

September 11, 2023

VIA Electronic Submission

Ms. Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

***Re: AHCA Response to Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program. CMS-1784P-P (RIN 0938-AV07)***

Dear Administrator Brooks-LaSure:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 14,600 long term and post-acute care facilities, or 1.06 million skilled nursing facility (SNF) beds and over 292,000 assisted living beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living (AL) communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD).

We appreciate the opportunity to comment on the Physician Fee Schedule Proposed Rule for calendar year (CY) 2024. SNFs serve a dual purpose. First, SNFs provide short-term Medicare Part A post-acute services to beneficiaries who require skilled nursing and/or rehabilitation services on an inpatient basis. Second, SNF's furnish and bill Medicare Part B under the PFS for long-stay and residents under a Part A stay for services excluded from consolidated billing requirements, as well as for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services for beneficiaries in nursing facilities who are either not eligible for or have exhausted Part A benefits. Additionally, SNF providers often also furnish Part B therapy services to ambulatory outpatients and AL residents, often to provide follow-up care after a SNF stay.

Long- and short-term SNF, AL, and ID/DD residents have complex health care conditions, comorbidities, and functional deficits requiring ongoing interdisciplinary care. In addition to outpatient therapy payment rates and policies associated with services furnished by PT and OT assistants, our members have a vested interest in assuring that other Part B policies that impact care for residents, including physician, portable x-ray, clinical labs, and telehealth providers, provide adequate and timely access to these necessary services to improve care and reduce unnecessary hospitalizations for emergent conditions that could be better treated in place at a lower cost.

The Association appreciates the efforts of CMS in responding to the COVID-19 public health emergency (PHE) through the issuance of various waivers and other regulatory changes to permit more flexible, effective, and efficient care delivery through and beyond this crisis.

In this comment letter AHCA/NCAL would like to focus on the following key topics discussed in the proposed rule as they impact beneficiaries residing in our member's skilled nursing facility providers and assisted living residences:

- Changes in Relative Value Units (RVUs)
- Geographic Practice Cost Indices (GPCI)
- Potentially Misvalued Services Under the PFS
- Payment for Caregiver Training Services (CTS)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act
- Other Non-Face-to-Face Services Involving Communications Technology Under the PFS
- Extend Billing Flexibilities for Certain Remotely Furnished Services Through CY 2024
- Advancing Access to Behavioral Health
- Medicare Shared Savings Program
- Payment for Dental Services Inextricably Linked to Specific Covered Services
- Medicare and Medicaid Provider and Supplier Enrollment
- Updates to the Definitions of Certified Electronic Health Record Technology

If you have questions about any of our comments, please contact Daniel Ciolek at [dciolek@ahca.org](mailto:dciolek@ahca.org).

Sincerely,

A handwritten signature in black ink that reads "Daniel E Ciolek". The signature is written in a cursive, slightly slanted style.

Daniel E Ciolek

Associate Vice President, Therapy Advocacy

## AHCA/NCAL Detailed Comments

### 1. Changes in Relative Value Units (RVUs) (88 FR 52678)

In the Regulatory Impact Analysis section of the proposed rule, CMS proposes a Conversion Factor rate that is a 3.36 percent reduction from the CY 2023 rate. The rate reduction would have been 1.25 percent greater had it not been for the temporary statutory increase enacted in the Consolidated Appropriations Act of 2023. Additionally, CMS indicates that *“Approximately 90 percent of the budget neutrality adjustment is attributable to the O/O E/M visit inherent complexity add-on code with all other proposed valuation changes making up the other 10 percent”* (page 52686). In other words, 90 percent of the 2.17 percent budget neutrality adjustment could be eliminated if CMS elected not to implement the Evaluation and Management (E/M) complexity code, G2211, which had been previously delayed by law.

#### AHCA/NCAL Comment

- **AHCA/NCAL strongly opposes the negative adjustment to the Conversion Factor and asks CMS to consider deferring the implementation of E/M complexity code G2211 to permit a comprehensive reassessment of the policy as intended by Congress when the implementation was previously delayed.**

Due to statutory budget-neutrality requirements, the CMS proposal to implement the E/M complexity code G2211 for CY 2024 would result in devastating redistributive impacts on many providers and suppliers for residents of skilled nursing and assisted living residences not eligible to bill for the proposed new E&M complexity code implementation. When Congress previously intervened to delay implementation, the intent was for CMS to reevaluate the overall impacts on the proposed policy to address the Agency’s concerns that primary care reimbursement needed to be more appropriate, but that any adjustments made should consider the impacts on the appropriateness of payments to providers not eligible to bill for the proposed E/M code G2211 if implemented. We do not see in this proposed rule any evidence of a substantive reconsideration of the proposed policy approach beyond an adjustment of the estimated code use.

We also note that while the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) imposed a zero percent update for CY 2020 through CY 2025, this instead has resulted in yearly reductions in the conversion factor due to budget neutrality requirements. Therefore, MACRA has created a net negative annual update for many providers and suppliers, including AHCA/NCAL member providers. Given the staggering recent inflation triggered by the COVID-19 pandemic, these negative payment rate impacts for such providers are accelerating. Continuing these disproportionate cuts to non-E/M billing providers is increasing the risk for delayed or denied access to care for many beneficiaries, particularly those in rural and underserved areas.

In addition to this statutory update freeze, AHCA member facilities furnishing outpatient physical and occupational therapy and speech-language pathology (PT/OT/SLP) services via CMS 14-50 (UB-04) claim types have been deemed by CMS to be ineligible for either of the MACRA Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Model (AAPM) tracks to obtain quality incentive payments for Medicare Part B services, and therefore cannot earn any bonus or gainshare to mitigate the ongoing payment cuts.

### 2. Geographic Practice Cost Indices (GPCI)

In the proposed rule CMS highlights that Medicare statute requires the Agency to develop separate Geographic Practice Cost Indices (GPCIs) to measure relative cost differences among localities compared

to the national average for each of the three fee schedule components (that is, work, practice expense (PE), and malpractice (MP)). This means that higher cost geographic regions may have GPCI multiplier of greater than 1.0 while others have a multiplier of less than 1.0. However, since 2004, Congress has enacted legislation to set a GPCI multiplier floor of no less than 1.0 to minimize wide payment variances between geographic areas. The congressional relief ends on December 31, 2023, and without further Congressional intervention, CMS will resume the pre-2004 GPCI policy which may result in significant payment rate reductions for providers in GPICs with a multiplier of less than 1.0.

**AHCA/NCAL Comment**

- **We recommend that CMS consider mitigation strategies such as a phase-in approach should it remains necessary to eliminate the 1.0 GPCI multiplier floor for CH 2024 PFS payments.**

We are concerned with the significant impact on resident access to needed care should rate cuts that providers of services to residents of nursing homes and assisted living residences in those GPCI's be cut dramatically on January 1, 2024, especially if the cuts are layered on top of the proposed 3.36 percent cut in the Conversion Factor. While we are working with other organizations to advocate for Congressional relief, we urge CMS to consider implementing a two- to three-year phase-in of the removal of the 1.0 GPCI floor multiplier to allow providers more time to prepare for such a disruptive payment cut.

