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September 9, 2024

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, D.C. 20201

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments. [CMS–1807–P] RIN 0938–AV33. July 31, 2024

Dear Administrator Brooks-LaSure,

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 14,700 long term and post-acute care facilities, or 1.06 million skilled nursing facility (SNF) beds, more than 5,000 assisted living (AL) communities, and a number of residences for individuals with intellectual and developmental disabilities (ID/DD). We represent the majority of SNFs across the country and a growing number of assisted living residences. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and disabled individuals who receive services in our member facilities each day.

AHCA appreciates the opportunity to comment on the *CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments* proposed rule.

Of importance, and relevant to our comments, is that unlike other healthcare provider settings, most of the Medicare beneficiaries in our provider member communities are long-term residents – it is their home. Except for a relatively small portion of short-stay post-acute SNF patients who require certain nursing and/or rehabilitation therapy services to further address care initiated in a hospital, most residents in nursing facilities (over two-thirds) are medically stable but often have multiple chronic conditions and require residential care to manage physical and/or cognitive impairments. Some short-stay SNF residents, and many long-stay nursing facility residents, residents of assisted living centers, and residents of ID/DD communities require health services covered by the various beneficiary access, coverage, and payment provisions impacted by this proposed payment rule under Medicare Part B payment policies.

In the following comments we discuss our support of or suggested alternative approaches to the following policy subjects in the proposed rule:

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Key Proposed Medicare Part B Policy Changes Impacting AHCA/NCAL Members and Residents

A. Summary of Costs and Benefits [89 FR 61599]

Payment Rate Update

CMS proposes an estimated CY 2025 PFS rate conversion factor of $32.3562, which represents a decrease of $0.93 (or 2.80%) from the current CY 2024 conversion factor of $33.29XX. By factors specified in law, average payment rates under the PFS are proposed to be reduced by a net 2.93% in CY 2025 compared to the average amount these services are being paid for most of CY 2024. The change to the PFS conversion factor incorporates the 0.00 percent overall update required by statute, the expiration of the 2.93% increase in payment for CY 2024 required by statute, and a relatively small estimated 0.05% adjustment necessary to account for changes in work relative value units (RVUs) for some services.

AHCA Comment

We are again disappointed by, yet another payment cut applied to physicians, therapists, and other practitioners and suppliers of Part B services paid under the physician fee schedule furnished to residents of our member nursing home, assisted living centers and residences for individuals with intellectual and developmental disabilities. This is particularly challenging to our SNF provider members that CMS has excluded from participating in the Merit-Based Incentive Payment System (MIPS) for outpatient physical and occupational therapy services as well as speech-language pathology services, despite the statute clearly indicating that outpatient therapy services are included as MIPS-eligible services. Such incentive payments could help offset some of these cuts for high-quality outpatient therapy providers.

We realize that CMS has little latitude in the core physician fee schedule formulas due to statutory limitations that prohibit annual inflation updates. However, we hope the Agency reconsiders its opposition to including facility-based outpatient therapy providers into the MIPS program in some manner, and we further request that CMS encourages Congress to enact permanent fee schedule reforms to reverse these proposed cuts for CY 2025 and beyond, as well as reform the quality incentive programs under Medicare Part B to include all outpatient office- and facility-based providers.

B. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act [89 FR 61620]

Telehealth Policies to Sunset 12.31.2024

Due to expiration of several statutory waivers, the following telehealth flexibilities would be eliminated after December 31, 2024, unless there is Congressional action.

- **Geographic waivers** for non-behavioral health services would sunset and the policy would return to the pre-pandemic policy of only being available for rural and medically underserved locations.
- **Site-of-service waivers** permitting non-behavioral telehealth from a beneficiary's home would sunset and the policy would return to the pre-pandemic policy and would only be able to be provided from a recognized telehealth location (nursing home is a recognized telehealth location).
- **PT/OT/SLP** waivers permitting outpatient rehabilitation services to be furnished would sunset and physical and occupational therapy and speech-language pathology services would no longer be able to be furnished by therapy professionals via telehealth.

AHCA Comment

- **We are extremely disappointed that CMS could not find a way to extend these waivers administratively, however, we request that CMS be prepared to continue or immediately resume these waivers upon any legislative solution enacted by Congress.**

We are actively engaged with other stakeholder organizations in seeking Congressional action to prevent these extremely beneficial waivers for Medicare beneficiaries residing in nursing facilities, assisted living communities, and residences for individuals with intellectual and developmental disabilities. It is essential that CMS is administratively prepared to implement any enacted legislation and to educate providers and beneficiaries to prevent or at least minimize any care disruptions.

Telehealth Policy Enhancements beginning 01.01.2025

Telehealth Originating Site Facility Fee Payment Amount Update [89 FR 61636]
For CY 2025 the proposed payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) that the nursing facility could bill for under Part B is $31.04, an increase of 3.6 percent from the $29.96 rate in 2024.

