September 11, 2023

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

SUBJECT: CMS-1784-P, Medicare and Medicaid Program: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, Federal Register (Vol. 88, No. 50), August 7, 2023

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) 2024 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. We are concerned that the statutorily required reduction in the conversion factor will exacerbate access issues for Medicare beneficiaries.
- Supports the indefinite delay in the appropriate use criteria (AUC) implementation. We greatly appreciate that the agency has determined that the policy is unworkable given the current state of revenue cycle systems. Further, CHA continues to believe that it is inappropriate for CMS to penalize facilities that perform imaging services when referring providers inappropriately order said service.
- Supports CMS' continued delay of the evaluation and management (E/M) "split billing" policy. CHA again encourages the agency to rescind its policy of basing payment in situations where a physician and a non-physician practitioner split a visit based on the preponderance of time only.
- Appreciates the multitude of changes proposed to the Medicare Shared Savings Program (MSSP). While these changes are directionally correct, CHA continues to have concerns about

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the eventual transition to APP eCQMs and the limits on growth in ACO CMS-HCC scores as CMS contemplates attributing larger populations of underserved beneficiaries to ACOs.

- Supports CMS' proposals to extend Medicare telehealth flexibilities, as well as access to virtual hospital outpatient therapy services provided to patients in their homes, through 2024. We urge CMS to work with Congress to permanently expand telehealth and virtual services for Medicare beneficiaries.

PFS Conversion Factor

The proposed conversion factor (CF) for 2024 is $32.7476, which reflects the expiration of the 2.5% increase for services furnished in 2023 provided by the Consolidated Appropriations Act (CAA) of 2023; the 0.00% update adjustment factor specified under section 1848(d)(19) of the Act, the 1.25% increase provided by the CAA, 2023; and a budget-neutrality (BN) adjustment of -2.17%. The proposed 2024 PFS CF is -3.6% lower than the 2023 CF.

CHA is deeply concerned that this reduction in physician payments is reducing access to care not just for Medicare beneficiaries, but all residents in California. A report found that 75% of physicians said their patients are experiencing challenges accessing both primary care and specialist physicians.[1] These access issues are increasing health care costs and driving negative outcomes for patients. In addition, 74% of California's physicians report that emergency rooms in their communities are busier because of physician shortages, while 82% of physicians say they are seeing patients with more complex medical conditions because care has been delayed due to reduced access to physicians.

Medicare beneficiary access issues are driven by inadequate Medicare payments that have failed to keep up with the cost of running a medical practice. Since 2001, inflation has increased by 40%, yet physician Medicare payments have only increased by 7%. Further, 76% of physicians report that Medicare fee-for-service payments do not cover their costs to provide care, with 61% reporting average revenue losses between 11% and 50%, and 13% of physicians report average revenue losses over 50%.

These losses are not sustainable. In response to a California Medical Association survey, 41% of physicians report they are considering closing their practices to new Medicare patients and 29% are considering dropping out of Medicare entirely. Even more concerning, 45% are considering retiring due to inadequate payment rates. These actions, as a direct result of inadequate Medicare payment, could negatively impact over 1.3 million Californians.

CHA strongly urges CMS to work with Congress to eliminate the budget neutrality cut to the conversion factor for CY 2024 and extend the increases to the conversion factor provided by the CAA of 2023. Doing so will protect patients' access to care — particularly for already underserved individuals — and ensure Medicare maintains a robust network of providers of all specialties at a time when such access is critically important. **CMS must work with Congress to develop a long-term plan for ensuring the adequacy of the conversion factor and associated payments to sustain all types of physicians and physician practices. This plan must not be financed at the expense of other provider types. Shifting payment cuts from one type of provider "whack-a-mole" style will only exacerbate access issues in**

[1] https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Medicare%20Physician%20Survey%20-%20final%20(2022).pdf

another portion of the health care delivery system for Medicare beneficiaries and underserved individuals.

Medicare Economic Index

In the 2023 PFS final rule, CMS finalized its proposal to rebase and revise the Medicare Economic index (MEI) to reflect more current market conditions faced by physicians in furnishing physicians' services. In the past, CMS has proposed and (subsequently finalized) implementation of the MEI into its payment calculations by holding the work relative value units (RVUs) constant and adjusting the practice expense (PE) RVUs, the malpractice (MP) RVUs, and the conversion factor to produce the appropriate balance in RVUs among the PFS components and payment rates for individual services.

In the 2023 PFS final rule, CMS finalized a delay of adjustments to the PE pools and the recalibration of the relativity adjustment for the rebased and revised MEI due to concerns about using Census Bureau data instead of American Medical Association (AMA) survey data. CMS is, again, not proposing to incorporate the 2017-based MEI in PFS rate-setting for 2024 due to the AMA's intended data collection efforts and CMS' desire to balance payment stability and predictability with incorporating new data through more routine efforts. **CHA strongly supports CMS' decision to delay incorporating the 2017-based MEI in PFS rate-setting for 2024. Given the access issues described above that Medicare beneficiaries are experiencing as a result of inadequate payment, predictability and payment stability are important goals. In addition to predictability and payment stability, CHA strongly encourages CMS to explicitly add practice sustainability to these goals as well.**

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. However, CMS also proposed to delay the implementation of its definition of the substantive portion as more than half of the total time of the visit until Jan. 1, 2024.

In response to ongoing concerns, in the CY 2024 PFS rule CMS proposes to delay the implementation of its definition of the "substantive portion" as more than half of the total time through at least Dec. 31, 2024. For 2024, CMS proposes to maintain the current definition of substantive portion that allows for use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine who bills the visit.

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. Further, we are concerned that if CMS finalizes this policy, it will exacerbate physician shortages and be detrimental to the team-based care models that can help create additional physician capacity. First, making physicians "watch a clock" for billing purposes will further contribute to physician burnout and the loss of practicing physicians. Second, we are concerned that physician practices will stop using NPPs to minimize the incidence of reduced payment.

Medicare Telehealth Services

Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List

Under current policy, CMS assigns services to the Medicare telehealth list based on three categories: Category 1 services are similar to services that are currently on the Medicare telehealth list, Category 2 services are not similar to services on the list, and, as such, CMS requires supporting evidence of its clinical benefit to add said service to the list, and Category 3 describes services added during the COVID-19 public health emergency (PHE) for which there is clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence to consider the services as permanent additions under the Category 1 or Category 2 criteria.

Beginning with CY 2024, CMS proposes to replace the current three categories with two new categories: "permanent" or "provisional." CMS proposes that services currently identified as Category 1 or Category 2 would be redesignated as "permanent" beginning with CY 2024. Any codes that are listed as Category 3 or temporary would be assigned to "provisional" status. Provisional codes would be re-evaluated in future years to determine if they should be added on a permanent basis or removed from a list of eligible telehealth services. CMS does not propose a specific timeline for evaluating provisional services for inclusion in the permanent category or removal from the telehealth list. CHA supports this proposal, which will simplify the understanding of services included on the telehealth list.

Proposal to Add New Codes to the Permanent List

CMS proposes to permanently add HCPCS code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health (SDOH) Risk Assessment tool, 5-15 minutes) to the telehealth list, contingent on finalizing its proposal to establish this new code under the PFS. **As noted in our comments later in this letter, we strongly support the addition of this new G-code and further support its permanent inclusion on the Medicare telehealth list.**

Implementation of Provisions of the CAA of 2023

The CAA of 2023 extended several telehealth and virtual care flexibilities beyond the COVID-19 PHE until Dec. 31, 2024. CHA supports CMS' proposals to implement these provisions, including delaying the

in-person visit requirements for mental health services furnished via telehealth, waiving the geographic and originating site rules to allow telehealth services to be furnished in any geographic area and in any originating site setting — including the beneficiary's home — allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services, allowing certain services to be furnished via audio-only telecommunications systems, and allowing continued payment for telehealth services furnished by federally qualified health centers and rural health centers using the methodology established during the COVID-19 PHE.

