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September 6, 2022

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 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts. CMS–17701–P (RIN 0938–AU81)

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 1.08 million skilled nursing facility (SNF) beds and over 281,000 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) 2023. 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 during 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:

- CY 2023 PFS Ratesetting and Conversion Factor
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
- Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services
- Proposal to Rebase and Revise the Medicare Economic Index (MEI) in CY 2024
- Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)
- Proposals to Revise the Medicare Shared Savings Program
- Proposal to Revise the Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA–PD Plan (section 2003 of the SUPPORT Act)
- Proposed Revisions to the ''Incident to'' Physicians' Services Regulation for Behavioral Health Services
- Chronic Pain Management and Treatment (CPM) Bundles (HCPCS GYYY1, and GYYY2)

If you have questions about any of our comments, please contact Daniel Ciolek at dciolek@ahca.org.

Sincerely,

Daniel E Ciolek
Associate Vice President, Therapy Advocacy

AHCA/NCAL Detailed Comments

1. CY 2023 PFS Ratesetting and Conversion Factor

With the budget neutrality adjustments required by law, the proposed update to the conversion factor for CY 2023 of 0%, along with the expiration of the 3% increase in Medicare Part B physician fee schedule (PFS) payments for CY 2022, the proposed CY 2023 PFS conversion factor is $33.08, a decrease of $1.53 to the CY 2022 PFS conversion factor of $34.61. The net result in a reduction of Medicare base rates for Medicare Part B services of 4.42 percent compared to CY 2022.

AHCA/NCAL Comment:

- **We recommend that CMS consider applying any regulatory relief permissible within the Agency's authorities to mitigate for the significant 4.42 percent rate cut in CY 2023 for Medicare PFS.**
- **We recommend that CMS work with the provider community and Congress reform the PFS statute to better account for inflation.**
- **We recommend that CMS work with the provider community and Congress to mitigate for patient access issues in rural and underserved communities brought forth by the recently implemented physical therapist assistant and occupational therapy assistant payment adjustments.**

We believe that the PFS payment system is irreparably broken and persistent year-to-year payment cuts during an inflationary period will create significant patient access problems and poorer health outcomes as fewer providers elect to participate in Medicare. We urge CMS to work with stakeholders to identify a process to rebase and revise, or better yet – to replace the current PFS payment model that is more flexible to adopt to economic trends. While CMS works on more permanent revisions, we urge the Agency to implement temporary adjustments to the PFS payment model for CY 2023 using more current data in a manner consistent to how the Agency adjusted the market basket portion of the facility-based provider payment rates recent rulemaking to account for unprecedented recent inflation across all healthcare providers.

Additionally, we are very concerned with reports from the skilled nursing facility provider community the recently implemented Medicare Part B fifteen (15) percent payment adjustments for services furnished in whole or in part by physical therapist assistants (PTA) and occupational therapy assistants (OTA). This has had an unintended consequence of a devastating impact to access to care for beneficiaries residing in rural and underserved communities. As demonstrated in the recently issued report from Dobson DaVanzo & Associates titled *Impact on Medicare Spending of the Stabilizing*

Medicare Access to Rehabilitation and Therapy Act Assumptions and Methodology Final Technical Report, and the accompanying Detailed Data Appendix, there are a disproportionate percentage of PTA and OTA that work in rural and underserved locations, and in skilled nursing facilities, the majority of the therapy workforce consists of PTA and OTA clinicians. These are areas where there it is extremely difficult to recruit licensed therapists, and the wages of PTA and OTA practitioners also tend to be higher due to market demands. Such rural and underserved locations are unable to absorb the 15 percent PTA and OTA service adjustment on a long-term basis without access to care being compromised. We request that CMS consider regulatory flexibilities to provide relief in these geographic locations, and to work with the provider community and Congress to mitigate for patient access issues in rural and underserved communities brought forth by the recently implemented physical therapist assistant and occupational therapy assistant payment adjustments.

2. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

2.1. Requests To Add Services to the Medicare Telehealth Services List for CY 2023

In this Proposed Rule, CMS is proposing to revise the Medicare Telehealth Services List. With regards to physical and occupational therapy services (PT/OT), and speech-language pathology (SLP) services, CMS proposes to revise Medicare's coverage of telehealth services. Specifically, the Agency would:

- Maintain CPT codes 97110, 97112, 97116, 97161–97164, 97535, 97750, and 97755 on the Medicare Telehealth Services List on a Category 3 basis through the end of 2023.
- Add CPT codes 97150, 97530, and 97542 to the Medicare Telehealth Services List on a Category 3 basis through the end of 2023.
- Add CPT codes 97537, 97763, 90901, and 98960–98962 to the Medicare Telehealth Services List on a Category 3 basis through the end of CY 2023.