AHCA Comment

- **We support the proposed 3.6 percent increase to the telehealth originating site facility fee, but request consideration of establishing an add-on code.**

We appreciate the inflation adjustment for this code. However, we request that CMS consider in future rulemaking to include an add-on fee code for originating site providers when, due to the unique beneficiary needs, the telehealth visit extends beyond the time for a "typical" telehealth visit. For example, in the nursing facility environment, residents with complex conditions, multiple comorbidities, and physical and cognitive impairments may require the originating site clinician to spend significant time with the beneficiary during the telehealth encounter. The proposed $31.04 originating site facility fee is inadequate to cover the nursing facility's costs of the telehealth technology and the clinician's personnel time and may disincentivize appropriate use of this care option for such beneficiaries. The addition of an appropriately reimbursed originating site add-on code for such extended telehealth encounters may help avoid preventable and costly emergency room trips or hospital admissions for emergent conditions that can be treated in situ.

Physician telehealth nursing home visit limits [89 FR 61631]
CMS is proposing to continue the suspension of frequency limitations for subsequent nursing facility visits for CY 2025. If not finalized, only one follow-up telehealth visit would be permitted every 14 days for nursing home residents. The proposal applies to the following codes:

99307 - Subsequent nursing facility care, per day…; 10+ minutes
99308 - Subsequent nursing facility care, per day…; 15+ minutes
99309 - Subsequent nursing facility care, per day…; 30+ minutes
99310 - Subsequent nursing facility care, per day…; 45+ minutes

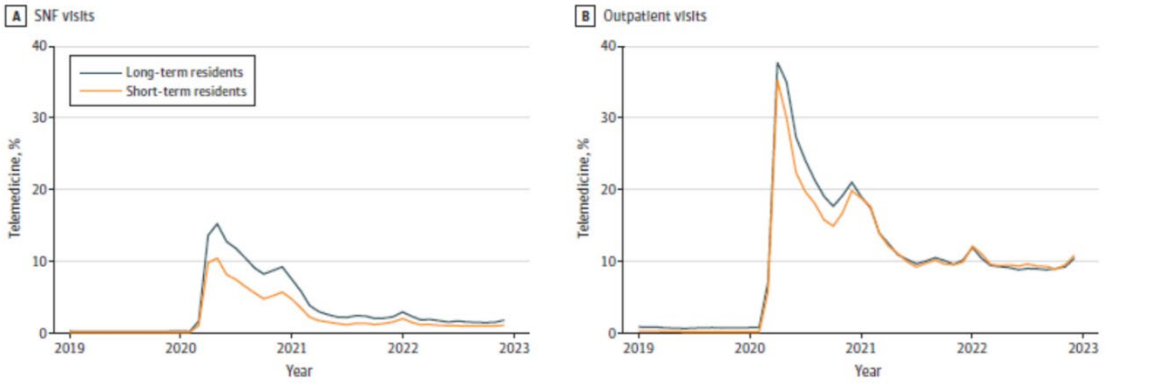
AHCA Comment

- **We support the proposed continued suspension of frequency limitations for subsequent nursing facility visits for CY 2025 but believe the frequency limitations should be eliminated permanently.**

We believe that the experience of the use of the telehealth waivers for physician nursing home visits for subsequent care clearly demonstrates that this care option was used appropriately and judiciously by the nursing home beneficiary's physicians for subsequent care, and the arbitrary once-per-14-day physician telehealth limitations should be eliminated permanently. For example, as published in the Journal of the

American Medical Association[1] (see SNF visits chart A in the Figure below), while the frequency of physician SNF telehealth visits for short and long-term residents spiked with the onset of the COVID-19 public health emergency (PHE) in early 2020 and the onset of the telehealth waivers at ten percent and fifteen percent of encounters respectively, the volume dropped precipitously to less than three percent once the COVID-19 vaccine and therapeutics became widely available and disseminated in early 2021, and remained at these low levels throughout the remainder of the PHE. Although not part of this policy proposal, about ten percent of SNF residents continue to receive the benefits of outpatient follow-up care (e.g. surgical follow-up) via telehealth which was nonexistent prior to the COVID-19 PHE.

Figure 1. Proportion of Skilled Nursing Facility (SNF) and Outpatient Visits Delivered by Telemedicine for Short- and Long-Term SNF Residents in 2019 to 2022



The group SNF visits (A) captures regular primary care encounters within SNFs, and the outpatient visits group (B) captures visits with primary and specialty care clinicians who are not affiliated with SNFs.

In other words, this evidence confirms that physicians overseeing the care of beneficiaries residing in nursing facilities continue to prefer face-to-face encounters as the first care option, however, they also recognize that there are situations where it is safe and effective to utilize telehealth services for subsequent care. For example, these waivers permitted nursing facility resident access to a physician during off-hours (nights/weekends/holidays/physician office hours) with emerging conditions to help prevent avoidable emergency room (ER) visits or hospital admissions. Prior to the PHE, if the physician were not immediately available for a face-to-face visit, all such beneficiaries would have had to go through the stress and disruption of being transported to a hospital, often waiting hours to be attended to, and then either being admitted to the hospital or being transported back to the nursing home. In many cases, this costly and disruptive event was avoided, and the resident received the appropriate care plan change interventions as a result of a physician telehealth encounter in situ. We are not aware of any governmental or academic studies that have suggested that patient care or clinical outcomes were compromised, or Medicare expenditures increased as a result of the physician SNF telehealth visit waivers, and we believe the subsequent nursing facility physician telehealth frequency limitations should be eliminated permanently.