CHA strongly supports permanently expanding access to telehealth services for Medicare beneficiaries. The COVID-19 PHE waivers allowed providers to demonstrate that telehealth services improve access and reduce barriers to care for some of our most vulnerable populations, helping to address health disparities experienced by underserved communities in both urban and rural environments. We urge the agency to continue to work with Congress to remove statutory barriers to the permanent expansion of telehealth services prior to Dec. 31, 2024, expiration of the CAA of 2023 flexibilities.

Place of Service for Medicare Telehealth Services

In the CY 2023 PFS final rule, CMS established that following the end of the calendar year in which the PHE ends, telehealth claims would no longer include modifier "95" (CPT telehealth modifier), and instead bill only with the following place of service (POS) indicators:

- POS "02" – Telehealth Provided Other than in Patient's Home (Patient is not located in their home when receiving health services or health-related services through telecommunication technology) and
- POS "10" – Telehealth Provided in Patient's Home (Patient is in a location other than a hospital or other facility where the patient receives care in a private residence when receiving health services or health-related services through telecommunication technology)

CMS proposes that beginning with CY 2024, claims billed with POS 10 will be paid at the higher non-facility PFS rate, while claims billed with POS 2 will continue to be paid at the PFS facility rate. **CHA strongly supports this proposal, and we appreciate that CMS recognizes in the proposed rule that telehealth services furnished in the patient's home have the same practice expense as services provided in person. However, we note that in making this proposal, CMS refers only to the practice expenses of mental health telehealth services. We urge CMS to clarify in the final rule that the proposal to pay for services billed with POS 10 at the non-facility rate applies to all telehealth services furnished in CY 2024**.

Provider Enrollment for Telehealth Services

During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. While not addressed in the proposed rule, CMS noted in a fact sheet[2] that this flexibility will remain in place until Dec. 31, 2023. **We urge CMS to continue this waiver through Dec. 31, 2024, in alignment with the other telehealth extensions included in the proposed rule.**

[2] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

Direct Supervision

During the COVID-19 PHE, CMS allowed providers to satisfy "direct supervision" requirements for diagnostic tests, physicians' services, and some hospital outpatient services through virtual presence using real-time audio/video technology. Prior to the COVID-19 PHE, supervision required the immediate in-person availability of the supervising practitioner. CMS previously finalized that this flexibility would remain in place through 2023, and in the proposed rule, proposes to continue allowing virtual presence to satisfy direct supervision requirements through the end of CY 2024. **CHA strongly supports this proposal, and we encourage CMS to permanently finalize policies to allow for virtual direct supervision when the supervising practitioner determines it is clinically appropriate.**

Supervising Residents in Teaching Settings

In the CY 2021 PFS final rule, CMS established that after the COVID-19 PHE, teaching physicians could meet requirements for key or critical portions of services through virtual presence (real-time audio-visual communications technology), but only for services furnished in residency training sites in non-Metropolitan Service Areas (MSAs). During the COVID-19 PHE, CMS extended flexibilities for virtual supervision to include MSAs. CMS is exercising enforcement discretion through CY 2023.

In this rule, CMS proposes to extend virtual supervision flexibilities for all residency training locations through the end of CY 2024. **CHA strongly supports this proposal and urges CMS to finalize permanent policies to enable the supervising clinician to determine when virtual supervision is clinically appropriate in all teaching settings.**

In response to CMS' request for additional examples to demonstrate where virtual direct supervision has been shown to improve efficiencies in medical workforce and patient safety, CHA offers the following scenarios:

- *Resident and Patient are Together in a Hospital; Attending Physician is Remote*: Virtual supervision is useful when the resident and patient are together in person, but the attending is at another site. For example, when a psychiatric resident is on call overnight and sees a patient in the hospital emergency department, virtual supervision allows the attending psychiatrist, who is at another clinical site or their home, to be present. The resident can provide a clinically valuable in-person examination while the attending supervises via a real-time audio-video connection. We urge CMS to consider allowing the flexibility for the supervising physician to participate in key portions of the service without being physically co-located with the resident.

- *Attending Physician Supervises Residents at Multiple Physically Distant Sites:* Many teaching hospitals operate hospitals and ambulatory clinics on multiple campuses across many city blocks (and sometimes different cities). A single attending physician can provide supervision to residents at different clinical sites within the system, or on the same large campus. When used in this manner, virtual direct supervision improves efficiencies and patient safety.

- *Attending Physician Supervises Residents Working Beyond Clinic Walls:* Teaching hospitals often work to expand access to care where patients are, rather than requiring patients to come to a facility. Virtual supervision allows residents to see patients in-person in their home, in mobile clinic vans, and in other non-traditional settings such as street medicine programs. In these situations,

the additional physical presence of an attending physician is impractical. Eliminating virtual supervision in these scenarios would dramatically limit patient access to care as it is not practical (or necessary) to staff all outreach programs with an "onsite" clinician.

Clarifications for Remote Monitoring Services

CHA appreciates that CMS is clarifying several of its policies related to 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. However, we remain concerned that there are challenges with the requirements for these codes that will unnecessarily limit their utilization.

For example, CHA continues to urge CMS to reconsider 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.

Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy When Furnished by Institutional Staff to Beneficiaries in Their Homes

During the COVID-19 PHE, CMS established the Hospital Without Walls policy, which enabled hospitals to reclassify patients' homes as temporary extension sites for the duration of the PHE. This also enabled billing of virtual services furnished by hospital outpatient departments. Previously, CMS said that these flexibilities would end with the termination of the COVID-19 PHE. However, for CY 2024, CMS proposes to allow institutional providers to continue to provide remote outpatient physical therapy, occupational therapy, speech language pathology, diabetes self-management training, and medical nutrition therapy in patient's homes.

CHA strongly supports this proposal, and we applaud the agency for responding to stakeholder concerns by reversing its previously held position. CHA encourages CMS to investigate options to extend the ability of hospital-based therapists to provide remote services as part of a patient's overall plan of care. Therapists employed in CHA member hospitals report that the use of telehealth has enabled them to increase beneficiary access to medically necessary therapy services, as in the following examples:

- Patients living in remote areas may not be able to access ongoing therapy services in person. For example, a patient living in a rural area who returns home after a stay in an inpatient rehabilitation facility (IRF) may have difficulty accessing some medically necessary therapy services in person. One CHA member IRF reported an example where a patient was able to access in-person physical therapy services at a local hospital. However, follow-up speech language pathology services were not available at the same location, and instead the IRF arranged to have these services provided via telehealth.
- Some patients travel to an academic medical center or urban hospital to attend a specialized clinic, such as multiple sclerosis, wheelchair seating, or developmental assessment. The participants in these clinics receive recommendations for therapy services and follow-up, and then return to their home location at some distance from the clinic location. Telehealth provision

of follow-up therapy services has proven to be a valuable tool, supporting patient participation and outcomes.
- CHA members also reported instances where the ability to provide at least some portion of therapy services remotely was particularly beneficial in addressing barriers caused by a health-related social need; for example, if a patient was unable to access transportation to attend a therapy session in person.

