physician payments as it sets Medicare reimbursement in the final rule. **Again, we ask the agency to work with Congress to permanently waive the statutory requirement to offset the cost of legislation that adds to the deficit as it relates to Medicare payments in the various COVID-19 relief bills that were essential to ensuring a sustainable health care delivery system.** Given the financial challenges facing practices discussed above,

[1] https://www.bls.gov/data/inflation_calculator.htm

[2] https://www.cmadocs.org/Portals/CMA/files/public/CMA%20COVID-19%20Financial%20Hardship%20Survey%203.0.pdf

merely delaying them will result in physician practice closure and limited access for Medicare beneficiaries — particularly those most at risk for inequitable outcomes due to health-related social needs.

Medicare Telehealth Services

CHA strongly supports expanded access to telehealth services, which have been proven to improve access to care and reduce barriers for some of our most vulnerable populations — including addressing health disparities experienced by people of color, as well as those living in rural and underserved communities — during the COVID-19 public health emergency (PHE). The regulatory flexibilities provided in response to the PHE have allowed hospitals to operationalize telehealth and other virtual services not as simply a replacement for in-person care, but as a new tool for improving care delivery. We appreciate that, in the proposed rule, CMS continues to support increased coverage and payment for telehealth services and offer our comments on specific proposals below.

However, we continue to urge the agency to work with Congress to remove statutory barriers to the greater adoption of telehealth. In particular, CHA supports the elimination of geographic and originating site restrictions that so often limit telehealth services to rural patients and do not recognize the patient's home as a suitable location to receive these services. In addition, we urge the agency to consider how its payment policies impact access to these services, which require significant investments in technology and workforce while maintaining the capacity for in-person services.

Implementation of Telehealth Provisions of the Consolidated Appropriations Act (CAA) 2021 and CAA 2022

CHA appreciates that Congress has recognized the need for a glide path to ending waivers related to telehealth after the end of the PHE, and we strongly support CMS' proposals to implement these statutory changes in regulation. This includes proposals to extend waivers of geographic and originating site restrictions until 151 days after the end of the PHE, an expanded list of eligible Medicare telehealth services, allowing the use of audio-only technology for E/M services, and allowing for telehealth to be provided by additional types of professionals and in federally qualified health centers and rural health clinics. CHA also supports CMS' proposal to delay the initial in-person visit requirement for mental health services, which unnecessarily restricts access to these vital services.

CHA is strongly supportive of the Advancing Telehealth Beyond COVID–19 Act of 2021 (House Resolution 4040), which would extend these flexibilities until December 31, 2024. This legislation passed the House in late July, and we look forward to its consideration in the Senate. Should Congress pass this legislation prior to issuance of the final rule, we urge CMS to clarify that these provisions are extended through 2024 — or if later, to expeditiously issue sub-regulatory guidance with this information. Further, we urge CMS to clarify in the final rule that Category 3 services — which are currently finalized to remain on the telehealth list through CY 2023 — will be automatically extended through 2024 should Congress make these changes.

Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19

For the duration of the COVID-19 PHE, the modifier 95 is reported on the claim to indicate a service furnished via telehealth, and the place of service (POS) code is reported as if the visit was in-person. CMS proposes that on or after the 152nd day after the expiration of the PHE, modifier 95 is no longer

reported and the appropriate POS will be included to determine where the service was furnished: POS 02 for telehealth provided other than in patient's home, and POS 10 for telehealth provided in patient's home. CHA does not object to the proposed modifiers, and we strongly support CMS' clarification that a patient's home can be defined to include temporary lodging, including for patients traveling or unhoused. However, we urge CMS to work with other payers to encourage consistency in the use of modifiers to reduce the challenges associated with tracking and reporting different modifiers across different payers.

CHA strongly opposes CMS' proposal to pay for services using either POS 02 or 10 using the facility rate for the professional claim, on or after the 152nd day after the PHE has expired. In the proposed rule, CMS states its belief that the lower facility payment amount best reflects the practice expenses, both direct and indirect, involved in furnishing services via telehealth. CHA strongly disagrees and urges the agency to reconsider this proposal, taking into account the significant investments in infrastructure, as well as clinical and administrative staff necessary to provide telehealth services while maintaining access to in-person care. We believe that CMS' assumptions of cost savings through increased utilization of telehealth misses two key cost drivers. First, patients using telehealth are still "virtually roomed" by nurses to improve the efficiency of the visit with the provider. When these nurses are not triaging patients for visits, they are following up on open items in care plans for patients. The practices still have the costs (both staffing and technology) related to scheduling, billing, and the electronic health record (many practices' largest expense). And practices are now incurring additional expenses related to more hardware and software to support telehealth. Any potential cost savings is limited to supply costs, which will be de minis given that these visits are for E/M services, not procedures. Second, analysis from McKinsey & Company[3] suggests that 24% of office visits could be performed virtually. This suggests that physicians will still require the same physical office space footprint to see the remaining 76% of their patients who will require in-person care.

The proposed lower telehealth reimbursement not only ignores these cost drivers, but also does not take into account increasing rents, inflation for medical supplies, and investments in the workforce needed to meet the demand for health care access, whether that care is provided in-person or remotely. This policy is especially problematic at a time when all hospitals are experiencing increasing financial challenges and 51% of California's hospitals[4] have negative margins. Further, this policy could inadvertently incentivize providers to see patients in the office when it would be clinically appropriate and the patient's preference to receive care virtually at their home. **We urge CMS to ensure that its telehealth services are adequately reimbursed at levels that recognize their important place in the care delivery system and provide reimbursement equitable to in-person care.**

CMS also proposes to require that eligible audio-only services be identified on the claim using modifier 93. CHA supports expanded availability of audio-only services, which have been a key factor in expanding access to patients without access to broadband services or who are unfamiliar with video technology. We appreciate that Congress has also recognized the importance of audio-only technology in expanding access to mental health services, as allowed under the CAA of 2021, when patients are unable or unwilling to use video technology. As CMS collects more data on audio-only services using modifier 93, we urge the agency to consider expanding the availability of this modality to other services, such as lower-level E/M services.