**3. Potentially Misvalued Services Under the PFS – 19 Therapy Codes (88 FR 52285)**

In the proposed rule CMS has identified 19 outpatient therapy procedure codes that have not been reviewed by the Agency since the CY 2018 PFS final rule (82 FR 53073 through 53074) as potentially misvalued. Specifically, CMS states in the CY 2024 proposed rule that:

*“We have reviewed the clinical labor time entries for these 19 therapy codes, and we are now reconsidering the values established in the CY 2018 final rule. **We do not believe that MPPR should be applied to these 19 nominated therapy codes’ clinical labor time entries** (listed in Table 8), and as a result, we would like the AMA RUC HCPAC recommendations from January 2017 to be re-reviewed. **We recommend nomination of these 19 codes as potentially misvalued for CY 2024, and we welcome comments on this nomination.**”*

**TABLE 8: 19 “Always Therapy” Service Codes Nominated for Potential Misvaluation**

| <b>HCPCS 2023</b> | <b>LONG DESCRIPTION</b>  | <b>CY 2023 STATUS CODE</b> |
|-------------------|--|----------------------------|
| 97012             | Application of mechanical traction   | A                          |
| 97014             | Application of electrical stimulation  | I                          |
| 97016             | Application of blood vessel compression device   | A                          |
| 97018             | Application of hot wax bath  | A                          |
| 97022             | Application of whirlpool therapy   | A                          |
| 97032             | Application of electrical stimulation with therapist present, each 15 minutes  | A                          |
| 97033             | Application of medication using electrical current, each 15 minutes  | A                          |
| 97034             | Application of hot and cold baths, each 15 minutes   | A                          |
| 97035             | Application of ultrasound, each 15 minutes   | A                          |
| 97110             | Therapy procedure using exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes                   | A                          |
| 97112             | Therapy procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes   | A                          |
| 97113             | Therapy procedure using water pool to exercises, each 15 minutes   | A                          |
| 97116             | Therapy procedure for walking training, each 15 minutes  | A                          |
| 97140             | Therapy procedure using manual technique, each 15 minutes  | A                          |
| 97530             | Therapy procedure using functional activities  | A                          |
| 97533             | Therapy procedure using sensory experiences  | A                          |
| 97535             | Training for self-care or home management, each 15 minutes   | A                          |
| 97537             | Training for community or work reintegration, each 15 minutes  | A                          |
| 97542             | Evaluation for wheelchair, each 15 minutes   | A                          |
| G0283             | Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care | A                          |

## AHCA/NCAL Comment

- **AHCA/NCAL fully supports the proposed review of the AMA RUC HCPAC recommendations from January 2017 for these 19 therapy procedure codes so that the nominated revisions are implemented as proposed for the CY 2024 payment year.** However, it is our understanding that the AMA RUC HCPAC will not be able to review these codes until January 2024 which could lead to an additional year of underpayment unless mitigated for.
- **As a mitigation strategy to prevent further damaging underpayments, AHCA/NCAL strongly recommends that CMS immediately apply administrative discretion and suspend the application of MPPR to these 19 codes for a temporary period until CMS can implement the AMA RUC HCPAC recommended procedure code valuation adjustments.**
- **To prevent unnecessary confusion, AHCA/NCAL also requests that CMS make clear that the enforcement suspension will be temporary until the new values are implemented, so the stakeholders, including the RUC, recognize that the values proposed for the CY 2025 fee schedule rulemaking cycle should be based on the assumption that the AMA RUC HCPAC code valuation adjustments would be promulgated in the CY 2025 payment year, and once implemented, CMS would resume application of the MPPR policy on these 19 codes.**

Medicare providers and suppliers of outpatient therapy services furnished under Part B have argued for years that the January 2017 American Medical Association's (AMA's) Relative Value Scale Update Committee (RUC) and Healthcare Professional Advisory committee (HCPAC) Review Board (AMA RUC HCPAC) recommendations for these 19 procedure codes were valued in a manner that already accounted for the reduced clinical labor time expenses that would occur for those procedures in which multiple service units were commonly furnished during a treatment session. Additionally, facility-based providers, including SNF, are also subject to the unfair additional application of the MPPR edits across the PT, OT, and SLP disciplines even though they represent distinct professional services and are furnished during separate sessions that require distinct preparation activities. Therefore, we opposed the additional application of the CMS multiple procedure payment reduction (MPPR) policy to these codes as they would result in redundant and excessive payment rate cuts. In this proposed rule CMS acknowledges that this indeed has occurred and that outpatient therapy providers have been underpaid for these 19 procedure codes beginning in 2018. CMS has an obligation to make things right.

We strongly support the CMS proposal to have the AMA RUC HCPAC committee revalue these codes as soon as possible. However, we have learned that the AMA RUC HCPAC will not be able to review these codes until January 2024.<sup>1</sup> This means, the earliest CMS could update the Medicare code values would be in the CY 2025 PFS rulemaking cycle, which would lead to yet another year of underpayment for these codes. We believe this is unacceptable, and that CMS should consider applying administrative discretion on a temporary basis to suspend the MPPR adjustment policy for these 19 codes immediately as a mitigation strategy to limit further damage due to underpayments that have occurred continuously since January 1, 2018. This temporary suspension would end when CMS is able to implement the updated code values that arise from the AMA RUC HCPAC review.

We also understand that the AMA RUC HCPAC review develops code values that apply to multiple payers and that each payer would require time to make any necessary adjustments resulting in changes to code values. Therefore, we believe it is important that CMS makes it clear to the RUC that the CMS

---

<sup>1</sup> CY 2024 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Proposed Rule Summary, American Medical Association – Page 2 (accessed 9.7.2023) <https://www.ama-assn.org/system/files/ama-summary-2024-mfs-proposed-rule.pdf>

MPPR enforcement suspension for these 19 codes will be removed once CMS is able to implement the AMA RUC HCPAC code valuation adjustments for Medicare payment purposes.

#### **4. Payment for Caregiver Training Services (CTS) (88 FR 52322)**

Historically, CMS has taken the position that codes describing services furnished to other individuals without the patient's presence are not covered services. In this proposed rule, CMS offers to establish an active payment status in CY 2024 for CPT codes 96202 and 96203 (caregiver behavior management/modification training services) and CPT codes 9X015, 9X016, and 9X017 (caregiver training services under a therapy plan of care established by a PT, OT, SLP). These codes allow treating practitioners to report the training furnished to a caregiver in strategies and specific activities to assist the patient to carry out the treatment plan. CMS states a belief this is especially beneficial the case in medical treatment scenarios where assistance by the caregiver receiving the CTS is necessary to ensure a successful treatment outcome for the patient--for example, when the patient cannot follow through with the treatment plan for themselves.

CMS has traditionally broadly defined a caregiver as a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition. In the context of our proposals for CTS services, CMS suggests defining a caregiver is an individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis in managing a patient's complex health care and assistive technology activities at home; and helping to navigate the patient's transitions between care settings. CMS also includes including a guardian in this definition when warranted. CMS is referring to a guardian as a layperson assisting the patient in carrying out a treatment plan that is established for the patient by the treating physician or practitioner and assists the patient with aspects of their care, including interventions or other activities directly related to a treatment plan established for the patient to address a diagnosed illness or injury.

CMS is seeking public comment on the proposed definition of 'caregiver', whether payment should be offered for individual or groups of individuals, whether the services can be furnished outside the presence of the beneficiary, whether consent is necessary for CTS, other details necessary for implementation and program integrity purposes.