In addition, CHA has heard from members that telehealth has significantly improved access to educational services, including diabetes self-management training and certain pre-operative appointments. We encourage CMS to establish policies to permanently finalize access to certain hospital outpatient department services.

Finally, we urge CMS to provide additional clarity on how institutional providers should bill for these services in CY 2024. We note that sub-regulatory guidance[3] currently states: "Through the end of CY 2023, hospital and other providers of physical therapy, occupational therapy, speech-language pathology, diabetes self-management training and medical nutrition therapy services that remain on the telehealth list, can continue to bill for these services when furnished remotely in the same way they have been during the PHE, except that beneficiaries' homes will no longer need to be registered as provider-based departments of the hospital to allow for hospitals to bill for these services." We urge CMS to state in the final rule that this policy also applies for CY 2024 and to clarify if any telehealth billing modifiers will apply.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

CMS proposes pausing implementation of the AUC program for re-evaluation and to rescind the current AUC regulations at §414.94. CMS believes the removal of these regulations is consistent with its proposal to pause efforts to implement the AUC program.

CMS believes this proposal is necessary because the agency has exhausted all options for operationalizing the requirement to use real-time claims-based reporting to collect information on AUC consultation for advanced diagnostic imaging services. CMS expects this program re-evaluation to be difficult and does not propose a time frame for recommencing implementation. CMS acknowledges that the existing Medicare claims processing system does not have the capacity to fully automate the process for distinguishing between advanced diagnostic imaging claims that are or are not subject to the AUC program requirement to report AUC consultation information as prescribed. **CHA strongly supports an implementation pause and re-evaluation of the AUC program. CHA has long opposed the program's structure, which inappropriately foists payment penalties on furnishing professionals based on actions of the ordering professional. CHA strongly urges the agency to include hospitals and other furnishing professionals in any efforts to re-evaluate the program. CHA notes that hospitals and other furnishing professionals have expended significant resources in preparing for the AUC requirements. As CMS contemplates a future AUC program, we urge the agency to consider how to leverage these existing investments by hospitals and other furnishing professionals and learn from the challenges that were experienced by those who worked to implement the flawed requirements.**

[3] https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

Services Addressing Health-Related Social Needs

CMS discusses how it is working to better identify and value practitioners' work for the additional time and resources used to help patients with serious illnesses navigate the health care system or remove health-related social barriers that interfere with the practitioner's ability to implement a medically necessary plan of care. CMS believes that this additional time and resources are not explicitly identified in current coding; this contributes to these activities being underutilized and undervalued. CMS believes the proposed new codes expressly identify and value these services and will promote activities and help distinguish them from care management services. **In general, CHA supports CMS' efforts to recognize through coding and payment policies, community health workers (CHWs) who are members of an interdisciplinary team for Medicare beneficiaries.**

Community Health Integration (CHI) Services

CMS proposes to create two new G codes describing CHI services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services, and under the general supervision of the billing practitioner. CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (referred to as the CHI initiating visit) during which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problems addressed in the visit. Subsequent CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initiating visit. CHI visits must be furnished in accordance with the "incident to" regulations. **CHA supports the addition of the two G codes describing CHI services performed by auxiliary personnel. Given that these services are currently not included in the benchmark for MSSP ACOs and other alternative payment models run by the Center for Medicare and Medicaid Innovation (CMMI), we ask CMS to clarify that payments for these two new G-codes will be removed from actual spending for APM entities when CMS reconciles actual spending to target prices. Further, we ask CMS to clarify if auxiliary staff must be employed by the provider in order for the provider to bill for CHI services provided by auxiliary staff.**

Social Determinants of Health (SDOH)

CMS proposes an HCPCS code to identify and value the work associated with administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit. The SDOH risk assessment must be furnished by the practitioner on the same date they furnish an E/M visit. The SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis and treatment plan established during the visit. The assessment includes administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using ICD-10 Z-codes (Z55-Z65). Billing for the assessment would be limited to once every six months. **CHA supports the addition of a G-code related to completing a SDOH risk assessment. Given this service isn't currently included in the benchmark for Medicare Shared Savings Program ACOs and other alternative payment models run by CMMI, we ask CMS to clarify that payments for the SDOH G-code will be removed from actual spending for APM entities when CMS reconciles actual spending to target prices.**

CHA notes that many hospitals and physician practices have embedded tools other than the three assessments provided in the proposed rule as examples of an "evidenced-based standardized SDOH

assessment." Further, MIPS CQM #487: Screening for Social Drivers of Health on requires a "standardized health-related social needs screening.[4]" The measures specification document does not specify which tool(s) must be used to satisfy the quality measure requirements. Additionally, we note that the measure specifications for the hospital inpatient quality reporting (IQR) program Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures do not specify that hospitals collect this data using an "evidence-based standardized assessment," and provides flexibility for hospitals to determine the most appropriate screening tool that is optimized for their workflow or patient population. We urge CMS to include similar flexibility in the description of the new code so that practices will not incur additional unnecessary costs implementing a new SDOH screening tool and not **penalize providers who have already deployed tools other than those referenced in the proposed rule.**

Finally, the rule states the "… SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis and treatment." **CHA asks CMS to clarify that providers can still bill for the service if no SDOH needs that result in a Z-code in the range of (Z55-Z65) are identified through the assessment.**

Principal Illness Navigation (PIN) Services

For 2024, CMS proposes two new HCPCS codes for PIN services. CMS is proposing for PIN services a parallel set of services to the proposed CHI services, but focused on patients with a serious, high-risk illness who may not have SDOH needs; and adding services to refer patients to appropriate supportive services, provide information about clinical trials, and inclusion of lived experience or training in the specific condition being addressed. Examples of illnesses that would qualify for PIN services include but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder. **CHA supports the addition of the two G-codes describing PIN services performed by auxiliary personnel. Given that these services are currently not included in the benchmark for the Medicare Shared Savings Program, ACOs, and other alternative payment models run by CMMI, we ask CMS to clarify that payments for these two new G-codes will be removed from actual spending for APM entities when CMS reconciles actual spending to target prices. CHA also respectfully asks CMS to clarify that autoimmune diseases and sickle cell anemia would be considered appropriate to bill for PIN services. Finally, we also ask CMS to provide a more expansive list of examples of diseases that PIN services would be covered for.**

The proposed rule notes that CMS currently makes separate payments for a number of care management and other services that may include aspects of navigation services, but these services are focused heavily on clinical aspects of care rather than social aspects. CMS also believes PIN services are generally performed by auxiliary personnel who may have lived experience or training in the specific illness being addressed. **CHA asks CMS to clarify if auxiliary staff must be employed by the provider in order for the provider to bill for PIN services provided by auxiliary staff. Additionally, we ask the agency to clarify if an SDOH assessment must be completed to bill for PIN services.**

Coverage of Dental Services

[4] https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

CMS proposes to cover dental services that are inextricably linked to covered chemotherapy services, CAR T-Cell therapy, and administration of high-dose bone-modifying agents (antiresorptive therapy). CMS proposes to pay for a dental examination performed as part of a comprehensive workup, medically necessary diagnostic and treatment services to eliminate an oral or dental infection, and services that are ancillary to these dental services, such as X-rays, administration of anesthesia, and use of the operating room. The above services could be paid under either Part A or B in inpatient or outpatient settings. **CHA supports CMS covering these services.** We respectfully ask CMS to cover dental services when they are provided in conjunction with radiation therapy more broadly, interventional cardiovascular procedures, and treatment for hemophilia and sickle cell anemia. CHA believes that doing so will improve outcomes for these individuals and reduce the total cost of care to the program by reducing unnecessary expenditures related to fighting infections that are preventable with proper dental care.