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[3] McKinsey, "Telehealth: A quarter trillion dollar post-COVID-19 reality?" May 29, 2020.
[4] https://www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf

Expiration of PHE Flexibilities for Direct Supervision Requirements

As previously finalized, providers can satisfy "direct supervision" requirements for diagnostic tests, physicians' services, and some hospital outpatient services through virtual presence, using real-time audio/video technology until the end of the calendar year in which the PHE ends. Virtual direct supervision policies have been particularly important in expanding access to care in rural areas and increasing opportunities to train the next generation of physicians in underserved communities. **CHA appreciates that CMS is seeking comments on extending these policies, and we urge the agency to consider permanent policies that would allow for virtual direct supervision when the supervising physician has determined it to be clinically appropriate in line with the relevant standard of care.**

Remote Monitoring Policies

CHA supports the continued development of policies to support the expansion of remote therapeutic monitoring (RTM) and remote patient monitoring (RPM) services. These technologies provide important opportunities to treat and manage chronic conditions while allowing patients to go about their lives without returning periodically to the physician's office. While we support CMS' proposals to create new RTM codes aimed at increasing patient access to these services while reducing physician and non-physician practitioner (NPP) supervisory burden, we are concerned that there are challenges with the requirements for these codes that will unnecessarily limit their utilization.

In particular, CHA is concerned with requirements for both RTM and RPM services that require 16 days of monitoring over a 30-day period. This arbitrary measurement period does not recognize the reality where fewer days of monitoring are clinically appropriate depending on the individual's plan of care. For example, patients with chronic hypertension are often monitored on a weekly basis, with more frequent blood pressure data monitored only when necessary, such as when medication changes. We urge CMS to remove this requirement for both RTM and RPM services and instead clarify that the monitoring requirement is consistent with physician or clinical staff orders as detailed in a patient's individual treatment plan.

AUC for Advanced Diagnostic Imaging Services

As required by the Protecting Access to Medicare Act of 2014, CMS continues to implement a program to promote the use of AUC for advanced diagnostic imaging services. Under the program, payment to the furnishing professional for an applicable advanced diagnostic imaging service is made only if the claim indicates that the ordering professional consulted with a qualified clinical decision support mechanism (CDSM) about whether the ordered service adheres to applicable AUC. Since 2020, the program has operated under an educational and operations testing period, during which ordering professionals are required to consult specified applicable AUC through qualified CDSMs and furnishing professionals must report the AUC consultation information on Medicare claims. However, CMS continues to pay claims regardless of whether AUC information is correctly indicated on the claim. In the CY 2022 final rule, CMS finalized its proposal to begin the payment penalty phase of the AUC on the later date of January 1, 2023, or the January 1 that follows the declared end of the PHE.

CMS has recently published a notification on the AUC outreach and education website stating that the penalty phase of the AUC program will not begin on January 1, 2023, even if the PHE ends in 2022[5]. The

[5] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/OandE

notice further states that the AUC program is delayed indefinitely and, during this time, the education and operations period will continue. **CHA strongly supports an indefinite delay of the penalty phase of the AUC program. CHA has long opposed the program's structure, which enforces payment penalties on furnishing professionals based on actions of the ordering professional, and we remain concerned there is a low level of awareness of the requirements amongst ordering physicians. We believe that it is necessary — as CMS appears to be doing — to conduct additional educational and technical assistance efforts prior to the implementation of payment penalties. Further, CMS should continue to analyze claims to ensure a significantly higher percentage of furnishing claims report compliant AUC information. CHA asks that CMS codify the delay in the CY 2023 PFS final rule. Further, we urge the agency to provide additional clarity on a timeline for implementing the penalty phase and provide ample notice for reinstating penalties.**

E/M Visits: Split or Shared Services

In the 2022 PFS final rule, CMS finalized a policy for E/M visits furnished in a facility setting, to allow payment to a physician for a split (or shared) visit (including prolonged visits), where a physician and NPP provide the service together and the billing physician personally performed a substantive portion of the visit. CMS finalized a phased-in approach to the definition of the substantive portion of the visit. For 2022, CMS finalized that the definition of substantive portion could be one of the following: history, or exam, or MDM, or more than half of the total time. For 2023, CMS finalized that the definition of the substantive portion would be limited to more than half of the total time for the visit. CMS proposes to delay the implementation of its definition of the substantive portion as more than half of the total time of the visit until January 1, 2024, to allow for providers to get accustomed to the new coding and payment changes for Other E/M visits. In addition, in the proposed rule CMS states the delay allows additional time to evaluate this policy.

CHA strongly supports delaying the split billing policy. We respectfully ask CMS to reconsider its decision to base the definition of the "substantive portion" on more than half of the total time once this policy goes into effect. We continue to disagree with CMS' stated belief that time is a more precise factor than medical decision-making for deciding which practitioner performs the substantive portion of the visit.

Fundamentally, E/M codes are designed to reimburse providers based on the cognitive services they provide to patients and the complexity of medical decision-making. In many instances, it is likely that the physician will provide most of the medical decision-making without having spent more than half of the total time in the room with the patient. **CHA again encourages CMS to allow for the determination of the "substantive portion" of a split visit based on who provided the preponderance of the medical decision-making, according to the provider's attestation.** Not only will this address concerns about the unnecessary physician resources spent tracking time during the split visit, but it will more appropriately reimburse the service based on the degree of cognitive services provided. It is a better use of a physician's time, skill, and effort for them to focus on providing care to the patient instead of monitoring a stopwatch to track their visit time for billing purposes.

Revising the Medicare Economic Index (MEI)

The MEI is a fixed-weight input price index, with an adjustment for the change in economywide, private non-farm business total factor productivity. This index is comprised of three broad categories: 1)

physicians' own time, 2) practice expense, and 3) professional liability insurance or malpractice. The current 2006-based MEI relies on data collected from the American Medical Association (AMA) for self-employed physicians from the Physician Practice Information Survey (PPIS). Because the AMA has not fielded another survey since that 2006 data collection effort, the MEI has continued to be based on 2006-based costs.

Ostensibly, the MEI, like price indices applicable to other provider types, would be used to update PFS rates for the rate of inflation in items and services that are used in the production of physician services. However, the MEI has not been used for this purpose for many years. From 2004 through 2014, Congress overrode the statutory formula — the sustainable growth rate — to establish the PFS update. Since 2015, Congress has established the PFS update in law, including a 0.0% update for 2020 through 2025.

The 2021 Medicare Part B Trustees Report expressed concern about the long-PFS inflation update:

> While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation … [these updates are not] expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large … Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.[6]

While changing the PFS update will require intervention from Congress and is beyond the authority of CMS, CHA requests that when adopting policy positions, CMS consider that long-term the PFS has been and will continue to be updated by less than the rate of inflation as measured by the MEI.

The MEI is not currently being used in the annual update to PFS for inflation. However, the MEI cost weights have historically been used to update the geographic practice cost index (GPCI) cost share weights to the four components of the practice expense GPCI (employee compensation, office rent, purchased services, and medical equipment, supplies, and other miscellaneous items). It is also used to recalibrate the total pool of aggregate work, practice expense relative value units (RVUs) and malpractice RVUs to match the MEI weights. The most recent recalibration was done for the 2014 RVUs, when the MEI was last updated as a result of technical adjustments that moved separately payable NPPs (nurse practitioners, physician assistants and clinical nurse specialists whose services may be independently billed) to the physician work component from practice expense. The MEI is also used for other purposes like updating the telehealth facility fee and updating the limit on the rural health clinic all-inclusive rate (at least until 2021 and then after 2028).