#### **AHCA/NCAL Comment**

- **AHCA/NCAL strongly supports the CMS proposal to add five codes for payment for caregiver training services related to behavior management/modification and strategies and techniques to facilitate the patient's functional performance in the home or community, that these services can be performed outside the presence of the beneficiary, that prior consent is obtained, and that such consent is adequately documented.**
- **AHCA/NCAL recommends that CMS clarify the definition of "home" to include the Medicare beneficiary's current residence to include a nursing facility and an assisted living residence.**
- **AHCA/NCAL recommends that CMS clarify that the definition of a "caregiver" includes a "layperson" neighbor/friend/other individual who may be compensated by the beneficiary or beneficiary's responsible party to perform the desired strategies and techniques included in the care plan between the health care provider visits.**

AHCA/NCAL skilled nursing facility providers and assisted living residence operators that furnish long-term residential care to over one million older adults and persons with disabilities daily recognize the immense value that a "layperson caregiver" can offer to support and enhance the implementation of a resident's care plan for both physical and psychosocial benefits. One of the most heartbreaking aspects of

the COVID-19 pandemic and subsequent government policies restricting the ability of a resident's "caregivers" to visit often resulted in social isolation and reduced resident activity which had serious impacts on resident mood and mobility. Informal "caregivers" are an essential part of the resident's long-term care experience.

However, for safety purposes, it is best if the "caregivers" involved were adequately informed of the specific behavior management/modification approaches and strategies and techniques to facilitate the resident's functional performance. For example, many persons residing in nursing facilities and assisted living residences have behavioral or cognitive challenges, and personalized "caregiver" training may be more effective and less stressful on the resident if delivered outside of the direct presence of the resident.

This proposed policy would allow providers the flexibility to offer "caregiver" training in the most appropriate method. We believe providers should also be allowed to furnish a hybrid approach of "caregiver" training where part is furnished in the presence of the resident while part is furnished away from the resident. In such cases, we recommend that the code billed would be the code that reflects most of the time spent training the "caregiver" (with resident present versus away from the resident).

We believe that these services could be appropriately furnished without duplicating payment from other payers. For example, in a SNF, such services could enhance care delivery and transition to the community planning prior to discharge under the Part A consolidated billing provisions. For long-stay nursing facility or assisted living residents under Medicaid HCBS payment models, Medicare Part B would be the primary payer for dual-eligible individuals unless such services were already covered under an individual state's bundled Medicaid payment model. We believe such services could be furnished under the individual or group payment codes at any time there is a substantive change in the patient's care plan needs that requires training or retraining the "caregiver" to assure that the approaches and techniques are safely applied by the "caregiver".

Finally, we believe that if a patient or their representative is unable to perform the approaches and techniques necessary to carry out the care plan outside of the provider's treatments, but would like to compensate a family member, friend or other "proxy caregiver" to be trained to apply the approaches and techniques, then this policy should not stifle such private arrangements, or place the provider in a position to "police" such private arrangements or be subject to potential program integrity compliance issues should it be learned later that the patient or responsible party compensated the "caregiver".

## **5. Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act) (88 FR 52286)**

CMS has proposed several updates to Medicare telehealth policies that directly impact AHCA/NCAL members and the post-acute and long-term residents our members serve.

### **5.1. Outpatient Therapy Services (88 FR 52291)**

CMS received requests to add Therapy Procedures: CPT codes 97110, 97112, 97116; Physical Therapy Evaluations: CPT codes 97161–97164; Therapy Personal Care services: CPT code 97530; and Therapy Tests and Measurements services: CPT codes 97750, 97763 and Biofeedback: 90901, to the Medicare Telehealth Services List on a Category 1 or 2 basis. In the proposed rule CMS has deferred consideration of these codes as the Agency does not have the statutory authority to expand the permanent list of eligible Medicare telehealth practitioners to include therapists (PTs, OTs, or SLPs) beyond the temporary extension through the end of CY 2024 granted by Congress in the Consolidated appropriations Act of 2023 (CAA).

However, to permit therapy providers the opportunity to furnish services as intended by Congress, CMS is proposing to keep these therapy services on the Medicare Telehealth Services List until the end of CY 2024 and will consider any further action regarding these codes in future rulemaking.

#### **AHCA/NCAL Comment**

- **AHCA/NCAL support the extension of therapy telehealth codes permitted during the COVID-19 public health emergency through the end of CY 2024 as proposed.**

AHCA/NCAL members and their therapy provider partners have historically reported significant staffing challenges in meeting the rehabilitation care needs of short-stay residents post-discharge from a SNF or for long-term residents residing in nursing facilities and assisted living residences, particularly in rural and underserved areas when mandatory in-person care was required prior to the COVID-19 PHE. The limited availability of therapists in rural and underserved locations has exacerbated since the onset of the PHE.

Since the start of the PHE through the current date, providers of Medicare Part B PT, OT, and SLP services have been able to furnish such telehealth services successfully, effectively, and efficiently to beneficiaries in a manner that better assures constancy of care and is least disruptive to the beneficiaries' lifestyles. The therapists have demonstrated judicious and appropriate use of telehealth services as demonstrated by the overall low volume of usage. However, when utilized, telehealth services have been essential for the beneficiary health and functional outcomes.

While Congress extended the ability of these therapists to furnish telehealth services through December 2024, we welcome the current CMS proposal to also extend the ability of these therapists to furnish the proposed list of therapy codes during this same period. We believe the additional period to use these codes will enhance the evidence necessary for CMS to consider adopting these codes as permanent telehealth procedures in future rulemaking.

#### **5.2. Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List (88 FR 52293)**

CMS proposes to simplify the classification levels and processes for considering changes to the Medicare telehealth services list. Specifically, CMS proposes:

1. To assign "permanent" or "provisional" status to any services for which the service elements map to the service elements of a service on the list that has a permanent status described in previous final rulemaking or for which there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the service is furnished via telehealth by an eligible Medicare telehealth physician or practitioner.
2. To redesignate any services that are currently on the Medicare Telehealth Services List on a Category 1 or 2 basis and would be on the list for CY 2024 to the proposed new "permanent," category while any services currently added on a "temporary Category 2", or Category 3 basis would be assigned to the "provisional" category.
3. To not set any specific timing for reevaluation of services added to the Medicare Telehealth Services List on a provisional basis because evidence generation may not align with a specific timeframe.



## AHCA/NCAL Comment

- **AHCA/NCAL support the clarifications and revisions to the process for considering changes to the Medicare telehealth services list as proposed.**

We believe the proposed “permanent” or “provisional” status definitions and processes for changing the Medicare telehealth services list will improve clarity for providers and beneficiaries and will help avoid disruptions in access to care due to archaic administrative processes.

### **5.3. Implementation of Provisions of the CAA, 2023 (88 FR 52298)**

CMS is not proposing new policy in this section of the proposed rule but, in response to prior AHCA/NCAL and other comments, is clarifying that several COVID-19 waiver policies enacted by Congress in the Consolidated Appropriations Act (CAA) of 2022 for 151 days after the end of the COVID-19 PHE have been extended through December 2024 along with the statutory addition of new telehealth practitioners via the CAA of 2023 provisions.

Specific telehealth waiver policies extended through December 31, 2024, include:

- In-Person Requirements for Mental Health Telehealth
- Originating Site Requirements
- Telehealth Practitioners:
  - Qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists continue to be included as telehealth practitioners.
  - Effective January 1, 2024, marriage and family therapists (MFT) and mental health counselors (MHC) are recognized as telehealth practitioners.