Medicare Shared Savings Program

In the CY 2024 rule, CMS proposes sweeping changes to the MSSP. These changes are designed to strengthen financial incentives for long-term participation by modifying the benchmarking and risk adjustment methodologies, expanding the assignment methodology to attribute more underserved individuals to MSSP ACOs, and creating Medicare eCQMs to provide a transitional pathway to APP eCQMs. **In general, CHA supports these changes. We believe they are directionally correct and could encourage existing MSSP participants to remain in the program. However, considering CMS' efforts — which CHA supports — to increase the number of underserved individuals attributed to MSSPs, we again ask CMS to remove the growth cap on MSSP participants' CMS-HCC score growth.**

We also remain concerned about the increasing costs of participating in the program. While some of these costs are driven by overly onerous notification and reporting requirements, we note that the rapid pace of recent changes in the program is a cost to MSSP ACOs unto themselves. A CHA member with multiple MSSP ACOs shared that it cost them over $150,000 to have an actuary model the 2023 PFS final rule changes, and they anticipate it will cost even more to model the 2024 proposed changes. These costs do nothing to improve patient care but are essential for MSSPs to understand how changes in the program will impact their performance so they can make an informed participation decision. CHA respectfully asks CMS to consider these costs as it plans future changes to the program. We note that many of the changes to the benchmark and risk adjustment methodology could have just as easily been proposed as part of last year's rule, thereby eliminating the need for multiple actuarial analyses.

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

Proposed Changes to Benchmarking and Risk Adjustment Methodology

Proposal to Cap Regional Service Area Risk Score Growth for Symmetry with ACO Risk Score Cap

CMS proposes to revise the Shared Savings Program regulations governing the calculation of the regional growth rate when updating the historical benchmark between benchmark year (BY) 3 and the performance year to incorporate a regional risk score growth cap adjustment factor. The proposed changes to the calculation of the regional component of the update factor would be applicable for agreement periods beginning on or after Jan. 1, 2024. **CHA generally supports this change.**

We agree with CMS' analysis that this will increase the accuracy of the regional update factor for ACOs operating in regional service areas with high-risk score growth and provide an incentive for ACOs to form or continue participation in such areas. **Therefore, we question why CMS is penalizing existing ACOs**

— particularly those ACOs in areas with large populations of underserved individuals — by delaying their eligibility for this important policy change until the beginning of their next agreement period. CHA respectfully asks that CMS make this improvement to the benchmark available to all ACOs on Jan. 1, 2024, if they request it. Further, as discussed in detail below, we still believe that this is insufficient. **CHA strongly reiterates its prior recommendation that CMS remove the cap on an individual MSSP ACO's CMS-HCC risk score growth.**

Mitigating the Impact of the Negative Regional Adjustment on the Benchmark to Encourage Participation by ACOs Caring for Medically Complex, High-Cost Beneficiaries

CMS proposes to modify the policies it adopted in the 2023 PFS final rule to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment. This modified approach would apply to ACOs in agreement periods starting on Jan. 1, 2024, and in subsequent years. CMS would continue to generally calculate the adjustment as finalized in the 2023 final rule but would modify its calculation based on whether the ACO's regional adjustment amount (expressed as a single per capita value) is positive or negative. **CHA generally supports this change.**

Under the proposed approach, ACOs that would face a negative overall adjustment to their benchmark based on the methodology adopted in the 2023 PFS final rule would benefit, as they would now receive no downward adjustment. Additionally, ACOs that have a negative regional adjustment amount (expressed as a single value) and are eligible for prior savings adjustment would also be expected to benefit from the proposed policy. Specifically, these ACOs could receive a larger positive adjustment to their benchmark or a positive adjustment instead of a negative adjustment, as CMS would no longer offset the prior savings amount by the negative regional adjustment amount when determining the final adjustment. This would make the prior savings adjustment more favorable, particularly for ACOs serving high-risk populations. CMS states that importantly, no ACO would be made worse off under the proposed policy. **Again, CHA questions why CMS is penalizing existing ACOs by delaying their eligibility for this important policy change until their next agreement period? CHA respectfully asks that CMS make this improvement to the benchmark available to all ACOs on Jan. 1, 2024, if they so request it.**

Proposed Revisions to Risk Adjustment Model

CMS proposes to transition from version 24 to version 28 of the CMS-HCC risk adjustment model. Additionally, CMS proposes to use the CMS-HCC risk adjustment model(s) applicable to the calendar year corresponding to the performance year to calculate a Medicare FFS beneficiary's prospective HCC risk score for the performance year, and for each benchmark year of the ACO's agreement period. This would be applicable to agreement periods beginning on Jan. 1, 2024, and in subsequent years.

Specifically, for an ACO beginning a new agreement period on Jan. 1, 2024, in PY1 (2024) all benchmark year and PY1 prospective HCC-risk scores would be calculated using a blend of 67% V24 CMS-HCC model and 33% V28 CMS-HCC model. In PY2 (2025), all benchmark year and PY2 prospective HCC risk scores are expected to be calculated using a blend of 33% V24 and 67 % V28. In PY3 (2026), all benchmark year and performance year prospective HCC risk scores are expected to be calculated using V28. **In general, CHA supports the transition to V28 and the use of a consistent risk adjustment model for both the BY and PY.**

CHA has heard concerns from a member who is renewing on Jan. 1, 2024, that the transition will be challenging from an information system perspective. While their EMR vendor will be ready for the transition to V28 by Jan. 1, there will not be sufficient time for the MSSP ACO to test and validate the changes to the code sets. Additionally, the changes between V24 and V28 are significant. The number of HCC categories will increase from 86 to 115 and categories are renumbered. More importantly for physicians, V28 assigns a risk score to 2,264 fewer diagnosis codes. For example, diabetes, which is a common chronic condition in the Medicare population, sees significant changes under V28 from V24**. In addition to the three-year transition period proposed (which CHA supports), CHA asks CMS to provide an "overlap period" of at least six months to smooth the transition from V24 to V28.** As part of this overlap period, CMS would map diagnosis codes under V24 to codes under V28. During the six - month "overlap period," any diagnosis codes submitted that would have impacted HCC assignment under V24 would automatically be mapped to its V28 analog and be captured. **We believe this is necessary to allow for additional time for physician education and to ensure that EMR systems are properly updated for V28.**

In analysis accompanying the proposal, CMS found that on average, ACOs would have earned roughly 0.2% in additional PY 2021 shared savings payments relative to the benchmark when both benchmark year and performance year prospective HCC risk scores are calculated under V28 compared to calculations under both V24 and V28. **Given this, CHA questions why CMS is penalizing existing ACOs by delaying their eligibility for the updated in-risk adjustment policy until their next agreement period. CHA respectfully asks that CMS make this improvement in the risk adjustment methodology available to all ACOs on Jan. 1, 2024, if they request it.**

Eliminate the Risk Adjustment Cap that Penalizes ACOs Serving Complex and Underserved Populations

In the CY 2023 PFS rule, CMS finalized a policy that modified the existing 3% cap on positive prospective HCC risk score growth. Under CMS' revised policy, an ACO's aggregate prospective HCC risk score would be subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year plus 3 percentage points.