Audio-only telehealth [89 FR 61632]

CMS is proposing that beginning January 1, 2025, an interactive telecommunications system may include two-way, real-time audio-only communication technology for any telehealth service furnished to a

[1] Ulyte A, Mehrotra A, Wilcock AD, SteelFisher GK, Grabowski DC, Barnett ML. Telemedicine Visits in US Skilled Nursing Facilities. *JAMA Netw Open.* 2023;6(8):e2329895. doi:10.1001/jamanetworkopen.2023.29895

beneficiary in their home if the , but the patient is not capable of, or does not consent to, the use of video technology.

AHCA Comment

- **We support in part the proposal to extend audio-only telehealth in situations where the patient is not capable of, or does not consent to, the use of video technology.**
- **However, this delivery method should also apply to residents of facility-based providers in situations where telehealth is permitted but the technology is not available or feasible, or in any facility where the patient is not capable of, or does not consent to, the use of video technology.**

While a distant site physician or practitioner is technically capable of using an interactive telecommunications system, not all nursing facilities, particularly those in rural and frontier communities, have access to the necessary broadband technology necessary for two-way audio-visual technology. Denying beneficiary access to permissible necessary and beneficial audio-only telehealth services when a physician or practitioner is not able to be physically present just because the beneficiary temporarily or permanently resides in a facility-based provider building that does not have broadband capabilities, while permitting such services if they were at a home in the community represents in an equity disadvantage for such individuals.

Additionally, excluding the option for the beneficiary to receive audio-only telehealth services while they are temporary or permanent residents of a facility-based provider where the patient is not capable of, or does not consent to, the use of video technology also creates an equity disadvantage. Such individuals residing in a facility would not have the same rights of access to audio-only telehealth services that they otherwise would be granted if they resided in the community.

Caregiver Training [89 FR 61627, 61665]

CMS is proposing to add several current and proposed new caregiver training codes to the provisional telehealth list that may benefit beneficiaries. The topics of trainings could include, but would not be limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, infection control, special diet preparation, and medication administration, as well as for caregiver behavior management and modification training that could be furnished to the caregiver(s) of an individual patient.

> 97550 - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; initial 30 minutes.
> 97551- Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; each additional 15 minutes.
> GCTD1-3 – New Codes - Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present); initial 30 minutes, each additional 15 minutes, or (group) with multiple sets of caregivers.
> GCTB1-2 – New Codes - Caregiver training in behavior management/ modification for caregiver(s) of a patient with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present); initial 30 minutes, or each additional 15 minutes.

AHCA Comment

- **We strongly support the proposal to add several current and proposed new caregiver training codes to the provisional telehealth list that may benefit beneficiaries.**
- **We are concerned that because the most likely types of clinicians that would be providing caregiver training services are physical therapists, occupational therapists, and speech-language pathologists, the potential benefit would be limited unless these therapy professions were granted permanent telehealth practitioner status**.

We believe this policy will help assure a successful and safe discharge to the community and prevent avoidable hospital readmissions. Over half of the residents admitted to SNFs for post-acute Medicare services are subsequently discharged back to their homes in the community where they may receive follow-up care from family members and other personal caregivers. Many of these caregivers may have jobs or other responsibilities that make it difficult if not impossible for them to come to the SNF to receive personal caregiver training prior to the resident's discharge. This policy will facilitate a continuity of care by assuring that caregivers have access to necessary training in a manner that is least disruptive to the beneficiary and the caregiver(s).

However, we are concerned that several of these codes to train unpaid caregivers are typically performed by PT/OT/SLP professionals so unless there is Congressional action to permit therapists to perform telehealth services in 2025, beneficiary access to these valuable services via telehealth may be severely restricted.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) [89 FR 61817]

CMS is proposing several telecommunication technology flexibilities for opioid use disorder (OUD) treatment services furnished by OTPs, as long as the use of these technologies are permitted under the applicable SAMHSA and DEA requirements at the time the services are furnished, and all other applicable requirements are met.

- CMS is proposing to make permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, so long as all other applicable requirements are met.
- CMS is proposing to 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 methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.

AHCA Comment

- **We support the proposed modifications related to Medicare coverage of OUD treatment services furnished by OTPs.**

We believe that the positive impacts related to improved beneficiary access to OUD treatment services furnished by OTPs via telecommunication technology that occurred during and subsequent to the COVID-19 PHE, particularly in remote and underserved communities have been substantial and we support the proposal to permanently extend these policies.