CMS believes that the MEI cost weights need to be updated to reflect more current market conditions as they continue to reflect data from the PPIS survey that was done in 2006. CHA agrees with this;

[6] The 2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, page 202.

however, we disagree with CMS' proposal and advise rescinding it, pending efforts being made by the AMA to field a new practice expense survey.

CMS proposes to rebase the MEI based on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership; that is, not limited to only self-employed physicians. In general, CMS proposes to use annual expense data collected from the U.S. Census Bureau's Services Annual Survey (SAS) to develop the 2017-based MEI cost weights. The SAS data were not designed for the purpose that CMS proposes using them. Further, the SAS data, unlike prior AMA practice expense surveys, go beyond self-employed physicians for source data.

As a result, the SAS data cannot fully serve CMS' needs. Therefore, CMS proposes to supplement the 2017 SAS expense data by using several data sources for further disaggregation of compensation costs and all other residual costs. This includes the 2017 Bureau of Labor Statistics Occupational Employment and Wage Statistics, the 2012 BEA Benchmark Input-Output data, the 2006 AMA PPIS, and the 2020 AMA Physician Practice Benchmark Survey.

The table below shows the impact on the shares of payment account by physician work, practice expense, and malpractice from the revised weights that CMS proposes. Physician work and professional liability insurance would be reduced by 3.6 and 2.9 percentage points, respectively while practice expense would increase by 6.5%.

Percent Distribution of Major Physician Expense Components: 2006 and 2017			
	Weight		Difference (percentage points)
RVU Component	Current	Proposed	
Physician Work	50.9%	47.3%	- 3.6
Practice Expense	44.8%	51.3%	+6.5
Malpractice or PLI	4.3%	1.4%	-2.9
Total	100.0%	100.0%	

If CMS were to follow past practice and adjust the aggregate pools of work, practice expense, and malpractice RVUs to match the shares in the MEI weights, the impacts on physician payments would be extremely large. As CMS notes, the majority of specialties would experience shifts of 1% or greater from the adjustment to the weights. As the changes are budget-neutral, all increases would be offset by decreases in other services.

Table 148 of the proposed rule shows that the largest increases would go to medical suppliers and not physicians (diagnostic testing facility: +16%, independent laboratory: +10%, portable x-ray supplier: +15). The largest decreases would go to physician specialties (cardiac and thoracic surgery: -9% and -8% respectively, neurosurgery: -8, emergency medicine: -7%, and anesthesiology: -6%). According to table 148, the payment impacts for the primary care physician specialties (family practice, general practice, pediatrics, geriatrics) would largely be unaffected or see small increases in payments.

These trends are counterintuitive and inconsistent with the public policy direction expressed by both CMS and Congress over the past several decades. Since the adoption of the PFS in 1992, there have been continuous efforts to improve payment for primary care services. There has never been an interest in

increasing payments for the technical component of diagnostic services that are not performed by physicians yet that is what the CMS proposal to rebase the MEI weights would do. CMS' proposal would substantially increase payment for services that are not done by physicians while allocating a lower share of overall payments for professional liability insurance. Such a policy is both illogical and inconsistent with public policy goals.

CMS is not proposing to implement these new share weights for setting 2023 PFS payments. Rather, it is proposing to delay the implementation of the proposed rebased and revised MEI cost weights for both PFS rate setting and the proposed 2023 Geographic Practice Cost Indexes (GPCIs). It believes that this will allow stakeholders the opportunity to review and comment on the proposed rebased and revised MEI cost share weights before CMS uses these weights for purposes of proportioning the work, PE, and MP RVU pools in PFS rate setting and updating the GPCIs. CHA strongly supports delaying CMS' proposal. Further, we respectfully ask that CMS withdraw its proposal altogether and instead wait for the completion of an updated AMA survey that is expected to be done by 2024.

In the past, CMS has always relied on AMA survey data to update the MEI weights. The initial MEI was first implemented in 1975 using weights derived from surveys completed by the AMA. From inception through 2006, CMS always rebased the MEI based on AMA survey information (first, the AMA's Socioeconomic Monitoring Survey and then the PPIS). CMS' proposal to use SAS data will be the first use of non-AMA survey data to develop the MEI weights since its inception in 1975. It is not necessary for CMS to deviate from its long-standing practice of using AMA survey data to update the MEI weights.

We understand that the AMA has had processes in place since 2019 to field a new PPIS survey. While AMA had a strategy to collect practice expense information in 2021 based on 2020 cost information, this effort was postponed due to the COVID-19 PHE and its impact on 2020 costs for self-employed physicians. As we emerge from the PHE, we understand the AMA expects to field a survey in 2023 that will collect practice expense data from 2022. If this information is furnished to CMS in 2024, it is possible that CMS will be able to update the MEI and the practice expense methodology beginning in 2025 or no more than one year later than if CMS finalizes its proposal to use SAS data on January 1, 2024, (as CMS is not planning to finalize its proposal effective January 1, 2023).

GPCIs

CMS' proposal to rebase the MEI would also affect the GPCIs. While a larger share of the PFS payment would be adjusted by the practice expense GPCI (as it would increase from 44.8% to 51.3%), the second-largest component of the practice expense GPCI (office rent) would decline from 10.2% to 5.9%, while other components would increase (employee compensation from 16.5% to 24.7% and purchased services from 8.1% to 13.9%).

These changes in the GPCI weights would be geographically redistributive and would be expected to lead to reductions in the payment to urban localities and increases in payment to rural areas and states with a single GPCI. CMS does not show the geographic redistribution that would result from its proposal. CHA believes it imperative that geographic impact of its proposal be shown in the proposed rule in order for us to meaningfully comment on reweighting of the GPCIs. It is our belief that the change to the GPCIs would be devastating to urban areas in California where office rents remain high and have not become a smaller percentage of total practice expenses.

Once again, CHA requests that CMS not adopt this proposal and considers that the revisions to the GPCI weights would result from the adoption of the SAS survey that was done for a different purpose than being used by CMS and may not be fully reflective of costs that are being experienced by physicians in today's markets. For instance, it is unreasonable to believe that office rents are declining from 10.2% percent to 5.9% of total expenses for physicians (inclusive of the physician work component and professional liability insurance). Rental markets for physician office space have been extremely tight for long periods of time. Further, it is difficult for a physician office practice to move given the amount of fixed equipment in a typical practice. This gives landlords substantial leverage in lease renegotiation. It seems untenable in urban areas that are unlikely to have seen any reduction in office rent as a percent of total expenses much less a reduction of more than four percentage points.