While CHA appreciates this change and believes it is an improvement over prior policy, we remain 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. We raise this issue in the context of CMS' proposed changes to the assignment methodology that will attribute more underserved individuals to MSSP ACOs. These individuals typically have not had an established, stable primary care relationship. As a result, their risk scores are likely to be unreliable. An accompanying analysis in the proposed rule supports this by noting that these individuals are lower cost and have lower HCC scores, yet are more likely to have higher mortality rates, and greater hospice care and SNF utilization. This suggests to CHA members that these individuals may have complex conditions that are not properly diagnosed. Once attributed to an MSSP ACO, these conditions will be diagnosed and the patient will begin receiving treatment for them, which will raise their per capita costs. However, due to CMS' policy capping HCC score growth at 3% plus changes in demographics, risk scores will not increase to reflect these changes. As a result, ACOs that are attributed more complex, historically underserved beneficiaries via proposed step three in the assignment methodology will experience losses and may be forced to drop out of the MSSP.

CHA strongly believes that the benchmark for a given performance year needs to be fully risk-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 is initially discovered and appropriately managed — as in the case of many of the individuals who will likely be attributed through proposed step 3. For example, when a beneficiary who has been continuously attributed to an ACO is 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.**

Proposed Changes to Beneficiary Assignment

Proposed Third Step in Beneficiary Assignment

CMS proposes adding a third step to the MSSP assignment methodology to attribute more underserved individuals to MSSP ACOs. Beginning in CY 2025, CMS proposes adding a third step to the step-wise methodology. This would provide an extended 24-month period, including the 12-month assignment window and the previous 12 months. For beneficiaries who do not meet pre-step requirements, but do have at least one primary care service during the assignment window, the beneficiary would be assigned to the ACO if allowed charges for primary care services furnished by primary care professionals in the ACO during the expanded window are greater than allowed charges for primary care services furnished by primary care professionals not assigned to the ACO. As a result of these changes, the definition of the assignable population would be expanded to include Medicare FFS beneficiaries who both (i) received at least one primary care service from a Medicare-enrolled nurse practitioner, physician assistant, or clinical nurse specialist during the 12-month assignment window, and (ii) received during the 24-month expanded window at least one such service with a Medicare-enrolled physician who is a primary care physician or specialty designation physician.

CMS conducted an analysis that simulated the effects of the proposed step 3 and proposed revised definition of an assignable beneficiary, using 2021 as the assignment window (Jan. 1, 2020, through Dec. 31, 2021). Applying the proposed policies added 76,156 assignable beneficiaries.

The group of added beneficiaries included a larger share of beneficiaries with disabled Medicare enrollment type, who resided in areas with slightly higher-than-average ADI national percentile rank and had a larger share with any months of part D LIS enrollment. The added population also included beneficiaries with a lower average HCC-risk score, lower total per capita spending, higher hospice utilization, and higher mortality rate than assignable beneficiaries that would be determined without the proposals. **As discussed above, CHA has concerns about the proposed third step in the assignment process, particularly under CMS' current risk cap policy. While we appreciate the high-level analysis CMS provided with the proposed rule, we respectfully ask CMS to provide additional data looking at the impact on rural ACOs and ACOs in different regions of the country given regional trend factors.** CHA believes that CMS must ensure that this policy will not harm any ACO. Otherwise, the harmed category of ACOs will likely exit the program.

Additionally, CHA is concerned that the lack of specialty designation for NPPs will lead to more specialty-driven assignments from these provider types. While the majority of NPPs practice in primary care settings, increasingly more NPPs work in specialty practices, often providing follow-up care after an

acute event such as a transplant. Because CMS does not have specialty designations for NPPs and classifies them all as primary care clinicians, this type of follow-up care delivered by NPPs in specialty practices can lead to beneficiaries being attributed to an ACO with which they have no primary care relationship. ACOs report that beneficiaries aligning through specialists in this way tend to be those who are receiving a high-cost procedure in the performance year and do not align to the ACO again in future performance years, making it challenging for ACOs to meet their benchmarks. **In the absence of CMS' ability to distinguish between NPPs who practice primary care and those who practice specialty care, we continue to advocate that ACOs be permitted to remove specialty-focused NPPs from assignment**.

Finally, as part of the additional analysis discussed above, CMS should investigate the impacts of specialty-driven assignment, including differences in risk scores and costs for beneficiaries attributed via specialists to inform future policy solutions. For example, if data show that these beneficiaries have higher risk scores and higher costs, there could be opportunities to address these challenges through benchmarking and risk adjustment policies. Attribution churn is another area with opportunity for improvement. ACOs struggle to maintain attribution for beneficiaries attributed through specialists because they do not have a primary care relationship with the ACO.

Updates to HCPCS Used in Assignment
CMS proposes including Office-Based Opioid Use Disorder Services (HCPCS Codes G2086, G2087, and G2088) for beneficiary assignment. Since these codes are identified as codes for alcohol and substance abuse-related diagnoses that are excluded from the Shared Savings Program Claim and Claim Line Feeds, ACOs will not be able to see claims that have been used in assignment for those receiving these services. Since the services include overall management and care coordination activities, CMS believes they should be included. **CHA does not believe it is appropriate to include HCPCS codes in the MSSP beneficiary assignment methodology for which the ACO cannot receive the claims for. Therefore, we respectfully ask CMS not to include HCPCS codes G2086, G2087, and G2088 in those used for beneficiary assignment.**

CMS also proposes to add Remote Physiologic Monitoring Treatment Management Services (CPT codes 99457, 99458). While these codes may be billed by primary care providers to support the overall management of a patient's care, the codes can also be billed by specialists and importantly, can only be billed by one treating provider for a given patient. Therefore, if a specialist is billing these codes to support management of a specific condition, that patient's primary care provider would not be able to also provide RPM treatment management services to the patient. Further, because these are monthly billable codes, this could result in the allowed charges for RPM services furnished by a specialist surpassing the allowed charges for primary care services furnished by the PCP. **CHA cautiously supports the addition of these codes, as they support comprehensive care management. However, we encourage CMS to monitor billing of the codes to ensure their addition is not shifting beneficiary attribution away from primary care relationships in favor of specialty care.**

Medicare Clinical Quality Measures (CQM) Reporting Option

Starting in CY 2025, MSSP ACOs will no longer be able to use the CMS Web Interface to report quality measures. In response to stakeholder concerns that not all ACOs are operationally ready to collect all-payer quality data as part of the transition, CMS proposes ACOs will have the option to report APM Performance Pathway (APP) CQMs on only the Medicare beneficiaries in their ACO beginning in CY

2024. CMS indicates that Medicare CQMs are a "transition collection type" that the agency believes would help ACOs build the infrastructure and expertise needed to report on all-payer data. CMS also states its belief that offering a Medicare-only CQM reporting option can help the agency advance its goal of moving to digital quality measures. The proposed rule does not indicate how long the Medicare CQM reporting option would be available if finalized.

To report Medicare CQMs, an ACO would aggregate patient data for eligible beneficiaries across all ACO participants and match the aggregated patient data with each Medicare CQM specification to identify the eligible population for each measure. To assist ACOs in this process, at the beginning of each quality data submission period for the PY, upon an ACO's request, CMS would provide the ACO with a list of beneficiaries who are eligible for Medicare CQMs within the ACO. Since CMS would not have complete claims data before the start of the data submission period, the list may not be complete and ACOs would need to ensure that all who meet the applicable Medicare CQM specification and the definition of a beneficiary eligible for Medicare CQMs be included in the ACO's eligible population for reporting.

CHA appreciates CMS' efforts to provide a transitional reporting model that attempts to address stakeholder concerns about reporting all -payer data. This mitigates concerns about being evaluated on a broader population of patients than the MSSP ACO is taking risk for in the Medicare program. However, it does not permanently address many of the key concerns that MSSP ACOs have regarding reporting APP eCQMs.