C. Outpatient Therapy Provisions: CMS proposes certification burden reduction and other statutory required updates.

Outpatient Therapy Certification [89 FR 61737]

CMS proposes to revise the outpatient therapy physician certification requirements so that if during the first 30 days of care, if a signed and dated order/referral from a physician/NPP combined with documentation of such order/referral in the patient's medical record along with further evidence in the medical record that the therapy plan of treatment was transmitted/submitted to the ordering/referring physician or NPP, such documentation is sufficient to demonstrate the physician or NPP's certification of these required conditions. Rather than characterizing this proposal as a "presumption," CMS is taking the view that when the patient's medical record includes a signed and dated written order or referral indicating the type of therapy needed, CMS (and the CMS contractors) would treat the signature on the order or referral as equivalent to a signature on the plan of treatment. No separate physician signature on a certification statement would be necessary if the above documentation is present. CMS is not proposing to change the requirement for a physician signature on subsequent recertifications at this time but is requesting feedback on this topic for future rulemaking consideration.

AHCA Comment

- **We support the CMS proposal that a signed physician/NPP referral, along with documented evidence that a therapy plan of treatment was transmitted/submitted to the ordering/ referring physician or NPP within 30 days of the start of care, is sufficient to satisfy the initial outpatient therapy certification requirement.**

We appreciate the burden reduction intent of the CMS proposal that, subsequent to a documented referral/order, the submission of the therapy plan of treatment to the physician/NPP that occurs within 30 days of the start of care, can satisfy the initial certification requirement. This certification would be valid for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. Given the physician/NPP has the opportunity to review and modify the plan of care established by the therapist at any time, the current signature requirement subsequent to a valid referral/order adds unnecessary administrative burden for both the physician/NPP and the therapy provider. We welcome the removal of this burden that takes time away from patient care.

Regarding subsequent recertifications, we believe the current policy of permitting recertifications of up to 90 days as is permitted with initial certifications is reasonable. We request that if CMS is considering continuing the physician/NPP signature requirement for recertifications, then the Agency continue to make clear for medical review contractors that no specific form or format is necessary to meet the recertification requirement as is current policy. For example, if a physician/NPP signed therapy plan of care OR a physician/NPP signed referral/order contains all of the required elements listed in the Medicare Beenfit Policy Manual, Chapter 15, Section 220.1.2.B, specifically, Diagnoses; Long term treatment goals; and Type, amount, duration and frequency of therapy services, then the recertification requirement is met.

KX Modifier Thresholds [89 FR 61739]

The KX modifier thresholds were established through section 50202 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123, February 9, 2018) (BBA). For CY 2025, CMS proposes to increase the CY 2024 KX modifier threshold amount by 3.6 percent by law to $2,410 for physical therapy and speech-language pathology services combined and $2,410 for occupational therapy services. Once a beneficiary surpasses this annual threshold, the provider must add the KX modifier to outpatient therapy services as an attestation of medical necessity. Claims above this threshold without the KX modifier will be denied.

Additionally, Section 1833(g)(7)(B) of the Act describes the targeted medical review (MR) process for services of physical therapy, speech-language pathology, and occupational therapy services. The threshold for targeted MR remains at $3,000 through CY 2027.

AHCA Comment

- **We appreciate the publication of the statutorily updated threshold amounts for CY 2025.**

Outpatient Therapy Codes on Telehealth List [89 FR 61626]
CMS proposes to keep the current outpatient therapy codes on the provisional telehealth procedure list for further analysis and to be prepared in case Congress acts to permit PT, OT, and SLP clinicians to provide telehealth services beyond December 31, 2024.

AHCA Comment

- **While we are disappointed the outpatient therapy codes on the telehealth list were not made permanent, we appreciate that they remain on the provisional list to permit further evidence to be developed/presented.**

Value of Physical Medicine and Rehabilitation (Outpatient Therapy) Codes: [89 FR 61657]
CMS indicates the Agency reviewed data from the AMA CPT RUC panel and from the APTA and AOTA therapy associations regarding the practice expense portion of the therapy codes and proposes not to change the values at this time but welcomes comments on potential revisions in future rulemaking.

AHCA Comment

- **We are disappointed that the practice expense portion of the outpatient therapy codes were not updated to reflect current costs presented by the therapy professional associations, we appreciate that the Agency is welcoming further evidence to be developed/presented.**

D. E-Prescribing: Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan - Extended Compliance Date. [89 FR 61997]

Section 2003 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. L. 115-271, October 24, 2018) generally mandates that the prescribing of a Schedule II, III, IV, or V controlled substance under Medicare Part D be done electronically in accordance with an electronic prescription drug program beginning January 1, 2021. In prior rulemaking, CMS finalized policies for the Electronic Prescribing for Controlled Substances (EPCS) Program requirements specified in section 2003 of the SUPPORT Act. CMS finalized a policy to require prescribers to electronically prescribe at least 70 percent of their Schedule II, III, IV, and V controlled substances that are Part D drugs, except in cases where an exception or waiver applies. The implementation date applying to long term care (LTC) settings was delayed until January 1, 2025. However, due to numerous technical and administrative challenges described in the proposed rule, CMS proposes to extend the date after which prescriptions for covered Part D drugs for Part D eligible individuals in LTC facilities would be included in the CMS EPCS Program compliance threshold calculation from January 1, 2025, to January 1, 2028, and that related non-compliance actions would commence on or after January 1, 2028.