Again, we believe that instead of deviating from past practice of using AMA survey data, CMS should wait at least one year for the AMA to complete a revised PPIS survey that can be used to update the GPCIs as well as the underlying RVUs.

Cardiac Ablation (CPT Codes 93653, 93654, 93655, 93656, and 93657)

Atrial fibrillation is the most common of all cardiac arrhythmias and occurs predominantly in the elderly. Cardiac ablation stops errant electrical signals from firing. In considering this topic, it is important for CMS to keep in mind the clinical value that ablation services offer to patients. Ablation has been shown to improve a patient's quality of life and decrease hospitalizations and mortality, particularly in patients with heart failure. It also has been shown to improve patient outcomes when performed early. Significant health care resources are conserved through avoidance of complications, such as stroke, myocardial infarction, tachycardia, and heart failure. Dramatic reductions in payment could reduce the number of physicians offering ablation services, result in longer wait times for procedures at sites that may be farther away, and even mean that some patients may not be offered ablation therapies at all.

In the 2023 proposed rule, CMS proposed payment reductions for cardiac ablation services that will total 40% over two years. The revisions to these codes have been troubled from the start. From the survey results presented to CMS last year, the Relative Value Update Committee (RUC) believed that many of the survey respondents may not have realized that the code descriptors had been substantially revised and that they may not have read the updated code descriptors thoroughly enough to understand that services that are separately billed, were now combined into the existing codes (since CPT did not issue new codes for the revised descriptors). Since then, the RUC re-surveyed these cardiac ablation codes in April 2021 for re-review. Based on that resurvey, the RUC recommended significant reductions to these cardiac ablation services.

However, CMS did not accept the RUC's recommendation and decided to reduce the values even more than recommended by the RUC based on a completely inappropriate comparator code — a lower limb revascularization that is unrelated to cardiac ablation. While it is not possible at this time to return to the reimbursement model for these services that existed in 2021, consistent with the position of the Heart Rhythm Society, CHA requests that CMS provide a payment that is comparable to 2021 for the physicians who perform these cardiac ablation services.

Medicare Shared Savings Program

In the CY 2023 rule, CMS proposes sweeping changes to the Medicare Shared Savings Program (MSSP). These changes are designed to strengthen financial incentives for long-term participation by modifying the benchmarking methodology and expanding opportunities for certain low-revenue accountable care organizations (ACOs) and those serving high-risk and dually-eligible populations. It also aims to make operational improvements to reduce administrative burden and makes numerous revisions to the quality reporting and the quality performance requirements. **In general, CHA supports these changes. We believe they are directionally correct, long overdue, and will have the effect of encouraging existing MSSP participants to remain in the program and attract new providers.**

Below, please find our specific comments on the key changes proposed.

Incorporating a Prospective, External Factor in Growth Rates Used to the Historical Benchmark

CMS proposes to incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost referred to in the proposed rule as the Accountable Care Prospective Trend (ACPT), into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each payment year (PY) in the ACO's agreement period.

CMS would calculate a three-way blend as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for use in updating an ACO's historical benchmark between benchmark year (BY) 3 and the PY. CMS proposes setting the ACPT growth factors for the ACO's entire five-year agreement period near the start of the agreement period. The ACPT factors would remain unchanged throughout the ACO's agreement period, providing a degree of certainty to ACOs. CMS would calculate benchmarks using the three-way blend that incorporates the ACPT to update benchmarks for agreement periods that begin on January 1, 2024, and subsequent years. **In general, CHA appreciates CMS' consideration of an approach that uses the ACPT as part of a three-way blend to calculate trend factors. We believe this approach, if coupled with stronger guardrails as discussed below, has merit and could address many of the challenges facing ACOs that participate in the program over multiple agreement periods.**

If CMS ultimately finalizes this methodology for updating benchmarks, we ask CMS to provide MSSPs with flexibility in terms of the timing of when it is implemented. First, for MSSPs that will be in the middle of an agreement period on January 1, 2024, we ask that CMS allow them to opt into having their benchmark calculated under this methodology. Second, for MSSPs that start the last year of an agreement period on January 1, 2023, we ask that CMS allow them to defer implementation of this methodology for up to one full agreement period to allow them to better understand the financial impact of trending benchmarks forward using a factor calculated using the three-way blend. This is particularly needed if CMS does not strengthen the guardrails (as discussed below), yet chooses to calculate trend factors using a three-way blend that incorporates the ACPT.

CHA is concerned about the negative impact of including the ACPT in the calculation of benchmarks for some MSSP participants. We respectfully ask the agency to take additional steps to mitigate any potential negative impact on these ACOs. First, we are concerned that the three-way blend only benefits 62% of providers. This means that it either does not insulate 38% of MSSP ACOs from the "ratchet effect" as discussed by CMS or it actually harms some MSSP ACOs. While CHA's members are generally

supportive of the proposed guardrails, we believe they must be expanded significantly to ensure the stability of benchmarks and the sustainability of the MSSP.

CMS proposes a "guardrail" to protect ACOs from larger shared losses that would recalculate the ACO's updated benchmark using the national-regional blended factor (two-way blend). If under the two-way blend the ACO did not incur losses, it would not be responsible for any repayment to the program. If the ACO generates savings using the two-way blend (but not in the three-way blend), the ACO would neither be responsible for shared losses nor eligible for shared savings for the applicable performance year.

CHA respectfully encourages CMS to modify its guardrail proposal to allow ACOs that achieve savings under the two-way blend to receive their share of that savings if they meet applicable quality and minimum savings rate requirements (MSR). At a minimum, we believe this option should be available for the first agreement period in which the ACPT is incorporated to allow ACOs to adjust to the new benchmarking methodology. Further, this is necessary given that 38% of ACOs could be disadvantaged by the ACPT. Failing to do this will limit the MSSP's attractiveness to providers given the financial pressures they are currently facing. The ongoing annual expenses associated with the infrastructure necessary to participate in the MSSP are significant. Without shared savings, an ACO will need to finance those costs from other sources of already constrained revenue. Further, the ability to share savings with participating physicians is an important incentive to align community physicians with the ACO. Given the financial pressures these practices are facing — pressures that are exacerbated by the inadequate conversion factor update in this proposed rule — without receiving shared savings from the ACO, many will question the benefits of participating in this important program for Medicare beneficiaries. **If CMS does not expand the guardrail to allow an ACO to receive shared savings achieved under either the three-way or two-way blend, CHA does not support incorporating the ACPT into the benchmark calculation.**

Second, CMS states that the ACPT will be calculated at the beginning of an agreement period and remain in effect for the full five years to ensure predictability. While CHA's members appreciate CMS' efforts to provide predictability, we are concerned that a five-year prospective trend factor will not be flexible enough to accommodate advances in therapeutics that will significantly improve outcomes but bring with it a high cost. **Therefore, we ask CMS to provide a safety value to any administratively set, prospective benchmark that adds the anticipated increase in cost growth for new, high-cost therapeutics to the ACPT.** Otherwise, MSSP participants will be penalized for providing clinically indicated care to Medicare beneficiaries.