First, Medicare CQMs do not fully solve issues with identifying the eligible population on which an ACO must report. The proposed rule notes that beneficiaries eligible for Medicare CQMs would be beneficiaries who are either (i) a Medicare FFS beneficiary who meets the criteria for a beneficiary to be assigned to an ACO and had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician, has a specialty designation, or is a PA, NP, or CNS; or (ii) a Medicare FFS beneficiary assigned to an ACO because the beneficiary designated a professional participating in the ACO as coordinating their care. To assist ACOs in identifying these beneficiaries, CMS would provide the ACO with a list of beneficiaries who are eligible for Medicare CQMs within the ACO at the beginning of each quality data submission period for the PY. The proposed rule notes CMS would not have complete claims data before the start of the data submission period, and therefore the list may be incomplete. However, ACOs would still need to include all eligible beneficiaries who meet the applicable Medicare CQM specification in the reporting. **If CMS is unable to identify all beneficiaries who are eligible for Medicare CQM reporting, CHA questions how an MSSP ACO will be able to do so. Therefore, CHA respectfully asks CMS to modify its proposal such that only beneficiaries who are on CMS' list of beneficiaries eligible for Medicare CQMs should be included in reporting.**

Second, Medicare CQM reporting will still require 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. While the organization does not yet have an estimate of what it will cost to ingest and clean the quality data necessary from participating practices to create a QRDA file to submit Medicare CQMs, it estimates that doing so for eCQMs will add $1 million per year to the overhead cost of running the ACO. This is not uncommon.

Third, we note that many MSSPs and the vendors that support them are not ready to report eCQMs. According to a poll of our National Association of ACO's membership, only 38% of ACOs responding said they will be able to report eCQMs in 2025. Similar to the experience described by a CHA member, this transition is unsustainably expensive for many ACOs. Of those surveyed, 41% estimated a cost of $100,000 to $499,000 and 32% estimated more than $500,000 to achieve eCQM requirements for the first year of reporting. Further, many vendors continue to tell ACO clients they are unable to support this work at this time.

Fourth, 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.

Finally, CMS does not provide a timeline for transitioning to all-payer eCQMs. However, the proposed rule is clear that Medicare CQMs are intended to be a transitional reporting option. Therefore, it does nothing long-term to alleviate concerns about having the financial performance of MSSP participants — who have only agreed to assume risk for Medicare beneficiaries — tied to other payers whose members may not be in total cost of care models. 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 is providing an Advance Investment Payment (AIP) to address these issues, as discussed above, it is currently only available to a limited number of ACOs, and it is unclear if these funds can be used to address SDOH for all patients or just Medicare beneficiaries.

CHA is concerned that eventually 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.

Given the concerns articulated above, CHA respectfully asks CMS to delay eliminating the web-reporting interface indefinitely until it can resolve the challenges that eCQMs pose to MSSP participants. If CMS does not take this step and it finalizes Medicare CQMs as a reporting option, CHA respectfully asks CMS to provide a timeline for when it anticipates sunsetting the Medicare CQM option. Understanding this timeline will help MSSP ACOs take the necessary steps to prepare for APP eCQM reporting and/or make decisions about continued participation in the program.

Data Completeness
It is unclear from the proposed rule what the data completeness requirement for Medicare CQMs is. The regulation discusses a 75% data completeness requirement and also states ACOs are expected to report on all patients meeting the Medicare CQM eligibility criteria that also meet the measure criteria.

CHA respectfully asks CMS to set a data completeness standard lower than 75%. It is impractical to expect ACOs to have 100% complete data when aggregating data across many practices (both employed and independent), EHRs, and instances of EHRs. CHA strongly urges CMS to adopt exclusions and/or a lower data completeness requirement for ACOs to account for obstacles ACOs are working to overcome when reporting data to CMS for eCQMs, MIPS CQMs and Medicare CQMs when reporting at the ACO level. CHA notes that other reporting methods began with a lower data completeness standard that then increased over time.

Advance Investment Payment (AIP)

CMS proposes modifications to refine AIP policies to better prepare for initial implementation of AIP beginning with ACOs entering agreement periods on Jan. 1, 2024. This includes the following proposals:

- Allow ACOs to advance to two-sided model Levels within the BASIC track's glide path beginning in PY3 of the agreement period in which they receive advance investment payments.
- Recoup advance investment payments from shared savings for ACOs that wish to early renew to continue their participation in the Shared Savings Program.
- Terminate advance investment payments for future quarters to ACOs that elect to terminate their participation in the Shared Savings Program.
- Require ACOs to report spend plan updates and actual spend information to CMS in addition to publicly reporting such information.
- Codify that ACOs receiving advance investment payments may seek reconsideration review of all payment calculations.

In general, CHA is supportive of AIP and the proposed changes. However, they don't go far enough. CHA remains frustrated that CMS continues maintaining an artificial distinction between high-revenue and low-revenue ACOs, precluding high-revenue ACOs from also qualifying for AIP. 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.

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. Making the AIP available to all MSSP participants and allowing it to be used to improve care for all patients of the participating practices 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 activities that directly address the SDOH 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).**

Proposals to Align CEHRT Requirements for Shared Savings Program ACOs with MIPS
To integrate MIPS promoting interoperability (PI) category requirements under the Share Savings Program, CMS proposes that any MIPS PI category requirements would also apply to MIPS-eligible clinicians, QPs, and Partial QPs participating in an ACO. CMS proposes to sunset the Shared Savings Program CEHRT threshold requirements at the end of PY 2023. Beginning with PY 2024, MIPS-eligible clinicians, qualifying APM participants (QPs), and partial qualifying APM participants (partial QPs), regardless of track, would be required to:

- Report the MIPS PI performance category measures and requirements to MIPS as (i) an individual, group, or virtual group; or (ii) the ACO as an APM entity; and
- Earn a MIPS performance category score for the PI performance category at the individual, group, virtual group, or APM entity level.

CHA strongly opposes this proposal. It will increase the costs associated with reporting promoting interoperability for providers. Further, it is counter to CMS' goals to encourage specialists to participate in alternative payment models. The reduced burden associated with having the ACO certify that their clinicians are using certified EHR technology to document and communicate clinical care to patients or other health providers is one of the strongest incentives for specialists to join an MSSP ACO.

Request for Information: Incorporating a Higher Risk Track than the ENHANCED Track
The proposed rule notes that CMS has considered a higher-risk Shared Savings Program track and seeks feedback on such a track. The rule anticipates the shared savings/loss rate would be between 80% and 100%. This new track would build the Next Generation ACO and ACO Realizing Equity, Access, and Community Health Models. It would provide more potential upside for reward and incentivize ACOs to improve performance, which may result in reduced health care costs for Medicare.

CHA respectfully asks that if CMS implements a higher risk, it must be provided as an option for MSSP participants, not a requirement. Many beneficiaries avoided non-emergent care during the COVID-19 pandemic, missing preventative care and the opportunity to identify treatable conditions before they became more complex/costly. Additionally, many providers are facing significant financial challenges resulting from higher labor and supply costs coupled with inadequate payment updates from the Medicare program and other governmental payers. In this environment, CHA is concerned that if a higher-risk track is incorporated into the MSSP glide path, many ACOs will exit the program if they are forced to take additional risk beyond the ENHANCED track.