AHCA Comment

- **We support the CMS proposal to extend the EPCS program requirements physician prescribing compliance threshold from January 1, 2025 to January 1, 2028 to permit several necessary technical and administrative issues to be addressed.**
- **We request that CMS work with the ASTP/ONC, Congress, and SNF stakeholders to establish viable and cost-effective positive incentive approaches for SNF providers to be able to accept e-prescriptions covered under the EPCS e-prescribing rule provisions by January 1, 2028.**

While we welcome the CMS proposal to extend the physician compliance threshold for e-prescribing controlled substances to LTC facilities until 2028 due to numerous technical and administrative challenges noted in the proposed rule, instead of applying a burdensome waiver program for physicians that prescribe medications to LTC residents, we believe this is only a partial solution. We believe that CMS needs to work with the Assistant Secretary for Technology Policy Office of the National Coordinator for Health Information Technology (ASTP/ONC), Congress, and SNF stakeholders to establish viable and cost-effective approaches for SNF providers to be able to accept e-prescriptions covered under this rule by January 1, 2028.

By CMS' own estimates in the proposed rule, "*In 2022, approximately 4.7 percent (4.5 million) of Part D Schedule II, III, IV, and V controlled substance prescriptions were written for beneficiaries in LTC facilities, with roughly 52 percent (2.4 million) of them not meeting the CMS EPCS Program standards for e-prescribing."* In the proposed rule discussion, CMS recognizes that there are unique challenges in LTC settings in that effective and timely three-way communications between the physician, the LTC pharmacy, and the LTC facility itself may not be feasible due to incompatible health information technology between any or all of the three participants. Additionally, current manual work-arounds via portals add significant burden to physicians and pharmacies that serve multiple LTC facilities. This creates a risk for delays in LTC short- and long-stay residents receiving necessary medications in a timely manner, resulting in unnecessary pain and other negative clinical outcomes.

While CMS asserts a belief that the three-way communication in the NCPDP SCRIPT standard version 2023011 to be implemented prior to January 1, 2028 will improve communication of the controlled substance prescription as a medication order to the LTC facility's EHR when the pharmacy fills the prescription, this will only be feasible if the LTC facility's EHR vendor upgrades their capabilities and the LTC provider has the resources to update their EHR system to the script standard. Like other long-term and post-acute providers (LTPAC), LTC facilities were excluded from HITECH Act funding that hospitals and primary care providers obtained to upgrade to interoperable EHR technology, and LTPAC providers continue to be excluded from incentive programs that encourage the adoption of interoperable EHR technology. Therefore, unless there is more focus on providing positive incentives for LTC facilities to upgrade their systems, we are concerned that the adoption of the NCPDP SCRIPT standard version 2023011 in itself may not be sufficient to overcome these unique e-prescribing challenges in the LTC setting.

E. Medicare Shared Savings Program: [89 FR 61837]

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, particularly in rural and underserved areas. CMS notes that the totality of the proposals is expected to increase the number of beneficiaries assigned to ACOs by up to four million in the next 10 years, 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.

CMS is proposing several changes to strengthen the Medicare Shared Savings Program (MSSP) including discontinuation of ACO termination if assigned beneficiaries fall below 5,000, sharing MSSP application with antitrust agencies, updating definition of primary care services, allowing for a voluntary aligned beneficiary to be claims based aligned to a disease specific CMMI model under certain circumstances, modifications to beneficiary notifications, option for "prepaid shared savings" for certain ACOs, health equity benchmark adjustment and alternative payment model pathway to align the Shared Savings program with the Universal Foundation Measure Set, as well as proposals to minimize the impact of "Significant, Anomalous, and Highly Suspect (SAHS) billing activity".

AHCA/NCAL Comment

We urge CMS to:

- **Implement a mechanism for noting and updating a beneficiary's ACO assignment in the Common Working File (CWF). By integrating ACO assignment data into the CWF, healthcare providers and partners will have immediate access to crucial information about which ACO is responsible for a beneficiary's care. Timely identification of a beneficiary's ACO assignment will enable providers across various settings to seamlessly coordinate care especially during care transitions.**
- **Refine its beneficiary assignment methodology for high-cost, medically complex beneficiaries residing in nursing facilities, by allowing assignment at the facility level. This approach mitigates misalignment to historic community-based physicians and improves accountability and partnership.**
- **Establish a distinct track within the Medicare Shared Savings Program (MSSP) specifically designed for beneficiaries residing in residential settings, such as nursing facilities, and those with complex care needs 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. By eliminating the requirement, unnecessary hospitalizations are reduced, resulting in less disruption to beneficiaries and avoiding the risks associated with hospital stays for events that can be managed within the nursing facility at a higher level of care.**

AHCA/NCAL members are aligned with CMS' objective to prevent unnecessary care, enhance beneficiary outcomes and experience, and 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.