## AHCA/NCAL Comment

- **AHCA/NCAL appreciates the CMS clarification of the impact of the CAA of 2023 provisions on extending these telehealth provisions through 2024.**

AHCA/NCAL appreciates the CMS clarifications in the proposed rule that therapy telehealth waiver policy extensions through December 2024 also apply to both office based and facility-based PT, OT, and SLP clinicians. We offer to work with the Agency to work with Congress to permanently add PT, OT, and SLP clinicians to the permanent telehealth practitioner list beyond 2024.

### **5.4. Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations (88 FR 52300)**

During the COVID–19 public health emergency (PHE) CMS stated that as it was the Agency’s assessment that there was a patient population who would otherwise not have had access to clinically appropriate in-person treatment, and that CMS did not believe these frequency limitations in certain settings, including nursing facilities (NF), were appropriate or necessary under the circumstances of the PHE. Therefore, the Agency removed the frequency restrictions for certain subsequent inpatient visits, subsequent NF visits, and for critical care consultations furnished via Medicare telehealth for the duration the PHE. Since the end of the PHE CMS has extended these waivers by exercising enforcement discretion through December 2023 pending promulgation of this proposed rule. CMS is now proposing to permanently remove the telehealth frequency limitations for several telehealth codes including the following codes that apply to NF settings:

- 99307 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward*

*medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.*)

- 99308 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.*)
- 99309 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*)
- 99310 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*)

### **AHCA/NCAL Comment**

- **AHCA/NCAL strongly supports the CMS proposal to permanently remove the SNF telehealth payment limits for subsequent nursing facility care by a beneficiary’s attending physician/practitioner.**

We appreciate the efforts of CMS at improving SNF resident access to telehealth services during the COVID-19 PHE by removing the frequency restrictions for physician/practitioner subsequent NF visits furnished via Medicare telehealth for the duration of the PHE for the COVID–19 pandemic and through 2023 via enforcement discretion. This waiver was extremely useful to help reduce the transmission of COVID-19 and to permit the physician to address emergent beneficiary health conditions by removing the arbitrary requirement for the beneficiary’s attending physician to see all SNF patients face-to-face if a health need was identified during an arbitrary fourteen day period between telehealth visits, regardless of the complexity of the patient status or whether the physician determined the service could be effectively furnished remotely. This waiver has been invaluable in improving the timeliness of responding to emergent care needs, particularly in rural and remote locations, and on evenings and weekends where the inability of the attending physician to visit a beneficiary face-to-face in a timely manner may result in a preventable emergency room visit or hospital admission.

We believe that the decision to furnish the appropriate amount of subsequent nursing care in person versus via telehealth in the best interest of delivering timely, safe, and effective services to the beneficiary should be made by the physician responsible for such care in consultation with SNF clinicians on a case-by-case basis, following best practice or other sub-regulatory guidance, and not restricted by arbitrary limits. For example, it may be much less disruptive for a SNF resident with dementia that is developing an emergent but non-emergency condition on a night or weekend to receive a telehealth visit with the facility nursing staff supporting the distant site physician examination to determine if any treatment plan changes are necessary – as opposed to automatically sending the resident to the emergency room. CMS’ own utilization data demonstrates that physician have used this flexibility in a limited and judicious manner, as the vast majority of SNF physician visits continue to be furnished in a face-to-face manner, and we would expect them do continue to do so.

We note that this change would not subvert existing beneficiary protections as they would not supersede existing federal nursing home mandatory physician visit requirements at 42 CFR 483.30(c)(3) or any applicable state law or regulation. Those mandatory face-to-face visits would continue to be required. However, this policy change would service to improve beneficiary access to needed physician/practitioner services associated with routine follow-up care or care for emergent conditions that could be treated in

place without having the beneficiary be subject to the costs and physical stress of transportation to an emergency room or admission to a hospital in cases where a physician/practitioner face-to-face visit was not feasible or necessary to address the clinical need.

## **6. Other Non-Face-to-Face Services Involving Communications Technology Under the PFS (88 FR 52301)**

### **6.1. Direct Supervision via Use of Two-Way Audio/Video Communications Technology**

In the March 31, 2020, IFC (85 FR 19246) and in the CMS CY 2022 PFS final rule (see 85 FR 65063), the CMS noted that the temporary COVID-19 PHE waiver exception to allow immediate availability for direct supervision through virtual presence facilitates the provision of Medicare telehealth services by clinical staff of physicians and other practitioners' incident to their own professional services. CMS notes concerns that the current policy waiver is due to expire at the end of 2023 and is proposing to extend the policy through 2024 to align with other Congressional telehealth policy extensions, as well as asks whether CMS should make this policy waiver permanent to better assure beneficiary access to necessary care due to provider workforce challenges, particularly given the absence of evidence that the waiver has caused harm since the treating practitioner would still have immediate access to the supervising practitioner communications technology. CMS indicates this is also "*especially relevant for services such as physical therapy, occupational therapy, and speech language pathology services*", who have been able to furnish telehealth services through the COVID-19 PHE through December 2024 as enacted in the CAA of 2023."

#### **AHCA/NCAL Comment**

- **AHCA/NCAL strongly supports the CMS proposal to extend through 2024 for all telehealth practitioner specialties, and preferably to permanently extend the ability of telehealth practitioners to supervise such care virtually if the practitioner determines such services can be furnished safely and effectively.**

With the aging population demographic and shrinking percentage of healthcare practitioners, we applaud that CMS is considering such a rational proposal to assure that beneficiaries have access to necessary telehealth services by reducing archaic and burdensome direct supervision policies. The COVID-19 PHE experience of the waivers has demonstrated that patient safety is not compromised when the supervising telehealth practitioner is not physically in the office of to the telehealth clinician but is still immediately available via communication technology to address any issues that arise.

### **6.2. Clarifications for Remote Monitoring Services (52303)**

CMS notes that the Agency has received many questions from interested parties about billing scenarios and requests for clarifications on the appropriate use of remote patient monitoring codes in general. In the proposed rule CMS is providing a restatement/clarification of certain policies that expired on the last day of the PHE for COVID-19. CMS is soliciting comments on the proposals and clarifications and requests general feedback from the public that may be useful in further development of payment policies for remote monitoring services that are separately payable under the current PFS.

#### **AHCA/NCAL Comment**

- **We encourage CMS to clarify that the 16-day data collection requirement only applies to 98975, 98976, 98977, and 98978 and does not apply to 98980 and 98981.**
- **We support the ability of multiple providers to bill for RPM and/or RTM services during the same period so long as the data being analyzed is not duplicative and is for different purposes.**

- **We urge CMS to clarify that this policy does not apply when RTM is furnished as part of a therapy plan of care, and that RTM may be billed for a related diagnosis in this instance.**

AHCA/NCAL concur with arguments offered to CMS in response to this proposed rule by ADVION, who represents many of our member communities' ancillary providers. The below statements align with ADVION's.

We believe CMS may have misconstrued the code descriptors for the various RTM codes. We would like to clarify that only 98975, 98976, 98977, and 98978 require 16 days of monitoring and are billed per a 30-day period. However, 98980 and 98981 are billed based on the amount of time spent in a calendar month inclusive of one synchronous interaction with the patient without requirement for a certain number of days of data collection. 98980 is billed when 20 minutes of monitoring and treatment management is provided in the calendar month, and 98981 is billed when an additional 20 minutes is provided in a calendar month. It appears that CMS intends to require data collection for at least 16 days in a 30-day period for all RTM when only 98975, 98976, 98977, and 98978 have that requirement in the official code descriptor.