Request for Information: Expanding the ACPT Over Time and Addressing Overall Market-Wide Ratchet Effects
CMS seeks feedback on future refinements to its new Accountable Care Prospective Trend (ACPT), including replacing the national trend in the current two-way blended update with the ACPT, along with scaling the weight of the ACPT to account for ACOs' market share in its region. CHA is concerned that the ACPT, because it's based on national Medicare spending, hurts ACOs in regions whose spending

growth was higher than the ACPT. For new agreements starting in 2024 and beyond, MSSP benchmarks will be a combination of two-thirds of the current national-regional blend rate and one-third of the ACPT.

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

CHA, as it did in response to proposals related to the ACPT in the CY 2023 rule, asks that guardrails be put into place to protect ACOs who would see lower benchmarks because of the ACPT. These include:

- Setting ACOs' historic benchmark at the higher of the proposed three-way trend adjustment or the current two-way trend adjustment.
- Basing the ACPT on regional spending, rather than national. Because there is significant variation in regional spending growth, the use of a national trend will benefit ACOs in regions with slower spending growth and reduce benchmarks for ACOs in regions with higher spending growth.
- Using a 3-year projection of the ACPT, which is the current projection used in the USPCC. It would be difficult to project five years out, and reserving the right to make mid-agreement period adjustments simply introduces uncertainty.

MSSP Administrative Burden

CMS does not propose any changes to the MSSP beneficiary notification requirements in this rule. However, based on member feedback, CHA would like to reiterate concerns with the requirements. Beneficiary notifications were required in the early years of MSSP, and the requirement was later removed due to the administrative burden, beneficiary confusion, and operational complexity caused by the notifications. CMS later reintroduced the requirement and made changes to the policies but has not addressed the fundamental issues with the requirement.

In last year's rulemaking, CMS added a follow-up communication requirement in conjunction with the notice, which CHA strongly opposed due to concerns it would exacerbate beneficiary confusion and operational complexity. ACOs have struggled in implementing this new element of the requirement and CMS did not provide any guidance on the follow-up requirement until April 2023, nearly four months after the requirement went into effect, and the guidance and FAQs provided failed to answer numerous questions about compliance or CMS expectations for ACOs. Based on feedback from CHA members, there are four fundamental concerns with the notification requirements.

First, ACOs that have elected preliminary prospective assignment with retrospective reconciliation (retrospective assignment) struggle to identify the denominator of beneficiaries to which they are required to provide the notice and follow-up. While ACOs with prospective assignment are only required to provide these to prospectively assigned beneficiaries, ACOs with retrospective assignment are required to provide them to all Medicare FFS beneficiaries. CMS provides these ACOs with information on preliminarily assigned and assignable beneficiaries but does not provide a list of or contact information for all FFS beneficiaries, making it infeasible for ACOs to identify and contact these beneficiaries to comply with the requirements. While CMS attempted to alleviate some burden by reducing the

frequency with which ACOs must provide the notice, it is not uncommon for an ACO's beneficiary population to change significantly from year to year. It is not uncommon to have hundreds of new providers and thousands of new beneficiaries. This churn makes it incredibly challenging to identify all "new beneficiaries" each performance year. As such, some ACOs have expressed they may have to continue sending the notice to all beneficiaries to be compliant.

Second, the timing requirements of the initial notice and follow-up are impractical and make it effectively impossible to be fully in compliance. Under current regulations, ACOs are required to provide the notice at or before the first primary care service visit of the performance year and provide the follow-up "no later than the earlier of the beneficiary's next primary care service visit or 180 days from the date the standardized written notice was provided." Some beneficiaries will inevitably have a primary care visit on Jan. 2 and ACOs do not receive attribution lists for the upcoming performance year until December, leaving very little time to send notifications by Jan. 1.

MSSP ACOs are comprised of many different TINs and types of groups. This makes the notification and follow-up requirements challenging, especially when tied to sending prior to their first visit of the year. Providers don't have sufficient staff or resources to allocate to the notice, so the burden is on the ACO. This, as discussed below, confuses beneficiaries. While CHA understands that CMS would like the information to come from the provider in person, requiring clinic staff to furnish the notice at point-of-care adds significant administrative burdens to primary care practices. These additional administrative activities include staff training, changing workflows, and documenting and tracking when beneficiaries receive the notice at each individual practice location. CHA members estimate that the notification requires 0.2 FTEs per location if it is to be delivered in person as CMS intends.

Further, the timing of the follow-up communication poses even more challenges. Many ACOs do not have access to practice-level scheduling data to determine whether the beneficiary's next primary care visit takes place before the end of the 180-day period after the notice was provided. At a minimum, CMS should only require the follow-up communication within 180 days, removing "the next primary care service visit" as it is a difficult and impractical standard for all ACOs to track.

Given that many practices are experiencing staffing shortages and high levels of provider burnout, CHA strongly believes that providers and clinicians should be focused on the patient — their specific reason for the visit and managing their overall health — not educating them about value-based agreements. Given that CMS seeks to have 100% of Medicare beneficiaries in a value-based arrangement (VBA) by 2030, and all Medicare FFS beneficiaries are subject to participation in VBAs, CHA strongly believes the agency must shoulder much of the responsibility for educating beneficiaries about these models. Not only will it reduce provider and clinician burnout and reduce practice expenses, but it will ensure that beneficiaries receive a consistent message in a manner that does not interrupt their clinic visit. For these reasons, we strongly recommend that CMS use the annually published "Medicare and You" handbook to educate beneficiaries about accountable care organizations.

Third, lack of appropriate guidance from CMS and contradictory information provided by ACO coordinators have caused significant confusion among ACOs about how to comply with the requirements. As previously mentioned, written guidance documents from CMS fail to answer questions about implementation, required documentation, and what CMS considers to constitute compliance with the requirements. Additionally, because this guidance was not published until the second quarter of the

year, some ACOs had to re-do many of the notifications to comply with the guidelines, adding costs and administrative burden. ACOs that have contacted their ACO coordinators with questions about these requirements have received information that contradicts answers provided by other ACO coordinators or conflicts with guidance and statements made by CMS.

Fourth, CHA members estimate the cost of mailing the second notice is approximately $2 per beneficiary. For larger MSSP ACOs, this could be as much as $150,000 annually. This is a significant, unnecessary expenditure that does not improve patient care and could actually be detrimental to the patient-provider relationship as described below.

Finally, and perhaps most importantly, these requirements have caused confusion and frustration for Medicare beneficiaries, in direct contrast with the intention of the requirements. As a result of the notifications, some beneficiaries choose to opt-out of data sharing without understanding what the data sharing process entails, making it difficult for ACOs to coordinate and manage patients' care effectively. The new follow-up communication has increased confusion and frustration. Some patients believe these communications are part of a scam, or that they have been enrolled in a managed care plan without their consent. ACOs have also reported that after providing the follow-up communication, they received a high volume of patient calls about clinical care, coverage issues, and questions about medication management, none of which were relevant to MSSP or appropriate for ACO operational staff to address. **CHA supports efforts to improve beneficiary education and engagement, and we are concerned to hear from ACOs, Medicare beneficiaries, and consumer advocates that the current beneficiary notifications are having the opposite effect. Therefore, we again respectfully ask CMS to eliminate the 180-day follow-up requirement.**

Medicare Provider Enrollment

CMS proposes a series of changes to the Medicare provider enrollment process. These proposals touch on revocations of enrollment, stays of enrollment, and reporting changes in practice location among other items. CMS is proposing these changes to "clarify" or "strengthen" certain components of the enrollment process. **CHA appreciates CMS' efforts to safeguard Medicare beneficiaries and the program.**

Proposed Medicare Provider Enrollment Provisions

CMS proposes a number of modifications to §424.535(a) related to revocation of enrollment, including for certain misdemeanors citing examples of where providers pled guilty to reduced misdemeanor charges for assault and obtaining controlled substances by fraud. Under current regulations, CMS may not revoke a provider's or supplier's enrollment due to a misdemeanor.