Beneficiary Assignment Methodology [89 FR 61843]
For the purposes of beneficiary assignment, CMS is proposing to apply an expanded definition of primary by adding a number of new HCPCS codes and CPT codes, including codes for safety planning interventions, post-discharge telephonic follow-up contacts intervention, virtual check-in services, advanced primary care management, cardiovascular risk assessment and risk management services, interprofessional consultation services, direct care caregiver training services, and individual behavior management/modification caregiver training services. With regards to the addition of the "advanced primary care management" codes, CMS affirms the furnishing of services "supported by a team-based care structure".

AHCA Comment

The team-based structure is the bedrock of care in a nursing facility or other residential care settings such as assisted living, where the primary care team fundamentally comprises the facility staff and the primary care physician or advanced practice professional. Effective care in a nursing facility requires a collaborative approach where facility staff and the primary care physician or NP work together seamlessly to ensure well-coordinated and responsive primary care. Similarly to CMS' recognition of the "advanced primary care management" codes, CMS should utilize the nursing facility as a key site of primary care, accounting for it in beneficiary assignment methodology for this high-cost, medically complex beneficiary population. Including the nursing facility TIN or CCN in beneficiary assignment methodology would not only facilitate greater partnership between ACO and nursing facility staff but would also mitigate issues in misalignment which occurs when new institutionalized beneficiaries are misaligned to their historic community based primary care providers. 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.

Proposed Revisions to Criteria for ACO Models to Waive Shared Savings Program Statutory Requirements Giving Precedence for Assignment based on Beneficiary Voluntary Alignment [83 FR 61851]
CMS is proposing to revise the MSSP regulations to expand a specific exception to the voluntary alignment policy. This revision would permit a beneficiary who is voluntarily aligned with an MSSP ACO to be assigned to an entity participating in a disease or condition-specific CMS Innovation Center model based on claims data, under certain conditions.

AHCA Comment

A key tenet of healthcare is respecting and honoring beneficiary choice. This principle underscores the importance of allowing beneficiaries to make informed decisions about their healthcare providers and care settings based on their preferences and needs. CMS's proposal to have claims-based assignment for certain CMMI disease or condition specific models for testing and evaluation purposes take precedence over beneficiary voluntary alignment while understandable in its intent, undermines the foundational principle of healthcare and is a concerning precedence. There are already concerns around beneficiaries being in ACOs via claims based alignment unknowingly and the idea of beneficiaries being placed in an ACO after they have made an affirmative choice, diminishes their autonomy in selecting their healthcare providers. Trust between patients and healthcare providers is crucial for effective care management and outcomes and should be protected. Prioritizing assignment for administrative reasons might disproportionately affect beneficiaries from marginalized or underserved populations, who may have fewer options or face additional barriers in accessing preferred care settings.

Prepaid shared savings: [89 FR 61869]
For certain ACO providers in Basic (levels C-E) and Enhanced tracks, with a history of success in earning shared savings, the opportunity for advance shared savings to invest in direct beneficiary services and care coordination services through staffing and healthcare infrastructure.

AHCA Comment

While conceptually we support the idea of advanced shared savings for ACOs with a history of success with the guardrails CMS has put forth i.e. 50 percent needs to be in direct beneficiary services, we are concerned that providers serving underserved or vulnerable populations might be disproportionately disadvantage. In addition, it will be critical that CMS monitor how these "direct beneficiary services" are implemented even though CMS has put restrictions on the direct beneficiary services as AHCA has observed issues with flex cards and cash benefits under the Part C program. For example, community-dwelling dual eligible beneficiaries are likely to benefit from health-related social needs support furnished by plans providing flex cards with funds designed to aid with rent, groceries, utilities, and other essential expenses. However, these additional benefits are unlikely to provide any differentiation/value for dual-eligible beneficiaries residing in an LTC facility. These additional benefits are most likely duplicative in this case, as the items additionally supported are those furnished as routine services compensated by the Medicaid room and board rate, however, are attractive to consumers and have sometimes been used as a marketing strategy to gain enrollment.

Similarly, D-SNP plans offering monetary healthy food supplemental benefits designed to assist community-dwelling beneficiaries have been observed marketing this offering to beneficiaries residing in assisted living settings. Given that most assisted living facilities provide structured dietary services, this is unlikely to generate unique value for beneficiaries residing in an assisted living facility. Additionally, certain supplemental benefits serve as inducements to family members and might attract an enrollee due to the benefit generated for a family member instead of the enrollees themselves, creating misalignment in the intent of the benefit and its utility.

Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set, Scoring Methodology, and Incentives to Report via electronic Clinical Quality Measures (eCQMs): [89 FR 62008]
In an effort to move the Shared Savings Program towards the Universal Foundation of quality measures, CMS is creating an alternative payment model performance pathway is proposing to create better quality measure alignment for providers and propelling care transformation.

AHCA Comment

We support CMS' goal to move towards improved quality measurement with a reduction in administrative burden and streamlining of measures. However, quality measurement presents significant challenges for nursing facility (NF) providers for several reasons. Establishing and assessing appropriate measures for this population is complex, identifying relevant reference populations can be difficult, and existing measures may not always align with the specific needs of residents in nursing facilities. As a result, ACOs serving beneficiaries in nursing facilities often appear as outliers on metrics that are primarily designed for the community-dwelling majority of Medicare beneficiaries, highlighting the limitations of these measures in capturing the quality of care in residential settings.