Additionally, CMS notes that it will require that Remote Therapeutic Monitoring (RTM) services be furnished only to an established patient. Patients who received initial remote monitoring services during the COVID-19 PHE are considered established patients for purposes of the new patient requirements that are effective after the last day of the PHE. We request that CMS clarify this requirement, as the terms "new patient" and "established patient" are defined by CMS specifically as it relates to physicians and the billing of E/M codes. We request that CMS clarify that RTM services may be billed when provided under a physical therapist plan of care that is developed based on the completion of a physical therapy evaluation.

CMS proposes to clarify that Remote Physiologic Monitoring (RPM) and RTM may not be billed together. We do not agree with this. CMS states this is so no time is counted twice by billing for concurrent RPM and RTM services. CMS further states that when the same patient receives RPM and RTM services, there may be multiple devices used for monitoring, and in these cases, CMS will apply its existing rules, meaning that the services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary. We urge CMS to reconsider this position. As indicated by the descriptions of RPM and RTM, these services involve the analysis of different data for unique purposes. Additionally, different providers utilizing RPM or RTM would do so in the context of a specific plan of care and to support the achievement of their unique goals. We support the ability of multiple providers to bill for RPM and/or RTM services during the same period so long as the data being analyzed is not duplicative and is for different purposes. As an example, a physician may be monitoring cardiac symptoms via RPM and a physical therapist might be monitoring performance of the home exercise program using remote sensors and patient self-reported symptoms. Another issue could arise when a physical therapist (in this scenario) is billing for this service without knowing if the MD is or is not billing under the RPM code. In this scenario, and assuming CMS chose to only pay for one or the other, how would the determination be made as to whom would receive payment and who would not?

CMS also proposes to clarify that, when an individual beneficiary may receive a procedure or surgery and related services that are covered under a payment for a global period, RPM services or RTM services (but not both RPM and RTM services concurrently) may be furnished separately to the beneficiary, and the practitioner would receive payment for the RTM or RPM services, separate from the global service payment, so long as other requirements for the global service and any other service during the global period are met. CMS further states that for an individual beneficiary who is currently receiving services during a global period, a practitioner may furnish RPM or RTM services (but not both) to the individual beneficiary, and the practitioner will receive separate payment, so long as the remote monitoring services are unrelated to the diagnosis for which the global procedure is performed, and as long as the purpose of

the remote monitoring addresses an episode of care that is separate and distinct from the episode of care for the global procedure, meaning that the remote monitoring services address an underlying condition that is not linked to the global procedure or service. We urge CMS to clarify that this policy does not apply when RTM is furnished as part of a therapy plan of care, and that RTM may be billed for a related diagnosis in this instance. CMS, in the 2022 physician fee schedule, noted that the primary billers of RTM would be psychiatrists, NPs, and physical therapists. As physical therapy is not included in the global period payment and is billed and paid for separately, RTM services should be treated similarly when furnished as part of a physical therapist's plan of care. Failing to make this clarification risks eliminating the RTM benefit for many postoperative Medicare beneficiaries.

## **7. Proposal To Extend Billing Flexibilities for Certain Remotely Furnished Services Through the End of CY 2024**

In the proposed rule CMS details that the Medicare outpatient therapy benefit paid under the physician fee schedule, including PT, OT, and SLP services, are covered when furnished by therapists in private practice as well as by facility-based providers including hospitals, SNFs, home health agencies, and others. CMS notes that during the COVID-19 PHE, the agency issued specific guidance for institutional providers of therapy services to use modifier 95 (indicating a Medicare telehealth service), along with the specific bill types for outpatient therapy services furnished by their staff. The CAA, 2023 extended many of the flexibilities that were available for Medicare telehealth services during the PHE for COVID-19 under emergency waiver authorities, including adding physical and occupational therapists and speech-language pathologists as distant site practitioners through the end of CY 2024. In developing post-PHE guidance, CMS initially took the position that institutions billing for services furnished remotely by their employed practitioners (where the practitioners do not bill for their own services), would end with the PHE for COVID-19. However, after reviewing input from interested parties, as well as relevant guidance, including applicable billing instructions, the Agency extended this policy through 2023 and is considering whether certain institutions, as the furnishing providers, can bill for certain remotely furnished services personally performed by employed practitioners. Specifically, CMS is proposing to continue to allow institutional providers to bill for these services when furnished remotely in the same manner they have during the PHE for COVID-19 through the end of CY 2024.

### **AHCA/NCAL Comment**

- **AHCA/NCAL strongly supports the CMS proposal to extend through 2024 the ability of facility-based providers of PT, OT, and SLP services, including SNF providers, to be able continue furnishing medically necessary Medicare Part B outpatient therapy services via telehealth, and that the billing processes remain unchanged during this period.**
- **AHCA/NCAL strongly supports that CMS clarify that if and when Congress adds, or gives the Secretary administrative authority to add PT, OT, and SLP practitioners to the permanent telehealth practitioner list, that facility-based PT, OT, and SLP practitioners also be deemed eligible telehealth practitioners for Medicare telehealth coverage and payment purposes.**

In the past, including during the COVID-19 PHE, AHCA/NCAL and other organizations representing facility-based PT, OT, and SLP practitioners have provided extensive statutory and regulatory documentation supporting the assertion that there is no practical difference between the Medicare Outpatient Therapy service benefit when services are furnished by an individual therapist in private practice or a therapist working for a facility-based provider. These services are covered under the same benefit, the clinicians have the same licensure and regulatory definition regardless of setting, and are paid under the same physician fee schedule. There should be no difference in physician fee schedule policy for therapy telehealth coverage should these specialties be added to the permanent telehealth practitioner list. We note that the Medicare Payment Advisory Commission states that 63 percent of the Medicare

Outpatient Therapy Benefit is accessed via facility-based providers<sup>2</sup>. Failure to include facility-based PT, OT, and SLP clinicians as telehealth practitioners would create a great disparity in access to this benefit for most Medicare beneficiaries solely because of the designation of the therapy provider type, rather than for any difference in the qualifications of the PT, OT, or SLP practitioners themselves.

## **8. Advancing Access to Behavioral Health (88 FR 52361)**

In the proposed rule CMS proposes regulatory changes necessary to implement statutory changes in Section 4121(a) of the Consolidated Appropriations Act of 2023 that provides for Medicare coverage of and payment for the services of health care professionals who meet the qualifications for marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. CMS also reiterated that Section 1888(e)(2)(A)(ii) of the Act, as amended by section 4121(a)(4) of the CAA, 2023, excludes MFT and MHC services from consolidated billing requirements under the skilled nursing facility (SNF) prospective payment system.

### **AHCA/NCAL Comment**

- **AHCA/NCAL supports the policies to permit MFTs and MHCs to bill Medicare for behavioral health services beginning January 1, 2024, as proposed.**

Behavioral health services represent an essential healthcare need for many older adults and persons with disabilities residing in AHCA/NCAL member short- and long- term nursing homes and assisted living residences and we welcomed the recent Congressional actions in the CAA of 2023 to expand the behavioral health practitioner list to improve beneficiary access to these services, particularly in rural and underserved areas and other areas with a shortage of traditional Medicare behavioral health practitioners. We appreciate the clarification in the proposed rule that the expanded behavioral health coverage to MFT and MHC practitioners is excluded from SNF Medicare Part A consolidated billing requirements and can be separately billed to Medicare Part B by the newly defined behavioral health practitioners beginning January 1, 2024.