However, CMS points out that although therapists are the practitioners who primarily furnish these services, therapists are not permitted under current statute to furnish telehealth services outside of the COVID-19 PHE (and the 151-day period following the expiration of the PHE). Therefore, although the codes would be available to furnish via telehealth through the end of 2023, therapists will not be able to furnish the services via telehealth beginning 152 days after the end of the PHE.

AHCA/NCAL Comment:

- **We support the CMS proposal to add additional codes to the Category 3 Medicare Telehealth Services List through the end of 2023.**
- **We request that CMS also add the CPT evaluation codes for Occupational Therapy (97165, 97166, 97167) and Speech Therapy (92522 and 92523) that appear to have been an inadvertent omission from the proposed Category 3 therapy code list additions.**

Therapy services furnished via telehealth have been an invaluable tool to maintain continuity of care for Medicare beneficiaries throughout the COVID-19 PHE when face-to-face care was not feasible or safe. We appreciate that CMS recognizes the need for additional time to evaluate the benefits of this treatment option to determine whether the services should become available permanently as a care delivery resource. We note that the proposed therapy codes to be added to the telehealth only includes evaluation codes for PT, and not those for OT and SLP. We respectfully request these two specialties be included in the Category 3 list as well.

While we appreciate that CMS' hands are somewhat tied by existing telehealth statute regarding the fact that PT, OT, and SLP clinicians are not listed as permanent telehealth practitioners once 151 days past the end of the PE occurs, we respectively request that CMS provide technical assistance support to Congress in support of correcting this statutory oversight that if not addressed, will restrict beneficiary access to necessary therapy services, particularly for those living in rural and underserved locations.

2.2. Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID–19

During the COVID-19 PHE, CMS has directed practitioners to add the modifier "95" to claims to indicate a telehealth service instead of using place of service (POS) "02" for all telehealth claims. This temporary policy has allowed claims for telehealth services to be paid based on the POS where the service generally would be during the PHE. In the Proposed Rule CMS is proposing that practitioners continue to use the "95" modifier for 151 days after the end of the PHE. After the 151-day period, CMS would no longer require the "95" modifier, and practitioners would instead be required to use the following POS indicators for telehealth services:

- POS "02" – This code would be redefined, if finalized, as Telehealth Provided Other than in Patient's Home; or
- POS "10" – Telehealth Provided in Patient's Home

AHCA/NCAL Comment:

- **We do not support this proposal in its current form. We would support only of facility-based providers submitting CMS-1450 (UB-04) claims could continue to submit claims for telehealth services using the "95" modifier or similar option.**

AHCA believes that in this proposal CMS has inadvertently overlooked that facility-based providers that submit CMS-1450 (UB-04) claims would not be able to bill for telehealth services beginning 152 days after the end of the COVID-19 PHE if this proposal is adopted without modification. Early in the pandemic, therapy providers had multiple discussions with CMS officials to brainstorm how CMS could permit facility-based providers to furnish and bill for telehealth services because POS code fields are not available on the CMD-1450 (UB-04) institutional claim form. The solution was to permit facility-based providers furnishing telehealth services to use the "95" modifier. We request that CMS addresses this oversight by permitting facility-based providers to be able to continue to submit Form CMS-1450 (UB-04) claims for telehealth services using the "95" modifier or similar option.

3. Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services (section II.L.)

In the Proposed Rule, CMS is proposing to amend § 411.15(i) to codify that payment can be made 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. CMS further proposes to amend § 411.15(i) to include examples of services for which payment can be made under Medicare Parts A and B on that basis. Specifically, CMS proposes to include as examples the following dental services for which payment is permitted under our current policy: (1) dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery; (2) reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor; (3) wiring or immobilization of teeth in connection with the reduction of a jaw fracture; (4) extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and (5) dental splints only when used in conjunction with medically necessary treatment of a medical condition. CMS further proposes that Medicare payment would be made for these dental services regardless of whether the services are furnished in an inpatient or outpatient setting, and we propose that payment can also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, use of an operating room, other facility services.

AHCA/NCAL Comment:

- **We support the CMS proposals to amend regulations at § 411.15(i) to codify that payment can be made 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. We further support the CMS proposal to amend § 411.15(i) to include examples of services for which payment can be made under Medicare Parts A and B on that basis.

Medicare beneficiaries residing in our member skilled 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 easting 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 toed to currently covered Medicare been, and that this linkage included such services furnished on either an inpatient or outpatient basis.

4. Proposal to Rebase and Revise the Medicare Economic Index (MEI) in CY 2024

In the Proposed Rule, CMS is proposing to rebase and revise the Medicare Economic Index (MEI) from a base year of 2006 to 2017 to reflect more current costs and would have the effect of changing the cost weights of the PE, work, and malpractice (MP) components. CMS is proposing for this change to take effect in CY 2024.