In the skilled nursing facility/nursing facility setting, measures that encourage hospital and SNF/NF partnerships focused on effective care transitions and discharge planning is critical. Measures that focus on the timely completion of discharge summaries by healthcare providers upon transfer from an acute

care hospital to the SNF/NF, inclusion of a comprehensive order set for admission to SNF and advanced care planning are some key measures for this beneficiary population. Further, CMS should promote measures that support meaningful shared savings and partnerships.

Skilled Nursing Facility 3-Day Rule Waiver

AHCA Comment

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.

For skilled nursing facilities (SNFs) accepting patients under the MSSP 3-day SNF waiver, several providers have encountered issues related to the accuracy of information provided by hospitals or hospital-based ACOs. For instance, SNFs have admitted patients based on referrals from ACOs or hospitals, believing these patients meet the waiver criteria. However, it was later been discovered that the patients did not have the required 3-day hospital stay for Medicare reimbursement, as they were not actually assigned to the referred ACO. Consequently, the SNF, having accepted the patient in good faith, faces denied claims and bears the financial burden of providing care without appropriate compensation. Currently, there is no process for SNFs to independently verify patient assignment, and feedback from AHCA members indicates that ACOs do not assume liability for inaccuracies in the provided information. To address this, we recommend that CMS enhance real-time data sharing between hospitals, ACOs, and SNFs to ensure accurate, up-to-date information about patient eligibility for the 3-day SNF waiver. Implementing a centralized system, such as including patient ACO attribution details in the Common Working File (CWF), would enable SNFs to access and verify patient data prior to admission. This improvement would streamline the coordination of care, enhance the accuracy of patient assignment information, and support better resource management for patients.

Future Policy Proposals

AHCA Comment

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.

F. Other Proposed Policies impacting AHCA/NCAL Members and Residents.

Portable X-Ray (HCPCS codes R0070-R0075) [89 FR 61662]

CMS indicated that several Portable X-Ray (PXR) suppliers and trade organizations continue to express longstanding concerns with how payment is established for transportation related to these services and are wanting more consistency in the pricing of these services, including the application of an inflation factor. This issue is creating portable x-ray access issues for nursing facilities in certain geographic areas. To remain consistent and transparent in the pricing of PXR services, CMS is proposing to revise language in our Medicare Claims Processing manual (Chapter 13, 90.3 and Chapter 23, 30.5) to reflect any updates to the Agency's guidance to the Medicare Administrative Contractors (MACs) for these services.

AHCA Comment

- **AHCA supports the proposal to improve Medicare Claims Processing Manual guidance to help assure that MACs apply appropriate inflation factor and other required updates to portable x-ray provider transportation costs.**
- **AHCA supports efforts and recommendations submitted by ADVION and other portable x-ray supplier groups for solutions above and beyond those proffered in this proposed rule.**

Many of our nursing facility providers in certain regions of the country, particularly in more remote locations, have reported increased difficulty in obtaining necessary portable x-ray services for residents due to portable x-ray suppliers limiting their service range as certain MACs have not adequately increased transportation-related reimbursement rates to account for inflation and other factors as is required by law. As a result, many of these beneficiaries must face the costs and disruptions to their daily life and sometimes interrupted rehabilitation care in order to be transported to a hospital or freestanding x-ray center to obtain needed images.

We believe this CMS proposal is a first step in addressing this beneficiary access issue. Additional policy refinements could include those being offered by ADVION and other portable x-ray supplier groups in their comments including:

1. Ensure that MAC rate setting of portable x-ray transportation is consistent with statutory requirements for MPFS-paid services and reflects all direct and indirect costs.
2. Establish guardrails regarding the periodic review process to ensure these are conducted in a timely and transparent manner.
3. Require transparency regarding the annual update, including the rationale for the index.
4. Consolidate and reorganize the two MCPM sections related to PXR transportation (Ch. 13, 90.3 and Ch. 23, 30.5) so that MACs and PXR suppliers have a single guidance document.

Finally, CMS should also monitor the MAC compliance to the guidance closely and implement immediate steps to intercede if the MACs persist in providing inadequate reimbursement for these services.

Clinical Laboratory Fee Schedule (CLFS) [89 FR 61809]

Clinical laboratory rates are due for significant reductions that could impact access to these services for certain nursing facilities. On November 17, 2023, section 502 of the Further Continuing Appropriations and Other Extensions Act, 2024 (Pub. L. 118-22) (FCAOEA, 2024) was passed and delayed data reporting requirements for CDLTs that are not ADLTs, and it also delayed the phase-in of payment reductions under the CLFS from private payor rate implementation under section 1834A of the Act.

CMS proposes the change data collection periods to base the cuts from and then to make conforming changes to the phase-in of payment reductions requirements to indicate that for CY 2024, payment may not be reduced by more than 0.0% as compared to the amount established for CY 2023, and for CYs 2025 through 2027, payment may not be reduced by more than 15% as compared to the amount established for the preceding year. This proposal reflects amendments to section 502(a) of the Further Continuing Appropriations and Other Extensions Act, 2024 (FCAOEA, 2024).