Adjusting ACO Benchmarks to Account for Prior Savings

For agreement periods beginning on January 1, 2024, and thereafter, CMS proposes incorporating an adjustment for prior savings that would apply in the establishment of benchmarks for renewing ACOs and re-entering ACOs that were reconciled for one or more performance years in the three years preceding the start of their agreement period. CMS would adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. It would also use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area. **CHA appreciates CMS' proposal to adjust ACO benchmarks for prior savings and strongly supports it. We ask that CMS provide MSSPs that are in the middle of an agreement period on January 1, 2024, the flexibility to opt into having their benchmark adjusted to account for prior year savings without having to go through the onerous process of early renewal.**

Reducing the Impact of the Negative Regional Adjustment

For agreement periods beginning on January 1, 2024, and thereafter, CMS proposes to institute two policy changes designed to limit the impact of negative regional adjustments on ACO historical benchmarks and further incentivize program participation among ACOs serving high-cost beneficiaries. It proposes to reduce the cap on negative regional adjustments from negative 5% of national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries to negative 1.5%. It also proposes that after the cap is applied to the regional adjustment, to gradually decrease the negative regional adjustment amount as an ACO's proportion of dually-eligible Medicare and Medicaid beneficiaries increases, or its weighted-average prospective hierarchical condition category (HCC) risk score increases. **CHA appreciates CMS' proposal to reduce the impact of negative regional adjustments and strongly supports it. We ask that CMS provide MSSPs that are in the middle of an agreement period on January 1, 2024, the flexibility to opt into having their benchmark adjusted to reduce the impact of negative regional adjustments without having to go through the onerous process of early renewal.**

Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High-Cost Beneficiaries and Guard Against Coding Initiatives

For agreement periods beginning on January 1, 2024, and thereafter, CMS proposes to improve the MSSP risk adjustment methodology by accounting for all changes in demographic risk scores for the ACO's assigned beneficiary population between BY3 and the performance year prior by applying the 3% cap on positive adjustments resulting from changes in prospective HCC risk scores, and applying the cap in aggregate across the four Medicare enrollment types. **CHA appreciates this proposed change and believes it is an improvement on the current methodology for risk adjustment. We ask that CMS provide MSSPs that are in the middle of an agreement period on January 1, 2024, the flexibility to opt into this new risk adjustment methodology without having to go through the onerous process of early renewal.**

CHA remains concerned that even after applying a 3% cap on positive adjustments after accounting for changes in demographic risk scores the methodology will inadequately account for the increased costs of individuals who develop a medically complex, high-cost condition after they have been assigned to an ACO. It is important that CMS effectively address this concern given that COVID-19 caused many Medicare beneficiaries to delay regular screenings and other preventative care due to concerns about contracting the virus. CHA's members report[7,8] that they are now seeing higher volumes of patients with advanced illnesses (e.g., cancers identified in later stages) that are more costly to treat than if they had been diagnosed earlier. Unfortunately, the current proposed revisions to the risk adjustment methodology will not fully protect ACOs from insurance risk and adverse selection as a result of the PHE.

CHA strongly believes that the benchmark for a given performance year needs to be fully adjusted for changes in beneficiary health status. Failing to do so ignores the fact that even when care is optimally managed, individuals become sicker and, therefore, more expensive to care for as disease progresses (or initially present). For example, when a beneficiary who has been continuously attributed to an ACO is

[7] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789064#:~:text=Cancer%20screening%20is%20integral%20to,late%2C%20incurable%20stages%20is%20increasing

[8] https://www.aha.org/system/files/media/file/2022/08/pandemic-driven-deferred-care-has-led-to-increased-patient-acuity-in-americas-hospitals.pdf

diagnosed with cancer, it is inappropriate for the ACO to be responsible for that cost with no expectation from Medicare for higher spending related to that member. Without an appropriate adjustment to the risk score to reflect the onset of an acute condition, the MSSP has assumed insurance risk, not simply care management risk. **Therefore, we respectfully ask CMS to increase the cap to 5%, applied after changes in beneficiary demographics are accounted for.**

Additionally, CHA again encourages CMS to explore ways to implement the Center for Medicare & Medicaid Innovation-HCC concurrent risk adjustment model[9] in the MSSP. Concurrent risk models are better able to predict costs for populations with high-disease burden or who are otherwise seriously ill, because the approach can better capture a rapid deterioration in health in the current year, such as through the occurrence of acute episodes that are difficult to predict or prevent (e.g., heart attack). This is a departure from the existing CMS-HCC prospective risk adjustment model, which predicts current-year costs using health status indicators (diagnoses) from the prior year.

Increased Opportunities for Low-Revenue ACOs to Share in Savings

CMS proposes that low-revenue ACOs entering an agreement period in the BASIC track beginning January 1, 2024, that do not meet the MSR requirement but that do meet the quality performance standard (or the proposed alternative quality performance standard described earlier) would qualify for a shared savings payment if criteria are met. Eligible ACOs that meet the quality performance standard to share in savings at the maximum sharing rate would receive only half of the maximum shared rate (20% instead of 40% under Levels A and B, and 25% instead of 50% under Levels C, D, and E). For eligible ACOs that do not meet the quality performance standard required to share in savings at the maximum sharing rate but meet the proposed alternative quality performance standard, the sharing rate would be further adjusted based on the sliding scale approach included in the proposed rule for determining shared savings using the ACO's quality performance score.

CHA appreciates CMS' efforts to increase opportunities for ACOs to receive shared savings. While we support this proposal, we respectfully request that CMS expand the opportunity to receive shared savings to all ACOs subject to an MSR requirement. For the reasons discussed above in CHA's comments related to improving the "guardrail" proposed to protect ACOs if CMS finalizes its policy to incorporate a prospective trend factor into the benchmark, failing to allow all ACOs to share some savings if they do not meet their MSR requirement will continue to limit the MSSP's attractiveness to providers given the financial pressures they are currently facing.