## **9. Medicare Shared Savings Program (88 FR 52416)**

In the proposed rule CMS puts forth several proposals that are expected to advance equity and increase alignment and growth within the Shared Savings Program. CMS notes that the totality of the proposals is expected to increase participation by about 10% to 20%, enabling CMS to move closer to its goal of 100 percent of Medicare fee-for-service beneficiaries under an accountable care payment model by 2030. Specifically, CMS cites the following proposals.

*“... to continue to move ACOs toward a digital measurement of quality by establishing a new Medicare Clinical Quality Measure (CQM) collection type for ACOs under the Alternative Payment Model (APM) Performance Pathway (APP). We are also proposing additional refinements to the financial benchmarking methodology for ACOs in agreement periods beginning on January 1, 2024, and in subsequent years to apply a symmetrical cap to risk score growth in an ACO’s regional service area, similar to the cap applied on an ACO’s risk score growth, apply the same CMS-Hierarchical Condition Categories (CMS-HCC) risk adjustment methodology to both the benchmark and performance years, and further mitigate the impact of the negative regional adjustment on the benchmark to encourage participation by ACOs caring for medically complex, high-cost beneficiaries.*”

---

<sup>2</sup> Med PAC Outpatient Therapy Services Payment System: Payment Basics: October 2022.

[https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC\\_Payment\\_Basics\\_22\\_OPT\\_FINAL\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_22_OPT_FINAL_SEC.pdf)

*Additional proposals include adding a third step to the step-wise beneficiary assignment methodology to provide greater recognition of the role of nurse practitioners, physician assistants and clinical nurse specialists in delivering primary care services, and updates to the definition of primary care services used for purposes of beneficiary assignment to remain consistent with billing and coding guidelines, as well as refinements to policies for the newly established advance investment payments (AIP).*

CMS also seeks feedback on potential future policy proposals including incorporating a new track that would offer a higher level of risk and potential reward than currently available under the ENHANCED track, refining the three-way blended benchmark update factor and the prior savings adjustment, and promoting ACO and community-based organization (CBO) collaboration.

## **AHCA/NCAL Comment**

### **We urge CMS to:**

- **Equip the health care system with timely data to impact beneficiary care trajectories and outcomes more effectively. Timely identification of beneficiaries in ACOs is critical to ACOs and their partners especially during care transitions.**
- **Refine its beneficiary assignment methodology for high-cost, medically complex beneficiaries both residing in and those receiving short-term rehabilitative and skilled care in nursing facilities, by allowing assignment at the facility level and removing them from the regular attribution algorithm.**
- **Create a separate track in the Medicare Shared Savings Program for this unique population as part of CMS' future policies.**
- **Eliminate the arbitrary 3-day qualifying inpatient stay requirement for long stay residents in a nursing facility in the MSSP similar to the approach used in the ACO REACH program so that these beneficiaries are not discriminated against compared to beneficiaries residing in the community.**

AHCA/NCAL members are aligned with CMS' objective to prevent unnecessary care, enhance beneficiary outcomes and experience, and "capitalize on the strengths of each provider, allowing them to manage and influence the outcomes that they control". As such, our members are looking for arrangements that offer them the opportunity to assume greater leadership and meaningfully participate in the full care experience and outcomes of their residents and patients.

Beneficiaries residing in nursing facilities have more complex care needs; most have multiple chronic conditions, require assistance with three or more activities of daily living, and have higher rates of dementia. In addition, a significant majority of long-stay nursing facility residents (roughly 90 percent or more) are dually eligible. Although skilled nursing facilities and long-term care facilities are important drivers of savings and value in the value based care ecosystem, they continue to be relegated to ancillary or downstream providers. To date, very few Accountable Care Organizations (ACOs) have engaged LTC providers (SNF/AL) in a meaningful way, such as sharing any of the savings the ACO achieves by the care delivery transformation that long-term care providers offer to meet quality metrics and improve beneficiary outcomes. Typical relationships are one sided with the ACO establishing requirements and imposing utilization management like techniques to reduce costs.

### **9.1. Determining Beneficiary Assignment Under the Shared Savings Program (88 FR 52440)**

Beginning PY 2025, CMS proposes several changes to the beneficiary assignment methodology including revising the physician pre-step, expanding the window for assignment, modifying the definition of

“assignable beneficiary” and adding a third step to its current two step beneficiary assignment process, which would lengthen the period it uses to identify additional beneficiaries for assignment to include the current 12-month assignment window and an additional 12-months preceding the current window. AHCA/NCAL is concerned that these policy proposals could create further confusion to the health care system which currently lacks timely identification of beneficiaries to ACOs especially those focused on the long-term care population. For example, beneficiaries newly admitted to a nursing facility for long-term care are often misaligned to their previous community-based primary care practitioner as the new nursing facility based practitioner is not captured in the claims assignment lookback period assignment. This creates an issue not only for the new facility based practitioner but also the community based practitioner who will no longer be caring for the long-term care beneficiary. To address these challenges, we recommend the following:

- Exclude the long-term care institutionalized (LTI) population from initial assignment algorithms, preventing their misalignment to old community-based primary care relationships and the ACOs in which those community-based clinicians participate.
- Execute a discreet LTI population assignment process that identifies primary care physician visits and calculates the plurality of primary care services provided only in place of service (facility NPI) excluding those provided during a Part A SNF stay. Align LTI beneficiaries to ACO participating providers who meet the assignment criteria during the assignment window.

This approach to the claims alignment process would likely avoid the community dwelling patients from the long-term care focused ACO as well as eliminate beneficiaries being misaligned to a community based primary care practitioner no longer the PCP of record.

## **9.2. Skilled Nursing Facility 3-Day Rule Waiver**

A tenet of the Affordable Care Act is the right care, in the right place, at the right time. Currently, one of the eligibility requirements for beneficiaries for the Skilled Nursing Facility (SNF) 3-Day Rule Waiver precludes the beneficiary from residing in a SNF or other long term care setting. This exclusion is counter to the triple aim, as it forces beneficiaries who could be effectively cared for in their home (in this case the SNF or LTC setting) to be admitted to the hospital essentially for an avoidable hospital admission, only to qualify for a higher level of skilled care benefit. We encourage CMS to carefully consider the unintended consequences of this exclusion and remove this exclusion similar to its application in ACO REACH.

## **9.3. Future Policy Proposals (88 FR 52492)**

If CMS is looking to achieve its goal of a 100 percent of Medicare Fee-for-service beneficiaries in an accountable relationship by 2030, CMS needs to account for the important role that LTC providers play in caring for the frailest, medically complex, and vulnerable populations both on a long-term basis and from a short-term rehabilitative perspective. Providing a path for LTC providers to lead in ACO models, allows for meaningful engagement and accountability by LTC providers seeking to engage in the full healthcare experience and risk for their residents and patients and aligns with CMS’ vision.

AHCA/NCAL encourages the CMS to allow for this leadership with SNFs being able to directly contract with CMS to manage their population or, at the very least, requirements that ACO entities must meaningfully engage LTC providers not only in enhancing care but rewarding outcomes to ensure operational sustainability.

As such, we encourage CMS to establish a track within the MSSP program to account for this unique beneficiary population. This would include criteria and an assignment methodology that would account



for the beneficiary's level of care and the role of the SNF/NF team in the care delivery system. From a criteria perspective we suggest using criteria in keeping with other models such as the Program of All-Inclusive Care for the Elderly (PACE), Institutional Special Needs Plans (I-SNPs), and Institutional Equivalent Special Needs Plans (IE-SNPs), that use the NF level of care as a criterion. For example, reside in a nursing facility for 90 days or more or expected to reside for 90 days or more.