AHCA Comment

- **We recognize that the CMS proposed conforming regulatory changes are merely to comply with updated statutory requirements, however we remain concerned about access to care and quality of care issues for nursing home residents resulting from significant payment cuts to some clinical laboratory services of up to 15 percent per year.**

Short-term and long-term residents of nursing facilities typically have a complex array of post-acute and chronic conditions that often require clinical laboratory services to identify new conditions or to monitor the beneficiary's body's reaction to specific care interventions. While some clinical lab services can be furnished in the facility under CLIA waivers, most clinical lab services for nursing facility residents are furnished by outside laboratories that come to the facility and see the resident bedside, or the resident must face the costs and disruptions to their daily life and sometimes interrupted rehabilitation care in order to be transported to a hospital or clinical laboratory to obtain needed laboratory services. Access to these services may be disrupted, or the beneficiary might be required to travel further to obtain clinical lab services if nearby labs close or consolidate due to significantly reduced reimbursement.

Dental Services [89 FR 62167]

CMS is proposing to amend regulations at § 411.15(i)(3) to add to the list of clinical scenarios under which FFS Medicare payment may be made for dental services inextricably linked to covered services to include: (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease; and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with end-stage renal disease.

AHCA Comment

- **AHCA supports the proposed expansion of coverage for dental services for persons with certain end-stage renal disease needing dialysis services.**

Many residents of nursing homes and assisted living residences with end-stage renal disease requiring dialysis also have dental disease that may result in infections and other complications that can impair the effectiveness of the dialysis intervention. We applaud that CMS continues to expand the coverage of dental or oral examinations, and any necessary dental interventions to prevent/eliminate oral or dental

infections which will help prevent poor health outcomes and more costly care interventions for persons requiring dialysis care.

Expand Hepatitis B Vaccine Coverage [89 FR 62167]

CMS proposes to expand coverage of hepatitis B vaccinations by covering individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown. This proposal is intended to protect Medicare beneficiaries from acquiring hepatitis B infection and contribute to eliminating viral hepatitis as a viral health threat in the United States. If the proposed coverage expansion of hepatitis B vaccines under Part B is finalized, CMS clarifies that a physician's order would no longer be required for the administration of a hepatitis B vaccine in Part B, which would facilitate roster billing by mass immunizers for hepatitis B vaccine administration.

AHCA Comment

- **We support the proposal to expand coverage of hepatitis B vaccinations including the elimination of the requirement for a physician's order.**

We applaud the CMS proposal to make it easier for Medicare beneficiaries to obtain hepatitis B vaccinations under Medicare Part B preventive services coverage. We understand that as a preventive services vaccine, this expanded coverage would not be subject to SNF consolidated billing requirements.

Medicare Parts A and B Overpayment Provisions of the Affordable Care Act [89 FR 62004, 62104, 62157]

Currently, Section 1128J(d)(2) of the Act requires that an overpayment be reported and returned by the later of: (1) the date which is 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. Section 1128J(d)(3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation (as defined in 31 U.S.C. 3729(b)(3)) for purposes of the False Claims Act, 31 U.S.C. 3729. CMS proposes several changes to reporting and repayment timelines and exceptions circumstances associated with overpayments. The net impact is to provide an option for providers to be able to have the opportunity to have an overpayment reporting deadline suspended following the completion of a timely, good faith investigation under the following circumstances:

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

If the conditions above are satisfied, the deadline for reporting and returning the initially identified overpayment and related overpayments that arise from the same or similar cause or reason as the initially identified overpayment will remain suspended until the earlier of:

(A) The date that the investigation of related overpayments has concluded and the aggregate amount of the initially identified overpayments and related overpayments is calculated; or
(B) The date that is 180 days after the date on which the initial identified overpayment was identified.

AHCA Comment

- **We support the proposals to create a process to suspend overpayment reporting timelines in circumstances where good-faith efforts are being made in complex situations.**

A significant portion of our skilled nursing provider members are smaller single-owner facilities that operate on razor-thin margins and have limited personnel resources to conduct comprehensive internal investigations of overpayments withing the current 60-day limits. Additionally, larger multi-facility SNF organizations may have centralized personnel to support such internal investigations, but they often have a higher Medicare claims volume that also creates challenges in investigating the potential existence off related overpayments within the current 60-day limits. We believe the proposed policies to suspend the deadline to up to 180 days would provide much needed and appropriate relief to providers attempting to 'do the right thing'.

Conclusion

AHCA/NCAL appreciates the opportunity to comment on these proposed CY 2025 Medicare Physician Fee Schedule and other related policy change provisions impacting AHCA/NCAL member nursing facility, assisted living and ID/DD residences and the Medicare beneficiaries residing in their communities. Should you have questions or need additional information, please feel free to contact me at dciolek@ahca.org.

Sincerely,

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Associate Vice President, Therapy Advocacy