Revocation on Non-Compliance Grounds

The proposed rule would broaden the regulatory enrollment requirements that could subject a provider or supplier to revocation to those "described in this title 42," rather than just those "described in this subpart P." This would then encompass, for example, opioid treatment programs. **CHA respectfully asks CMS to specify the enrollment requirements that are located outside of 42 CFR part 424, subpart P that the proposed expansion would apply to.** Until this occurs, CHA asks CMS not to finalize this provision as stakeholders will not have sufficient opportunity to comment on this change. The proposed rule's discussion of this provision is limited and only provides "enrollment requirements pertaining to opioid treatment programs…in § 424.67(b)" as an example of one of the requirements.

Revocation on Misdemeanor Conviction
CMS proposes it may revoke a provider's or supplier's enrollment if they, or any owner, managing employee or organization, officer, or director thereof, have been convicted of a misdemeanor under federal or state law within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries, including:

- Fraud or other criminal misconduct involving the provider's or supplier's participation in a federal or state health care program or the delivery of services or items
- Assault, battery, neglect, or abuse of a patient (including sexual offenses)
- Any other misdemeanor that places the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct

CHA appreciates CMS' need to protect beneficiaries and the program. However, we are concerned that "any other misdemeanor that places the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct," is overly broad and could result in arbitrary decisions about revoking a provider's enrollment. **Therefore, we ask the agency not to finalize this catch-all. We believe that the agency must make available, for notice and comment in a future rulemaking, detailed criteria that describe when a provider may have their enrollment revoked for a misdemeanor conviction that is not related to program fraud or assault of a patient.** Such criteria, clearly articulated and made available for comment, will help ensure that enrollment revocations for misdemeanors are not arbitrary and capricious.

Time Frames for Reversing a Revocation
If a revocation was due to adverse activity (sanction, exclusion, felony) by an owner, managing employee, authorized or delegated official, supervising physician — the revocation can be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that party within 30 days of the revocation notification. The proposed rule expresses concern that a provider or supplier should be afforded that much time to terminate this business relationship, since each day the revoked provider or supplier remains affiliated with the party in question, the more Medicare dollars that could be paid out inappropriately. Therefore, CMS proposes to reduce this 30-day period to 15 days. CHA is concerned that 15 days does not provide sufficient time for a provider to terminate the relationship with the party in question. **We note that these notices are sent via ground mail. As a result, it could take five or more days for a provider to receive notification that its enrollment will be revoked if it does not sever its relationship with the excluded individual. This leaves a provider with 10 or fewer calendar days to terminate the relationship with an excluded individual, which is insufficient. While CHA appreciates CMS' concerns, we respectfully ask that CMS does not finalize this provision. We believe 30 days strikes a reasonable balance between allowing time for providers to terminate business relationships with an excluded individual and ensuring Medicare does not make inappropriate payments.** If CMS does finalize this change, we ask that CMS clarify that a provider has 15 business days from the documented date of receipt of the notice.

Stay of Enrollment
CMS proposes a new enrollment status labeled a "stay of enrollment" that would be a preliminary, interim status — prior to any subsequent deactivation or revocation. It would represent a "pause" in enrollment, during which the provider or supplier would remain enrolled in Medicare and CMS would neither formally nor informally treat the stay as a sanction or adverse action for purposes of Medicare enrollment. CMS would also notify the affected provider or supplier in writing of the stay. **CHA**

appreciates this new status and agrees that it would be less burdensome for providers than reactivating an enrollment.

The proposed rule states that a stay period would not last more than 60 days. CMS believes that MACs can generally process Form CMS-855 change requests more rapidly than a reactivation application, thus enabling a provider or supplier subject to a stay to begin receiving payments sooner than if deactivated. **In instances where MACs have a backlog of Form CMS-855 change requests, CHA respectfully asks CMS to extend the stay period for an additional 60 days as opposed to moving to deactivate the provider. Also, in these instances, CHA asks CMS to allow the provider to be paid for services provided during the initial 60 days to provide the cash flow necessary to continue operating and serving Medicare beneficiaries.**

CMS believes the affected provider or supplier should have an opportunity to raise a concern about a stay by submitting a rebuttal that generally mirrors the rebuttal process for deactivations and payment suspensions. The provider or supplier would have 15 calendar days from the date of the stay's written notice to submit a rebuttal, unless CMS extends the timeframe, at its discretion. **CHA notes these notices are also sent via ground mail. As a result, it could take five or more days for a provider to receive notification of the stay of enrollment. This leaves a provider with 10 or fewer calendar days to gather the necessary evidence that a stay is inappropriate, which is insufficient. While CHA appreciates CMS' concerns, we respectfully ask that CMS extend this time frame to offer a rebuttal to 30 days.** If CMS does finalize a 15-day rebuttal time frame, we ask that CMS clarify that a provider has 15 business days from the documented date of receipt of the notice to respond.

Definition of Pattern or Practice

Three existing Medicare enrollment revocation reasons[5] are based on the provider or supplier engaging in a "pattern or practice" of conduct. CMS has received questions as to what constitutes a pattern or practice under these provisions. The agency says it has always made these determinations on a case-by-case basis and does not propose changing this general procedure, due to the flexibility it provides. However, in order to provide additional clarity for stakeholders and to institute minimum regulatory parameters, CMS proposes to establish a definition of "pattern or practice" to mean, for each of the three existing Medicare enrollment revocation reasons above, that the provider or supplier engaged in the "pattern or practice" of conduct in at least three instances. The proposed rule states that only in the rarest of circumstances involving egregious non-compliance would it revoke enrollment based only on three instances. CHA appreciates CMS' attempt at providing clarity to what constitutes a definition of "pattern or practice." However, we do not believe that a "pattern or practice" should be defined as at least three non-compliant claims under §424.535(a)(8)(ii), prescriptions under §424.535(a)(14), or orders, certifications or referrals under §424.535(a)(21). **In general, CHA strongly believes that three or more is too low a bar to establish a pattern or practice of behavior that is intentional and harmful in any of these areas.**

Additionally, as it relates to §424.535(a)(8)(ii), it is unclear from the proposed rule what CMS means by "non-compliant." For example, three claims denied because the provider neglected to include the date of

[5] §424.535(a)(8)(ii) – submitting claims failing to meet Medicare requirements; §424.535(a)(14) – prescribing Part B or D drugs in an abusive manner; §424.535(a)(21) - prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries

service could be considered non-compliant. **Given the complexity of Medicare billing requirements, we respectfully ask CMS to clarify how it is defining "non-compliant" in the context of its definition of a "practice or pattern."** We believe this clarification is necessary regardless of whether the agency finalizes the proposed definition of at least three claims.

Finally, as it relates to §424.535(a)(14) and §424.535(a)(21), it is unclear what CMS means by abusive. CHA respectfully asks **CMS to clarify how it is defining "abusive" in the context of its definition of a "practice or pattern."** We believe this clarification is necessary regardless of whether the agency finalizes the proposed definition of at least three prescriptions, referrals, orders, or certifications.

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

As required by the CAA of 2023, 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 Jan. 1-March 31, 2024, and extend the phase-in of payment cuts for CLFS services through CY 2026. As a result, there is a 0% reduction for CY 2023, and payment may not be reduced by more than 15% for CYs 2024 through 2026. CHA supports these proposals.

However, as stated in our previous comments, 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 2024 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