From an assignment position, we suggest using an assignment methodology that requires both the primary care practitioner TIN and the facility NPI. For community dwelling beneficiaries, the physician and physician extender are the primary care team. However, when considering the intended composition of the primary care team for beneficiaries in residential settings (who are high needs), the primary care team by design comprises the integrated care team of the residential facility which should be accounted for when determining eligible provider participants for alignment purposes. This approach, in the claims alignment process, would likely avoid the community patients (i.e., because of the 90 day + requirement) and might also avoid claims aligned patients no longer in the care of the PCP or in a different SNF because of the requirement for both.

We encourage CMS to use an approach similar to the High Needs population track in ACO REACH with the edits to criterion and assignment as mentioned above.

#### **10. Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services (88 FR 52371)**

In the CY 2023 PFS final rule, CMS expanded dental health coverage linked to a covered Medicare condition such as cancer. This year CMS is proposing again to expand coverage to new dental services. Specifically, CMS is proposing to codify in section § 411.15(i)(3)(i)(A) additional policies to permit payment under Medicare Parts A and Part B for certain dental services that are inextricably linked to, and substantially related and integral to, the clinical success of, other covered services. These services include:

- Dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare covered: chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of.
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with: chemotherapy when used in the treatment of cancer, CAR T-cell therapy when used in the treatment of cancer, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer.

Furthermore, CMS proposes that that payment under the applicable payment system could also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, and use of the operating room as currently described regulation at § 411.15(i)(3)(ii).

#### **AHCA/NCAL Comment**

- **We support the CMS proposals as described to amend regulations at § 411.15(i) expand coverage under Medicare Part A and Part B for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, an otherwise covered medical service.**

Medicare beneficiaries that are short- or long-term residents in our member nursing facilities and assisted living residences often present with dental issues that impact their quality of life due to shortfalls of comprehensive Medicare dental benefits. When they are unable to afford effective preventive care and treatment for routine dental issues, this can lead to pain and difficulty with eating and obtaining proper nutrition, which can lead to depression, loss of weight, and dangerous life-threatening infections. Additionally, as CMS has highlighted in the proposed rule, there are clearly identified conditions that the successful outcomes for current Medicare covered services are explicitly dependent on a minimum level of oral health. We enthusiastically support this incremental improvement in Medicare coverage of certain dental procedures tied to currently covered Medicare benefits, and that this linkage included such services furnished on either an inpatient or outpatient basis.

## **11. Medicare and Medicaid Provider and Supplier Enrollment (88 FR 52515)**

In the CY 2023 Medicare Physician Fee Schedule final rule CMS made major changes to Medicare/Medicaid provider enrollment policies making them more stringent, with a particular focus on SNF providers. In this year's proposed rule CMS proposes several additional updates impacting all providers.

CMS states that the overarching purpose of the enrollment process is to help confirm that providers and suppliers seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements to do so. The process is, to an extent, a "gatekeeper" that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. CMS asserts that this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse, and that the rules are intended not only to clarify or strengthen certain components of the enrollment process but also to enable the Agency to take further action against providers and suppliers: (1) engaging (or potentially engaging) in fraudulent or abusive behavior; (2) presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or (3) that are otherwise unqualified to furnish Medicare services or items.

AHCA/NCAL does not oppose many of the proposed provider Medicare and Medicaid enrollment regulatory changes, however we wish to comment on the following specific proposed provisions of concern to our provider members.

### **11.1. Medicare Revocation Authority on Misdemeanor Convictions (88 FR 52516)**

CMS currently has regulatory authority to deny or revoke a Medicare enrollment if a provider, supplier, or any owner, managing employee, managing organization, officer, or director of the provider or supplier was convicted of a felony offense within the preceding 10 years of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries.

CMS now proposes new provisions at § 424.535(a)(16)(i) that CMS may deny or 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 previous 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. Proposed § 424.535(a)(16)(ii) would state that offenses under § 424.535(a)(16) include, but are not limited in scope or severity to, the following:

- 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 thereunder.
- 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.

CMS is soliciting comments on and is seeking feedback on: (1) whether there are any potential unintended consequences of our proposal that we are not considering; or (2) any guardrails we should consider so as not to create unintended consequences for persons with misdemeanor convictions.

**AHCA/NCAL Comment:**

- **AHCA/NCAL is concerned that the lack of guardrails in the proposed policy could have negative unintended consequences that CMS must mitigate before considering finalizing this proposal.**

While we support the general intent of the proposed policies to weed out “bad actors” before they become enrolled or after they are already enrolled, we have concerns regarding the revisions related to adding misdemeanors as cause for enrollment denials and revocations at 42 C.F.R. §424.530(a)(16)(i) and §424.535(a)(16)(i) as proposed.

Under federal and state law, misdemeanors can include a broad range of infractions, many of which have no bearing on the integrity of the listed employees to participate in the Medicare program. CMS lists examples in the regulation for certain misdemeanor offenses and has an additional limitation of “*Any other misdemeanor that places the Medicare program or its beneficiaries at immediate risk...*” but only offers one example of a misdemeanor plea deal offense that would meet the threshold. Additionally, CMS offers no parameters or examples that clearly demarcate types of misdemeanors that would not meet the threshold.

We are concerned that without further clarification, there will be great uncertainty as to what specific types of misdemeanors must be listed on the CMS-855 enrollment forms, as well as the consistency of how enrollment contractors will consider such misdemeanors in their enrollment denial or revocation decisions. Requiring applicants to complete background checks on each and every misdemeanor conviction for even the most nominal offense during the past 10 years could be extremely burdensome and have a chilling effect of increasing disparities of access to Medicare program participation for persons in populations already subject to disparities in the courts. We are concerned that providers could discriminate on hiring a person for a reportable position on the CMS-855 provider enrollment solely because of this ambiguity. For example, unless CMS clearly specifies that providers need not consider misdemeanors (for example, jaywalking) totally unrelated to the scope of their financial or patient care responsibilities in the organization, many qualified individuals subject to historical court disparities may be summarily excluded from the program even before CMS or its contractors have the opportunity to review the provider enrollment documentation.

Per existing regulations, provider enrollment can be denied or revoked if a provider does not submit all required information on the CMS-855 enrollment form, so clarification of what does not need to be included in the case of misdemeanor is essential. Clear limits on the types of misdemeanors that should apply to this proposed policy are absolutely necessary to protect providers from administrative reporting requirement overreach or potential sanctions associated with nonreporting of information unnecessary and irrelevant to the enrollment application process. The policy should not be for a provider to list every single misdemeanor, and then leave it to a CMS contractor to make an “*I’ll know it when I see it.*” decision whether any specific misdemeanor applies.

We are also concerned that denials or revocations based on misdemeanors should not be at the sole discretion of the Medicare contractors. We recommend that CMS implement policies to protect providers against unwarranted adverse actions. CMS should therefore provide clear instructions to the Medicare contractors on the types of misdemeanors that would not likely result in a denial or revocation from the Medicare program. Additionally, we recommend that any adverse action related to misdemeanors proposed by Medicare contractors be subject to CMS Provider Enrollment and Oversight Group review prior to issuing a decision.