Smoothing the Transition to Performance-Based Risk in ACOs

CMS proposes allowing currently participating ACOs, or ACOs that begin an agreement period in Level A or Level B on January 1, 2023, to elect to maintain their participation at Level A or Level B for the remainder of their current agreement period. **CHA appreciates and strongly supports this proposal. We ask that CMS expand it to ACOs in levels C and D of the BASIC track as well. Given the COVID-19 PHE, CHA believes that all MSSP participants in the BASIC track would benefit from — and, therefore, be more likely to continue participating in the program — if CMS afforded them more time to gain experience at lower risk levels.** We remain concerned that many of the lessons ACOs typically learn about using data, care coordination, and developing processes of care in the early years of participation in

[9] Direct Contracting Model: Professional and Global Options and Kidney Care Choices Model - Risk Adjustment, RTI International, pg. 17

the MSSP may not have been realized in the organization due to disruptions in staffing and care processes created by COVID-19. If financially fragile practices are forced to take more risks without the tools and lessons necessary to manage them, we believe many ACOs will drop out of the program.

In the case of an ACO that elects to remain in Level A for the entirety of its first agreement period, CMS proposes the ACO generally would be eligible to enter into a subsequent agreement period under the BASIC track's glide path, giving the ACO two additional years of one-sided risk (for a total of seven years in a one-sided model compared to the current limitation to two years).

CMS also proposes limiting an ACO that is inexperienced with performance-based risk Medicare ACO initiatives to participate in the BASIC track glide path for a maximum of two agreement periods (once at Level A for all five performance years and a second time in progression on the glide path). This option is limited in that an ACO that enters an agreement at either Level A or Level B is deemed to have completed one agreement under the BASIC track's glide path and is only eligible to enter a second agreement under the BASIC Track's glide path if the ACO continues to meet the definition of inexperienced with performance-based risk Medicare ACO initiatives and meets other criteria. **In general, CHA supports CMS' efforts to provide additional flexibility to MSSP participants. That will allow them to assume more risk when they believe they are capable of managing it appropriately. To that end, CHA asks that CMS expand this option to all new, not-renewing ACOs — regardless of whether the participant is deemed low or high revenue.**

CMS proposes that an ACO determined to be inexperienced with performance-based risk Medicare ACO initiatives but not eligible to enter the BASIC track's glide path may enter either the BASIC track Level E for all performance years of the agreement period or the ENHANCED track. CMS also proposes to make the ENHANCED track optional for all ACOs, regardless of experience with performance-based risk Medicare ACO initiatives, including high-revenue ACOs.

If an ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives, CMS proposes that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track However, it would be ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives and would be automatically advanced to Level E of the BASIC track at the start of the next performance year. **CHA is concerned with CMS' proposal to automatically progress a currently participating ACO deemed experienced with performance-based risk to Level E of the BASIC track the following year.** While an ACO may have participated in the program, the experience gained during that participation — through no fault of the providers participating in the ACO — may not prepare the ACO to assume the amount of risk conferred by Level E. As an example, CHA is aware of a group of rural providers who participated in a national ACO. As a result of that participation, CMS would consider that group of providers experienced with performance-based risk. However, these providers did not receive any meaningful data about the beneficiary population attributed to them from the national ACO in which they were participating.

Therefore, despite their participation in a Medicare ACO, they have not developed a core competency — the ability to receive and use data to improve care delivery pathways and coordinate care. If this group of providers is compelled into Level E, it is likely they will elect to exit the program. **CHA respectfully asks**

CMS to consider a more nuanced definition of experienced with Medicare risk-bearing programs if it persists in requiring all experienced ACOs to progress to Level E.

Extend Advanced Alternative Payment Model Bonuses

CHA shares CMS' concerns that the Quality Payment Program's incentive structure beginning in performance year 2023 does not create adequate incentives for providers to move from fee-for-service to alternative payment models (APMs). This is compounded by the proposed cuts to the conversion factor and the expiration of MACRA's 5% Advanced APM incentive payments. CHA believes Congress must extend these payments as ending them now would discourage and disincentivize providers' efforts to engage in APMs. The incentive payments not only help encourage providers to enter risk-based ACO and Innovation Center models but also provide additional resources that can be used to expand services beyond traditional fee-for-service. CHA respectfully asks CMS leadership to work with Congressional leaders to support an extension of the 5% Advanced APM incentive payments, along with giving CMS the authority to adjust the thresholds to qualify for the incentive payments.

Alternative Quality Performance Standard

CMS proposes to revise the Shared Savings Program's quality performance standard by adding a new, less stringent "alternative" quality performance standard beginning with PY 2023. Under the proposed standard, an ACO achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of four outcome measures in the Alternative Payment Model Performance Pathway (APP) measure set would be eligible for shared savings. The existing standard would be retained (30th percentile for PY 2023) and modified to include the proposed health equity adjustment if finalized. Each ACO's performance would be assessed using both standards.

An ACO that meets the existing standard would continue to be eligible for the maximum shared savings associated with its track and level (e.g., 50% for BASIC Level E). An ACO that meets only the alternative standard would be eligible to receive shared savings but in a lesser, scaled amount. An ACO that meets neither the existing nor alternative standard would be ineligible for shared savings. The rule makes a parallel proposal regarding shared losses accrued by ACOs bearing two-sided risk. **CHA appreciates CMS' proposal to create an alternative quality standard and strongly supports it.**

Extension of eCQM/MIPS CQM Transition Incentive

CMS proposes to extend the incentive for ACOs to transition from reporting quality data through the CMS web interface to using the APP's electronic clinical quality measures (eCQMs)/clinical quality measures (CQMs) measure set. The incentive, currently applicable through PY 2023, allows an ACO to meet the existing quality performance standard by 1) reporting three APP eCQMs/Merit-based Incentive Payment System (MIPS) CQMs, meeting completeness and case minimum requirements for each, 2) scoring at or above the 10th percentile on one or more APP outcome measures, and 3) scoring at or above the 30th percentile on one or more of the remaining APP measures. The extension would apply through PY 2024 and for that year would specify scoring at or above the 40th percentile, rather than at the 30th percentile for non-outcome APP measures as currently specified.

To meet the PY 2025 standard an ACO would be required to 1) report three APP eCQMs/MIPS CQMs, meeting completeness and case minimum requirements for each and 2) achieve a health-equity adjusted score that is equivalent to or above the 40th percentile across all MIPS quality performance category scores (excluding those eligible for facility-based scoring).

CHA appreciates CMS' efforts to provide a longer incentive for transitioning from the CMS web interface to using the eCQM/CQM measure set. Further, we greatly appreciate and support an extra year for MSSP participants to report metrics via the CMS web interface. However, our members are still deeply concerned about the transition to eCQMs. Even with this extended transition period, CHA has significant concerns with CMS' proposal to eliminate the web interface as a reporting option after CY 2024. First, as a practical matter, submitting quality data using electronic health records (EHRs) or one of the other mechanisms requires creating a quality reporting document architecture (QRDA) file. This significantly increases the administrative burden for ACOs that are comprised of multiple physician practices.