AHCA/NCAL Comment:

- **We recommend immediate temporary adjustments to the rate formula for FY 2023 to account for increased pandemic-related infection control costs as well as overall market inflation.**
- **We recommend using more recent data than the proposed use of a 2017 base year or revising the Medicare Economic Index (MEI).**

AHCA supports rebasing and revising the Medicare Economic Index (MEI) from a base year of 2006 to a more current year, which would have the effect of changing the cost weights of the PE, work, and malpractice (MP) components. However, we do not believe that the proposed base year of 2017 is adequate to reflect current inflationary costs to furnish care in the COVID-19 and now Monkeypox viral precaution world as well as during the most significant inflationary period in nearly 50 years. We urge CMS to work with stakeholders to identify a process to rebase and revise, or better yet – to replace the current PFS payment model that is more flexible to adopt to economic trends. While CMS works on more permanent revisions, we urge the Agency to implement temporary

adjustments to the PFS payment model for CY 2023 using more current data in a manner consistent to how the Agency adjusted the market basket portion of the facility-based provider payment rates recent rulemaking to account for unprecedented recent inflation across all healthcare providers.

5. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act established a new Medicare Part B benefit category for OUD treatment services furnished by OTPs during an episode of care beginning on or after January 1, 2020. Since then, CMS has been refining the regulations to best achieve the Congressional intent for access and safety.

For CY 2023, CMS is proposing several modifications to the regulations and policies governing Medicare coverage and payment for OUD treatment services furnished by OTPs. Of particular interest to our members are the proposed flexibilities for OTPs to Use Telecommunications for Initiation of Treatment With Buprenorphine. In the Proposed Rule CMS is proposing to: 1) allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine, to the extent that the use of audio-video telecommunications technology to initiate treatment with buprenorphine is authorized by DEA and SAMHSA at the time the service is furnished; and 2) to permit the use of audio-only communication technology to initiate treatment with buprenorphine in cases where audio-video technology is not available to the beneficiary.

AHCA/NCAL Comment:

- **We support the CMS proposal to increase flexibilities for OTPs to use telecommunications for initiation of treatment with Buprenorphine.**

We believe that timely access to such treatments, particularly in rural and underserved areas, is essential to negative consequences tht could occur in cases where a physician may not be immediately available for an in-person assessment, and we support the proposed policy improvements.

6. Proposals to Revise the Medicare Shared Savings Program

In this Proposed Rule CMS describes several proposals that are expected to advance equity within the Shared Savings Program. Specifically, the Agency cites the following proposed improvements intended to help achieve the Agency's objective to get 100

percent of Medicare fee-for-service beneficiaries under an accountable care payment model by 2030.

> *"...we are proposing to provide advance shared savings payments to low revenue ACOs that are inexperienced with performance-based risk Medicare ACO initiatives, that are new to the Shared Savings Program (that is, not a renewing ACO or a re-entering ACO), and that serve underserved populations. These advance investment payments (AIPs) would increase when more beneficiaries who are dually eligible for Medicare and Medicaid or who live in areas with high deprivation (measured by the area deprivation index (ADI)), or both, are assigned to the ACO. Subject to certain limitations, these funds would be available to address the social needs of people with Medicare, as well as health care provider staffing and infrastructure.*
>
> *We are also proposing other modifications to certain existing policies under the Shared Savings Program to support organizations new to accountable care by providing greater flexibility in the progression to performance-based risk, allowing these organizations more time to redesign their care processes to be successful under risk arrangements. We are proposing a health equity adjustment that would upwardly adjust ACOs' quality performance scores to continue encouraging high ACO quality performance, transition ACOs to all-payer eCQMs/MIPS CQMs, and support those ACOs serving a high proportion of underserved beneficiaries while also encouraging all ACOs to treat underserved populations.*
>
> *Finally, we are proposing certain changes to our benchmarking methodologies that are designed to encourage participation by health care providers who care for populations that include a high percentage of beneficiaries with high clinical risk factors and beneficiaries dually eligible for Medicare and Medicaid.*

AHCA/NCAL Comment:

- **We support the direction of the CMS proposals to revise the MSSP to expand opportunities for beneficiaries who are dually eligible for Medicare and Medicaid or who live in areas with high deprivation, or both, have the opportunity to benefit from better care coordination.**
- **We encourage CMS to also consider requiring ACOs that obtain such incentives to apply a portion of such incentives to help build the nursing facility health-information technology infrastructure interoperability capabilities so that the ACO has an adequate.**
- **As many Medicare/Medicaid beneficiaries reside in nursing facilities where team-based care is already foundational, we request that CMS also seek ways to provide a path for long-term care providers to lead in ACO models rather**

than the current model where there is not meaningful engagement from community-based ACO model owners.