## **11.2. Timeframes for Reversing a Medicare Revocation Under § 424.535(e) (88 FR 52519)**

In the proposed rule CMS indicated that Section 424.535(e) states that if a revocation is caused by actions linked to parties noted in § 424.535(e), such as owners and managing employees, the revocation can be reversed if the enrolled provider/supplier severs its business relationship with the concerned party within 30 days of the revocation notice. CMS proposes to modify § 424.535(e) by shortening the 30-day timeframe to 15 days. CMS notes that this change would not impact the provider/supplier's right to appeal a revocation under 42 CFR part 498. CMS is soliciting comments on whether 15 days is an appropriate timeframe.

### **AHCA/NCAL Comment**

- **AHCA/NCAL opposes the proposal to shorten the current 30-day revocation notice period to 15 days unless CMS improves the notification process.**

We do not believe that CMS has thoroughly considered the unintended consequences of this proposal and that the Agency did not propose conforming administrative process improvements that might have made this proposal plausible and fair. Specifically, the CMS' proposal to shorten the 30-day time to 15 days does not consider the fact that it often takes a significant amount of time for the notice of the revocation to reach the appropriate individual within the provider or supplier organization. This is particularly true for larger organizations when the revocation notice is being delivered via U.S. mail (which is typical). The mailing address may not be the same address where the company's principal or internal counsel is located, and it may take many days to reach the appropriate individual.

In addition, the proposed "15 days of the revocation notification" is defined as the date that CMS or its contractor mails the notice. It may take 7-10 days for that revocation notice to reach the appropriate individual, providing minimal time to act upon the revocation notice. Over the past several years, there have been numerous national and local emergencies as well as postal and express delivery service delays that have put providers at a disadvantage under the current 30-day window, which would be exacerbated with a shorter 15-day period. Therefore, we oppose any reduction in the 30-day time frame until CMS improves the integrity and timeliness of revocation notices. The appeals process is an insufficient remedy. We recommend that mitigation strategies could include the notice being sent via certified mail (or secure electronic equivalent), signature required, or other third-party notice with signature requirements. Protections should be made available that the notification period starts upon confirmed receipt of the notification unless there is evidence that the provider/supplier knowingly and intentionally avoided acknowledgement of receipt.

## **12. Updates to the Definitions of Certified Electronic Health Record Technology (88 FR 52546)**

### **AHCA/NCAL Comment**

- **We support the general direction of CMS in proposing regulatory changes to better align health information technology requirements across federal programs but voice ongoing frustration that more progress needs to be made in reducing the digital divide between acute and ambulatory care entities that received HITECH Act support, and long-term post-acute providers, including nursing homes and assisted living residences, and their technology vendors that remain ineligible for such support.**

AHCA/NCAL supports many of the changes proposed by CMS in seeking better alignment with health information technology (health IT) requirements and standards championed by the US Department of Health & Human Services' (HHS') Office of the National Coordinator for Health Information Technology (ONC). While we strongly support the use of health IT standards – to include standards named in ONC's

Certification Criteria – we have concerns about some of CMS’ proposals and associated implementation timeframes.

The majority of our more than 14,600 member long term and post-acute care skilled nursing and assisted living communities represent small business independent owners of between one and ten communities in urban and very rural of communities, most with between 25 and 100 residents. Our member communities were excluded from the technology advancement provisions of the Health Information Technology for Economic & Clinical Health (HITECH) Act, and therefore our members rely heavily on the support of the technology vendor community to address their needs to improve patient/resident care and to exchange necessary health information with other health care providers, patients/residents or their family/representatives, payers, and federal/state/local agencies. As such, we share many of the concerns and suggested improvements presented by ADVION, the national association that represents providers and suppliers of support services, including health information technology to our member communities. The following highlights some of the key comments submitted by ADVION that we would also like to emphasize.

We believe that the policies and programs established by HITECH and implemented by CMS and ONC achieved the federal government’s goal of ushering in a digital healthcare environment. Requiring eligible hospitals and professionals to use CEHRT ensured that HITECH funding was being used as intended. By identifying and testing the electronic health record (EHR) technology that hospitals and physician offices were incentivized to adopt and use, ONC’s Certification Program helped to ensure that such “Certified EHR Technology” or the software developed to meet CEHRT requirements had the necessary functionality that eligible hospitals and physician offices needed. **However, it does not reflect the functionality necessary to meet providers’ needs in other care settings, including the long term and post-acute care settings such as nursing homes and assisted living centers.**

Today, ONC’s Certification Program remains a voluntary program that uses third parties to perform conformance testing and issue certifications whereas the ONC’s role is to define the requirements for health IT and the process by which health IT may become evaluated, tested (if required), certified and maintain certification under the Certification Program. **We fully support the use of federally promoted, consensus-based health IT standards; however, we believe it is time to consider alternate means for evaluating the use of such standards in products designed for healthcare providers that did not benefit from federal incentives to adopt health IT and remain disadvantaged from this oversight.**

We appreciate that the ADVION health IT member companies and other technology vendors that provide services to our member communities have filled part of the gap and are involved in the work of standards development organizations (SDOs) such as Health Level Seven International® (HL7), Integrating the Healthcare Enterprise International, Inc. (IHE) and the National Council for Prescription Drug Programs (NCPDP). These technology representatives have also been tracking the progress of the Trusted Exchange Framework & Common Agreement (TEFCA). Most recently, ADVION and its members worked closely with CMS’ technical teams to ensure that most of the nation’s nearly 15,000 SNFs made a smooth transition to using CMS’ new Internet Quality Improvement & Evaluation System (iQIES) data platform. With the support of ADVION and its health IT company members, who service the vast majority of AHCA provider members, SNFs nationwide were able to successfully submit Minimum Data Set 3.0 (MDS 3.0) patient assessments through iQIES relatively seamlessly.

Despite these collective successes, we remain concerned about the existing digital divide, especially for those care providers, particularly our member communities, and those long-term and post-acute care (LTPAC) sector providers that our members need to share health information with, that did not receive the

funding and resource investments from the federal government that *HITECH* brought to the acute and ambulatory care sectors.

The lag in health IT adoption by LTPAC, behavioral health and other “ineligible” providers – *i.e.*, those sectors that received no federal incentives – coupled with the ever-increasing pace of rulemaking and requirements for the use of health IT, only adds to the challenge that LTPAC providers, and the health IT developers and vendors that serve them. We strongly believe in building on the foundation that *HITECH* created; however, the federal government cannot reasonably expect those left out of *HITECH* and without commensurate federal support or resources will be able to meet the same requirements or timelines that were designed to address the needs of hospitals and physicians – and not the rest of the healthcare continuum.

We believe that HHS understands this dichotomy. HHS’ *2020 – 2025 Federal Health IT Strategic Plan* highlights the need to extend federal support to incentivize health IT adoption by all post-acute care providers. By extending federal incentives to those caring for America’s seniors and underserved who rely on Medicare and Medicaid, post-acute providers will have the resources needed to fully participate in robust health information exchange. While the HHS plan does not provide parity across sectors, we were pleased that HHS acknowledged the need for such an investment in the following excerpt from the *2020 – 2025 Federal Health IT Strategic Plan*, which reads in part:

*“While programs like Promoting Interoperability focus on a subset of the healthcare community, the federal government recognizes the need for investment in and adoption of interoperable health IT by researchers and providers in all care settings (e.g., primary care, long-term and post-acute care, physical therapy, behavioral health, emergency medical services, and hospitals) so they can fully participate in robust [Electronic Health Information] EHI exchange.”*

**We echo these issues raised by ADVION in response to CMS’ rulemaking because, in a digitized healthcare environment and in federal health policy, it is becoming increasingly difficult to separate health and health IT policy.**