As an example, one of CHA's members anchors an MSSP ACO that includes over 100 tax identification numbers. The various practices that participate in the ACO use over 30 different EHR systems. This organization estimates that ingesting and cleaning the necessary quality data from its MSSP participant practices to create a QRDA file to submit eCQMs will add $1 million per year to the overhead cost of running the ACO. Beyond the increased cost of submitting data, CHA notes there are still some community physician practices that participate in MSSP ACOs and lack an EHR. CHA's members are concerned that if the web-interface reporting option is eliminated, it will not be practical for these practices to continue to participate in the MSSP. Any reduction in the number of physicians who participate in programs like the MSSP is contrary to CMS' stated goal of expanding the number of Medicare beneficiaries who receive their care from providers actively involved in value-based payment models.

Second, CHA's members are concerned that the data collection types that will be available to ACOs in CY 2025 and thereafter — EHRs, qualified registries, and qualified clinical data registries — all require data to be collected on an all-payer basis, and not simply on Medicare beneficiaries. The financial performance of MSSP participants, who have agreed to assume risk only for outcomes related to their Medicare patient population, will be in part determined on an all-payer basis. This is particularly concerning for MSSP-participating physicians whose panels have significant numbers of patients with unmet social needs. If these practices don't have a corresponding risk-sharing payment model offered by the payer that is responsible for patients with unmet social needs, the practice may not have the resources necessary to address issues that negatively impact measures like hemoglobin A1c and high blood pressure control. Also, moving to an all-payer measurement base disadvantages MSSP ACOs that have chosen to include specialists in the participating physician list. In many instances — for patients who are not attributed to them directly — the patient will be using the specialist for a specific clinical issue and not for primary care. Therefore, the specialist will likely not provide most of the primary care screenings, which will give the ACO the appearance of lower performance on the APP measure set. While CMS has proposed providing an Advanced Investment Payment (AIP) to address these issues, as discussed below, it is only available to a limited number of ACOs, and it is unclear if these funds can be used to address social determinants of health for all patients or just Medicare beneficiaries.

CHA is concerned that expanding the denominator of measures used to determine MSSP quality scores to include non-Medicare patients will likely cause some MSSP participants to drop out of the program given it will disadvantage certain types of providers. **Based on both the increased costs and the likelihood that some MSSP participants will leave the program, CHA respectfully asks CMS to delay eliminating the web reporting interface indefinitely until it can develop alternative quality reporting options that do not carry the same unintended consequences for both MSSP participants and their patients.**

Health Equity Adjustment

California hospitals are deeply committed to achieving health equity, and we appreciate that CMS recognizes that addressing health care disparities requires additional investments to meet the unmet needs of our communities. Specifically, CMS proposes to adopt a health equity adjustment into the Shared Savings Program beginning with PY 2023. The adjustment would be incorporated into the calculation of quality performance scores and shared savings and losses and into the extreme and uncontrollable circumstances policy. CMS further proposes that ACO eligibility for the adjustment would be determined by the proportion of assigned beneficiaries that are dually eligible or reside in disadvantaged neighborhoods as identified by the Area Deprivation Index (ADI).

However, CHA has significant concerns with using the ADI to determine which ACOs qualify for the Health Equity Adjustment (and the Advance Incentive Payment). The ADI contains a number of variables that are based on the national average. These include median family income, percentage of families below the federal poverty level, median home value, median monthly mortgage payment, and median gross rent. CHA is deeply concerned that given California's higher cost of living, MSSPs in California will be disadvantaged by any index that does not take into account the significant regional variation in wages and the cost of living. The table below illustrates the substantial difference in wages, rents, and home values (and, therefore, monthly mortgage payments) between the medians for each of these measures in the United States and California.

Median Household Income[10,11], Home Value[12,13], and Monthly Rent[14]
California Compared to the United States

	California	United States	Diff	% Diff
Median Household Income (2020)	$ 78,672	$ 67,521	$ 11,151	17%
Median Home Value (2022)	$ 788,679	$ 440,300	$ 348,379	79%
Median Monthly Rent (2020)	$ 747	$ 602	$ 145	24%

Further, research has shown that national and regional approaches to understanding area deprivation do not properly model the impact on health outcomes[15]. **Therefore, CHA asks CMS to adjust the ADI to better account for cost-of-living differences found in different communities. If CMS fails to do so, it will deprive MSSPs in high cost of living areas that care for at-risk populations of the necessary resources to address social determinants of health.**

The adjustment would be implemented through two proposed quality performance score adjusters and be capped at 10 points. CMS proposes to set a floor, such that an ACO with an underserved multiplier of less than 20% would be ineligible to receive any bonus points. As a result, CMS estimates that 70% of ACOs would not receive a health equity adjustment.

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[10] https://www.census.gov/library/publications/2021/demo/p60-273.html#:~:text=Median%20household%20income%20was%20%2467%2C521,median%20household%20income%20since%202011.

[11] https://www.census.gov/quickfacts/fact/table/CA/BZA210220

[12] https://fred.stlouisfed.org/series/MSPUS

[13] https://fred.stlouisfed.org/series/MSPUS

[14] https://www2.census.gov/programs-surveys/decennial/tables/time-series/coh-grossrents/grossrents-unadj.txt

[15] https://www.cdc.gov/pcd/issues/2016/16_0221.htm#:~:text=An%20area%20deprivation%20index%20(ADI)%20is%20a%20multidimensional%20evaluation%20of,outcomes%20at%20various%20geographic%20levels.

CHA supports the general concept of a sliding scale health equity adjustment, assuming CMS sufficiently addresses the measurement issue discussed above. However, we believe that this adjustment should not be limited to those ACOs with an underserved multiplier of 20% or more. Allowing all ACOs to be eligible for a sliding scale health equity adjustment — coupled with allowing all ACOs to receive AIP (discussed below) — could help ameliorate concerns about the transition to eCQM reporting (and all-payer quality measurement) if CMS does not provide a delay. Expanding the number of MSSPs eligible for a quality equity adjustment and AIP would provide additional resources to address unmet social needs for an MSSP-participating practice's patients.

AIP

CMS proposes providing advance shared savings payments to low-revenue ACOs that are inexperienced with Medicare ACO risk initiatives, that are new to the Shared Savings Program, and that care for underserved populations. The proposed AIPs increase as more beneficiaries who are dually eligible for Medicare and Medicaid or who live in areas with high deprivation (measured by the ADI), or both, are assigned to the ACO. These funds — a one-time fixed payment of $250,000 and quarterly payments for the first two years of an ACO's five-year agreement period, remaining available for use over the five-year period — would be available to address the social needs of people with Medicare, as well as health care provider staffing and infrastructure.