- **We also request that CMS eliminate the arbitrary 3-day qualifying inpatient stay requirement for long-term care nursing facility residents in an ACO so that these beneficiaries are not discriminated against compared to beneficiaries residing in the community.**

AHCA/NCAL members share this Administration's interest in arrangements that offer providers the opportunity to assume greater leadership for and meaningfully participate in the full care experience of their residents and patients. AHCA/NCAL appreciates the CMS' recognition of the disparity in the inclusion of high risk, dually eligible beneficiaries, and minorities in the current Medicare Shared Savings Program (MSSP) and the initiatives being proposed to remedy the challenges.

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 (roughly 90 percent or more) are dually eligible. Although, the updates such as advance investment payments, benchmark adjustments, opportunities to participate in one-sided risk paths longer are all positive adjustments to the Medicare Shared Savings Program and creates pathways to increase participation, the current structure of the MSSP program continues to relegate long term care (LTC) to 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 off the work done by the long-term care provider 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 without improving access to the type of enhanced primary care models known to improve resident outcomes especially with long term care beneficiaries.

Further, 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. 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.

Finally, 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.

7. Proposal to Revise the Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA–PD Plan (section 2003 of the SUPPORT Act)

In the proposed rule, CMS proposes to extend the existing noncompliance action of sending letters to non-compliant prescribers for the EPCS program implementation year (January 1, 2023, through December 31, 2023) to the following year (January 1, 2024 through December 31, 2024).

AHCA/NCAL Comment:

- **We request that CMS consider more structural improvements to this policy to mitigate for the lack of interoperability among providers that were excluded from the HITECH incentive program and/or lack high-speed internet connectivity.**

We agree the intent of the Support Act provision to improve communications and prevent medication errors envisioned by the provisions establishing the EPCS program. However, proper implementation of this program nationwide would require al nursing facilities to have systems that are high-speed internet able as well as have health information technology systems that are interoperable. As nursing facilities were excluded from the HITECH Act incentives that physician offices and hospitals we afforded, and the HIT standards are still not aligned with nursing facility workflow, a significant number of nursing facilities may not have the capabilities to accept e-prescribing by the 2025 deadline. We note that in this proposed rule, under the heading *"Previous Regulatory Action",* the agency stated, "*We did not adopt exemptions for prescribers issuing prescriptions for individuals who are residents of a nursing facility and eligible for Medicare and Medicaid benefits"*. This is concerning because it may make physicians reluctant to furnish care to nursing facility residents in cases where a facility does not have the capabilities to accept the e-prescription. We request that CMS revisit their decision to not make exclusions for physicians prescribing for nursing facility residents, and to instead specify those situations where a physician would not be

penalized under the EPCS program merely due to the fact that they furnish care in nursing facilities that are unable to accept e-prescriptions.

8. Proposed Revisions to the ‘‘Incident to’’ Physicians’ Services Regulation for Behavioral Health Services

In the Proposed Rule, CMS proposes to remove barriers to care and improve access to, and the quality of, mental health and substance use care. Specifically, the Agency proposes that to help address the acute shortage of behavioral health practitioners, the agency is proposing to allow licensed professional counselors (LPCs), marriage and family therapists (LMFTs), and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. Additionally, CMS is proposing to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient’s primary care team.

AHCA/NCAL Comment:

- **We support the posed revisions improving coverage and access to behavioral health services.**

Many residents of long-term care facilities have behavioral health needs that could be better served with more consistent availability of practitioners that furnish behavioral health services. AHCA supports the CMS proposal to revise the incident-to supervision requirements for these practitioners as well as the expansion of the types of practitioners that may furnish such services to Medicare beneficiaries.

9. Chronic Pain Management and Treatment (CPM) Bundles (HCPCS GYYY1, and GYYY2)

CMS is proposing to adopt new HCPCS codes and valuation for chronic pain management and treatment services (CPM) for CY 2023. The Agency states they believe the proposed CPM HCPCS codes would, if finalized, facilitate payment for medically necessary services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.

The proposed codes include a bundle of services furnished during a month that we believe to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders. CMS proposes to include the following elements in the CPM code: diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-

centered care plan that includes strengths, goals, clinical needs and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and coordination between relevant practitioners furnishing care, such as physical and occupational therapy and community-based care, as appropriate.

AHCA/NCAL Comment:

- **We support the posed revisions improving coverage and access to behavioral health services.**

Many long-term care residents in nursing facilities and assisted living residences suffer from chronic pain. AHCA/NCAL supports the proposed improvement to add these new chronic pain management and treatment bundled codes for physicians to encourage better care coordination and pain management for Medicare beneficiaries.