CHA strongly supports the provision of AIP, assuming (as discussed above) that the metrics used to determine the amount an MSSP should receive are sensitive enough to account for local wage and cost of living variation. These payments represent an important step by CMS toward achieving a goal shared by this administration and health care providers — reducing disparities in health outcomes due to socio-economic factors. However, their current construction arbitrarily excludes certain Medicare beneficiaries who have experienced, are experiencing, or are at risk of experiencing a negative outcome due to socioeconomic factors simply because they are attributed to a high-revenue ACO, an existing ACO, and/or an ACO that is experienced with Medicare risk-bearing programs. **In light of these concerns, CHA respectfully asks CMS to consider expanding the AIP funds to all MSSP participating ACOs.**

Once ACOs start reporting eCQMs their quality scores will be based on all-payer data, not just Medicare beneficiary data. As discussed above, many of the patients who will be included in the eCQM measures will not be covered under risk-sharing models that provide the financial resources necessary to address unmet social determinants of health. **CHA asks CMS to clarify that the AIP can be used for hiring staffing, investing in health care infrastructure, and addressing social determinants of health for all of an MSSP's patients, not just those Medicare beneficiaries attributed to the ACO.** Making the AIP available to all MSSP participants and allowing it to be used to improve care for all patients of the participating practices — with the guardrails discussed below in place — will provide ACOs with some of the necessary resources to address the unmet social needs of all patients cared for by a practice.

We appreciate that this request may raise concerns about the need to protect the Medicare program's solvency and make efficient use of limited funding resources. CHA believes CMS can address these concerns in two ways. **First, limit the use of AIPs for high revenue, existing, and/or experienced ACOs to those activities that directly address the social determinants of health that drive inequitable outcomes in the communities served by the ACO. Second, reduce the amount provided to high revenue, existing, and/or experienced ACOs by 50% of the amount available to new, low-revenue ACOs that are inexperienced with risk ($125,000 up front, up to $22.50 per beneficiary per quarter for eight quarters).**

Reducing Administrative Burden and Other Policy Refinements

Requirements for ACO Marketing Materials

CMS proposes to eliminate the requirement for an ACO to submit marketing materials to CMS for review and approval prior to their dissemination and reorganizes the regulation text of the section on marketing requirements. **CHA appreciates CMS' proposal related to the review of marketing materials and strongly supports it.**

Beneficiary Notification Requirements

CMS proposes to reduce the frequency with which beneficiary information notices are provided to beneficiaries from annually to a minimum of once per agreement period. The notice must be in the form and manner specified by CMS. At the beneficiary's next primary care service visit or no later than 180 days after the notice has been provided, the beneficiary must be given a meaningful opportunity to engage with an ACO representative and to ask questions. The follow-up communication may be verbal or written but must be tracked and documented by the ACO. CHA appreciates the intent of CMS' proposal on related beneficiary notifications. However, we are concerned that the requirement to provide an opportunity for "meaningful engagement" that must be tracked no later than the beneficiary's next primary care visit or 180 days after the notice has been provided may actually increase the resources required to meet the notification requirements. **To achieve the goal of reducing the resources required to participate in the MSSP, CHA respectfully asks CMS to eliminate the follow-up requirement.** Otherwise, we are concerned a well-intended reform to the MSSP will actually increase the costs associated with participating in the program.

Skilled-Nursing Facility (SNF) Three-Day Rule Waiver Process

To reduce the waiver process requirements, CMS proposes to drop the requirement that the ACO submit three narratives with its application — communication plan, care management plan, and beneficiary evaluation and admission plan. The ACO would be required to provide to CMS — upon request — narrative materials about its capacity to manage patients under the waiver if granted. **CHA appreciates CMS' proposal related to the SNF three-day rule waiver and strongly supports it.**

Request for Comment on Addressing Health Equity Through Benchmarking

The proposed rule states that benchmarks based on historically observed spending may be inequitable to the extent that historical patterns reflect existing inequities in both access to and the provision of care. The agency is interested in considering how to direct modification of benchmarks to account for existing inequities in care that can be used to advance health equity. Direct increases to benchmarks for historically underserved populations would grant additional financial resources to health care providers accountable for the care of these populations and may work to offset historical patterns of underspending that influence benchmark calculation.

CHA appreciates CMS' commentary on the linkage between inequitable access to care and higher spending for populations that reside in underserved communities. **In general, CHA supports increasing benchmarks for ACOs whose attributed populations are comprised of a significant percentage of individuals from underserved communities. However, we are deeply concerned with the budget-neutral approach taken by the Center for Medicare & Medicaid Innovation when it made a similar adjustment to benchmarks in the ACO Reach model.** The higher costs observed for underserved populations stem directly from inequitable access to care. These access issues are driven by a lack of affordable insurance coverage or, when an individual has governmental coverage (e.g., state Medicaid programs), inadequate

payment for services. It is not appropriate to penalize some MSSPs by reducing their benchmark and using those funds to offset a benchmark increase for MSSPs that care for underserved communities to address the longstanding problems stemming from inadequate payment in the Medicaid program and the lack of affordable insurance options. Both of these issues are beyond the control of participants of the MSSP. CHA is concerned that any arbitrary reduction in the benchmark will result in negatively impacted providers exiting the MSSP program. This is contrary to CMS' goal of improving outcomes for Medicare beneficiaries by increasing the number of beneficiaries attributed to an ACO.

Clinical Laboratory Fee Schedule (CLFS): Revised Data Reporting Period and Phase-in of Payment Reductions

As required by the Protecting Medicare and American Farmers from Sequester Cuts Act, CMS proposes to make certain conforming changes to the CLFS data reporting and payment requirements, including changes to the definitions of the "data collection period" and "data reporting period" and changes to the agency's phase-in of CLFS payment reductions. Specifically, CMS proposes to delay the reporting period for applicable laboratories until January 1-March 31, 2023, and extend the phase-in of payment cuts for CLFS services through CY 2025. As a result, there is a 0% reduction for CY 2021 and CY 2022, and payment may not be reduced by more than 15% for CYs 2023 through 2025. CHA supports these proposals.

However, as stated in our comments on the CY 2021 PFS proposed rule, we continue to be concerned that requirements for hospital outreach laboratories to report non-patient private payer information will be challenging to operationalize and will not influence payment rates established by the reported data. As acknowledged by agency statements both in the CY 2019 PFS final rule and a May 2019 letter to the Senate Finance Committee, additional reporting by hospital outreach laboratories is unlikely to impact payment rates. **We urge CMS to reconsider its requirement that hospital outreach laboratories be required to determine applicable laboratory status based on Medicare 14x type of bill revenue and revoke the policy.**

CHA appreciates the opportunity to comment on the CY 2023 PFS proposed rule. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Chad Mulvany, vice president, federal policy, at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy