AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 11, 2023

The Honorable Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: CMS-1784-P 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

Dear Administrator Brooks-LaSure:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Agency's Calendar Year (CY) 2024 Payment Policies Under the Physician Fee Schedule (PFS) proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include nearly 100 hospitals and more than 600 other health care facilities across the nation.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographic locations, we strive to provide objective and sound policy recommendations that work well for health care as a whole.

Daily, we observe the unique benefits that the Medicare and Medicaid programs offer to patients, their families and health care systems. AHPA seeks to provide an informed policy voice that. reflects our experience delivering whole person care to these communities. Specifically, we offer comments to CMS on the following issue areas within the CY 2024 PFS proposed rule:

- Payment Update
- New Medical Billing Codes
- Telehealth Services
- Behavioral Health
- Quality Payment Program
- Medicare Shared Savings Program
- Appropriate Use Criteria

Payment Update

This year's proposal will reduce the PFS conversion factor by 3.34 percent or to $32.75, compared to $33.89 in CY 2023. The update reflects a 1.25 percent decrease to PFS payments for CY 2024 as required by the Consolidated Appropriations Act (CAA) of 2023 and a 2.17 percent budget-neutrality adjustment.

AHPA is concerned as this update continues a trend of negative adjustments that started in 2021. We fear that further payment reductions will have a negative impact on patients' access to care and providers' viability. While AHPA understands that this payment reduction can only be stopped through Congressional action, we encourage the Agency to reassess any proposed reductions to Relative Value Units (RVUs). **We firmly believe, given the pending payment reductions, today's inflation and the rising costs of labor, that the Agency should abstain from making any further payment reductions. We also strongly recommend that CMS delay its implementation of complexity add-on code G2211. Delaying this cut would help to increase the conversion factor, minimizing payment reductions for clinicians.**

New Medical Billing Codes

AHPA supports CMS' proposals to include additional billing codes under the PFS that compensate providers for the work they already do to best serve those with complex medical needs and SDOH concerns and their caregivers. Additionally, AHPA recommends that CMS consider ways to better align data collection requirements and reimbursement across Medicare payment systems.

For example, hospital staff may conduct social risk screening during a patient's inpatient stay as part of the Inpatient Quality Reporting program and receive no additional reimbursement to fulfill this requirement. Yet, the same patient may be screened by a provider in an outpatient setting who would be able to bill under the PFS for the new SDOH Risk Assessment code, if finalized as proposed. **AHPA believes it is critical that important social risk factor data is captured as efficiently as possible by the right provider in the right setting. CMS should consider whether requiring any additional data collection without adequately adjusting reimbursement is equivalent to an unfunded mandate.**

Below we offer additional comments regarding the specifics of the billing proposals.

Add-on Code for Visit Complexity

During CY 2021 rulemaking, CMS established a new add-on code for the management of complex patients, G2211, that could be reported with office and outpatient (O/O) Evaluation and Management (E/M) codes. The primary goal of G2211 is to increase payments to primary care physicians and to reimburse them more appropriately for the care they provide to highly complex patients. At the time, CMS estimated that implementing G2211 would increase PFS spending by $3.3 billion, requiring a corresponding 3.0 percent cut to the CY 2021 PFS conversion factor to ensure budget neutrality. Given the significant projected impact, Congress imposed a moratorium on Medicare payment for G2211 before January 1st, 2024 in the Consolidated Appropriations Act of 2021.

For 2024, CMS proposes to implement the new G2211 code and decrease its prior utilization assumption from 90 percent to 38 percent. CMS does note that approximately 90 percent of the -2.17 percent budget neutrality adjustment to the PFS for 2024 is attributable to CMS' estimated impacts from G2211.

As mentioned above, AHPA recommends that CMS delay the implementation of this complexity add-on code. While we appreciate that CMS is trying to better compensate providers for the work they do managing complex medical needs, the budget neutral mandate will only shift the issue of low compensation to other provider types. Increasing payment to a select group of providers at the expense of others is short sighted and will ultimately restrict access to care. Last year, CMS also stated its intent to tie 100% of reimbursements to value-based contracts by 2030. This means that by 2030, most Medicare beneficiaries would be receiving care through an alternative payment model in which payments are already risk-adjusted for complex patients.

Payment for Caregiver Training Services

CMS requests comments about establishing a new payment for caregiver training services (CPT codes 96202, 96203, 9X015-9X017). For 2024, CMS proposes to allow payment for behavioral management/modification training for guardians or caregivers of patients with a mental or physical health diagnosis (CPT codes 96202 & 96203) and Caregiver training in strategies and techniques to facilitate the patient's functional performance (CPT codes 9X015-9X017) based on an established therapy plan.

AHPA supports this proposed policy and strongly recommends that CMS finalize it. We believe that support for caregiver behavior management training will result in better patient outcomes.

Services Addressing Health-Related Social Needs (HRSNs)

CMS proposes to create new provider billing mechanisms for three types of social need-related services: Community Health Integration (CHI), Principal Illness Navigation (PIN) and Social Determinants of Health (SDOH) Risk Assessments. Specifically, CMS proposes to create:

- Two new G-codes describing CHI services performed by certified or trained auxiliary personal, which may include a Community Health Worker, incident to the professional services and under the general supervision of the billing practitioner.
- Reimbursement for PIN services parallel to the proposed CHI services, but focused on patients with a serious, high-risk illness who may not have SDOH needs.
- An HCPCS code for the work involved administering an evidence based SDOH risk assessment when medically reasonable and necessary in relation to an E/M visit to inform the diagnosis and treatment plan.
- An add-on payment for administering an SDOH risk assessment as part of an Annual Wellness Visit (AWV).

AHPA commends CMS for its work on advancing health equity and tying reimbursement to efforts aimed at identifying social drivers of health. While we are energized by the work that CMS has undertaken to identify SDOH needs among patients, we would also like to encourage CMS to consider *how* to better address the identified needs in the patient population. For example, Community Referral Software (CRS) can be an expensive investment for many providers. For the providers that have established CRS in their system, there is no guarantee that Community Based Organizations (CBOs) will be able to accommodate the referrals or document that a patient's need was addressed. These issues can result in lengthy bottlenecks that make it difficult to address the SDOH needs identified through a provider's SDOH assessment tool. To at least strengthen the infrastructure needed to successfully address individuals' SDOH needs, CMS should work with Congress to dedicate funds aimed at increasing the capacity of CBOs tackling SDOH needs such as housing and food security. Separate financing, like the advanced health equity payments provided by CMS in the REACH model, should also be considered to help providers acquire CRS tools. This approach would be similar to the one taken by CMS when it developed the Meaningful Use Program, now called the Promoting Interoperability (PI) program, to help providers purchase Electronic Health Records (EHRs).

Below we offer additional comments regarding the specifics of the CHI, PIN and SDOH Risk Assessment proposed payments.

Community Health Integration

The CHI codes would describe services furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit. In the case of both CHI and PIN services, CMS is proposing that a billing practitioner may arrange to have the services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a CBO that employs Community Health Workers (CHWs) and peer support specialists. There must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be provided in this way. The billing practitioner must document in the medical record that CHI services were ordered and any activities conducted to address the SDOH need identified.

AHPA supports reimbursement for CHI services and new codes for assessing SDOH. We recommend that CMS expand the criteria for who can make the determination and bill for CHI codes. For example, given the current mental health care access crisis, it is important that CMS allow reimbursement of CHI services provided under the supervision of a clinical psychologist or "incident to" the services of a psychologist.

Additionally, we recommend that CMS clarify in the final rule whether solely providing a referral to a CBO for addressing the patient's identified SDOH need would make a practitioner eligible for the added payment. In the rule, CMS provides an example of how CHI services for a homeless patient would be documented. The rule states, "The PCP's auxiliary personnel provide tailored support, comprised of facilitating communication between the patient, local shelters, and the friend, to help the patient identify a single location to reliably store their medication while applying for local housing assistance. The auxiliary personnel document these activities (including amount of time spent) in the medical record at the PCP's office, along with periodic updates regarding the status of the patient's housing assistance application." As mentioned earlier, even for providers that have CRS in place, it's sometimes difficult to get responses from CBOs confirming that the patient received the help needed. Most CBOs are working at maximum capacity and may not have the necessary resources or personnel to respond to the referrals in a timely manner. There is also a shortage of community-based resources, particularly in rural areas, for addressing homelessness, food insecurity, or lack of adequate

transportation. Clinicians and their auxiliary personnel may also not have the time and resources to make regular phone calls and follow ups to a CBO or local agency in order to update the medical record. Requiring clinicians to close the referral loop in order to be eligible for the added payments would significantly reduce the utilization of these codes.

SDOH Risk Assessment

CMS is proposing separate codes and payment for SDOH Risk Assessments but only when furnished on the same day as an Evaluation and Management (E/M) visit, such as during the Annual Wellness Visit.

AHPA supports the creation of a stand-alone payment code for SDOH as part of an E/M visit and also as part of an AWV. However, CMS should not stipulate that SDOH Risk Assessments can only be furnished in conjunction with an E/M visit. CMS should give *all* eligible health care providers an equal opportunity to participate in initiatives aimed at providing whole-person care.

New Care Management Codes Billable as G0511

CMS proposes to further expand services billable by RHCs under the G0511, general care management code. If finalized, beginning in 2024, the G0511 code will be the special payment code that represents over 20 care managements services.

AHPA is concerned with this proposal as we fear it will limit RHCs' ability to utilize the G0511 code. The challenge for RHC stems from the Medicare Claims Processing Manual and a 2019 FAQ that state that "RHCs and FQHCs can only bill one care management service for an individual per month." Therefore, if an RHC patient is already enrolled in a clinic's Chronic Care Management (CCM) program, regardless of whether they may benefit from additional services, the RHC will only be eligible for one G0511 reimbursement for that patient each month. This differs from fee-for-service flexibilities, in that FFS providers can bill Remote Patient Monitoring (RPM), CCM, CHI and PIN all for the same patient, in the same month, so long as time and services are not duplicative.

AHPA recommends that CMS allow G0511 to be billed multiple times per patient per month, using modifiers to indicate which care management service was provided. RHCs would be subject to the same rules as fee-for-service providers as to which services could be billed in the same month, and which

were mutually exclusive. **Alternatively, CMS could create a more comprehensive set of G-codes that are separated by service type or by time.**

Telehealth Services

Extension of Virtual Supervision Flexibilities

CMS proposes to continue, until December 2024, certain flexibilities not extended by Congress through the Consolidated Appropriations Act of 2022 (CAA), such as:

- Allowing real-time audio and visual communications to satisfy direct supervision requirements for presence and "immediate availability" of the supervising practitioner. CMS seeks feedback on whether this flexibility should be made permanent, including whether this should be allowed only for a subset of services.
- Continue reimbursement of telehealth services provided in a patient's home (Place of Service 10) to be reimbursed at the higher, non-facility PFS rate.
- Removing the telehealth frequency limitations until CY 2024.

AHPA strongly recommends that CMS finalize these proposed policies as they will help to ensure continuity of care. Additionally, we strongly encourage CMS to also extend current payment for telehealth services provided outside of the patient's home until December 2024. This policy would eliminate the confusion and complexity of having to comply with different flexibilities' end dates while also maintaining access to care for patients. For example, AHPA providers are able to connect patients visiting our hospitals with behavioral health professionals that may not be available in certain communities.

We urge CMS to also finalize its "immediate availability" proposal and to not limit this flexibility to a particular subset of services unless there is an evidence-based safety or efficacy concern. Hospitals and health systems are currently making strategic workforce development and staffing decisions to deal with ongoing labor shortages. Offering permanency for this flexibility would allow longer-term strategic planning.

We recognize that CMS has limited authority to expand telehealth services following conclusion of the current Congressional expansion, which is set to expire in December 2024. Therefore, we urge CMS to

continue to work with Congress to adopt broader telehealth reforms and enhanced telehealth reimbursement coverage.

AHPA requests guidance for Rural Health Clinic (RHC) providers as to whether telehealth visits for which the RHC provider serves as the distant site are limited to only occurring during RHC hours of operation. To fully offer the benefits of telehealth flexibilities to patients, AHPA believes that RHCs should not be limited to only the hours of operation of the physical RHC.

Behavioral Health

To support the goal of expanding access to behavioral healthcare, CMS proposes several regulatory changes to covered Medicare benefits and billing requirements, including:

- Allowing addiction counselors to enroll as Mental Health Counselors (MHCs).
- Establishing new HCPCS codes for psychotherapy for crisis services that are furnished in an applicable site of service, including the home or a mobile unit (required by CAA, 2023).
- Allowing clinical social workers, Marriage and Family Therapists (MFTs) and MHCs to bill for Health Behavior Assessment and Intervention Services.
- Amending the hospice Conditions of Participation to allow social workers, MFTs and MHCs to serve on hospice interdisciplinary groups.

AHPA applauds CMS' continued commitment to improving access, quality and equity in behavioral healthcare for Medicare beneficiaries. We ask that CMS continue to examine whether additional behavioral health provider types could appropriately provide Medicare benefits to beneficiaries as well, further expanding access and alleviating critical workforce shortages.

Adjustments to Payment for Timed Behavioral Health Services

CMS is examining several dynamics in its processes for developing values for behavioral health services under the PFS. The agency acknowledges that any potential systemic undervaluation could serve as an economic deterrent to furnishing these kinds of services and be a contributing factor to the workforce shortage. A report suggests that there may be systemic overestimations of times for these services within the PFS, which would lead to overvaluation of these services and, by implication, undervaluation of other

services.[1] Given the emerging need for access to behavioral health care and difficulties in behavioral health workforce capacity, CMS is proposing to take steps to improve the accuracy of the valuation of these services until it can develop longstanding process limitations.

CMS is proposing to address the need for improvement in valuation for timed psychotherapy services in such a way that considers the policy it finalized to address valuation distortions for primary and longitudinal care through implementation of an add-on code for Office/Outpatient (O/O) E/M services that involve inherent complexity. CMS would apply an adjustment to the work RVUs for the psychotherapy codes payable under the PFS. This adjustment would be based on the difference in total work RVUs for O/O E/M visit codes (codes 99202–99205 and 99211–99215) billed with the proposed inherent complexity add-on code (HCPCS code G2211) compared to the total work RVUs for visits that are not billed with the inherent complexity add-on code. This would result in an approximate upward adjustment of 19.1 percent for work RVUs for these services, comparable to the relative difference in O/O visits that are also systemically undervalued absent such an adjustment, which CMS proposes to implement over a 4-year transition.

While AHPA supports CMS' proposal to increase the work values for the psychotherapy codes, we recommend that CMS also increase these values for the HBAI and Psychological and Neuropsychological Testing services. These services are systematically undervalued and warrant increases. The reimbursement discrepancy will negatively impact patient access to these critical services. Inadequately low valuations for testing services will force highly qualified neuropsychologists to make tough financial decisions about whether they can afford to see Medicare patients. Medicare payment rates are already considered low and an increasing disparity in work values will have a financial impact on practitioners and ultimately lead to reductions in behavioral health services provided to those who are in need.

[1] Urban Institute, Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units

Updates to the Payment Rate for the PFS Substance Use Disorder (SUD) Bundle

To update the valuation for these two codes, CMS is proposing to increase the current payment rate to reflect two individual psychotherapy sessions per month.

AHPA supports the increased reimbursement for psychotherapy services in the substance use services bundle. Despite some progress over the past several years, the substance use disorder crisis continues to devastate many communities, and this measure will help ensure continued access to common forms of substance use treatment.

Payment for Psychotherapy for Crisis Services

CMS is proposing to create two new HCPCS codes describing psychotherapy for crisis services furnished in any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting.

AHPA supports this proposal and commends CMS for expanding flexibilities that make it easier for patients to receive care wherever they are. A population health approach treats the health of community members wherever they are and often demands provision of services in non-traditional settings.

Request for Information on Expanding Behavioral Health Access

CMS seeks comment on whether there is a need for potential separate coding and payment for interventions initiated or furnished in the emergency department or other crisis setting for patients with suicidality or at risk of suicide, such as safety planning interventions and/or telephonic post-discharge follow-up contacts after an emergency department visit or crisis encounter, or whether existing payment mechanisms are sufficient to support furnishing such interventions when indicated.

AHPA is encouraged by CMS' request for comments on additional coding and payment for evidence-based interventions for patients at risk of suicide. **We urge CMS to work with the American Psychological Association Services and other medical societies to develop new codes for brief interventions and safety planning for patients at risk of suicide in the emergency department and other settings.**

To improve the sustainability and quality of our nation's behavioral health workforce, AHPA believes it is vital to stress the importance of also growing our academic workforce and research.

Quality Reporting Program

CMS is proposing to modify the Qualifying APM Participants (QP) determinations at the individual clinician level instead of at the APM entity level based on the collective performance of clinicians on an APM's Participant List, as it currently functions.

AHPA does not support this proposal of solely calculating QP status at the individual clinician level, as this may create undue burden on providers and APMs and may not achieve CMS' intended purpose. Specialists do not attribute significant alignment to APMs. As a result, many specialists would not achieve QP status at the individual level, despite their active engagement with an APM. Additionally, transitioning to individual QP determinations may create administrative burden on APMs as they rearrange participation lists based on who meets QP thresholds.

Medicare Shared Savings Program

CMS proposes to establish a new quality collection type, the Medicare Clinical Quality Measures (CQMs) – beginning with PY 2024 to aid Accountable Care Organizations (ACOs) in transition to reporting Electronic CQMs (eCQMs)/Merit-Based Incentive Payment System (MIPS) CQMs under the new Alternative Payment Model (APM) Performance Pathway (APP). CMS believes the proposed policy will address stakeholder concerns by only requiring reporting on the ACO's assignable population (vs. all payer/all patient eligible population, as required under the eCQM or MIPS CQM reporting options.) The policy is intended to be transitional and provide ACOs with time to build the required infrastructure to report broader eligible populations.

AHPA appreciates CMS's attempt to address ACO concerns regarding the all payer/all patient reporting, but is concerned that the proposed policies do not ultimately address the underlying challenges with eCQM / MIPS CQM reporting under the APP. We ask that CMS consider the current limitations of EHRs and burden associated with eCQM reporting. In order to report eCQMs, ACOs will be required to aggregate data across multiple Tax Identification Numbers (TINs) and EHR systems. It is

critically important to understand that ACOs vary widely in their electronic data extraction and aggregation capabilities. Some ACOs have a single EHR that covers the entire organization, but more commonly ACOs have multiple different EHR instances across the organization – in some cases, numbering well over 100 different EHR instances. For ACOs with multiple EHRs, producing eCQMs from those disparate systems requires time, money and effort in changing workflows and acquiring new technology services.

Additionally, Certified EHR Technology (CEHRT) standards have not advanced enough to support quality measurement derived from multiple sources. The interoperability standards aim to ease data sharing across providers; however, these standards are still under development and evolving. As a result, aspects of the ACO quality policies are not feasible in current systems. For example, CEHRT only allows for reporting eCQMs from a single EHR. As a result, combining data from multiple EHRs to produce a single result is not a capability that most ACOs have. Similarly, CMS requires that ACOs submit deduplicated patient data. However, at this time there is no technical way to deduplicate data when submitting aggregated Quality Reporting Document Architecture (QRDA) III files, since these files do not have patient-level data. Several vendors have indicated that modifications to their EHR systems to support revised MSSP quality reporting requirements will not be available until 2024 at the earliest. Even if these systems are available next year, ACOs will need time to adopt and test these changes.

AHPA recommends that CMS ensure a more gradual transition to these new requirements and continue to collect more data and stakeholder feedback prior to sunsetting the CMS Web Interface and requiring reporting of eCQMs/MIPS CQMs. Digital quality measurement is the goal but an adequate transition is needed.

We would also like to stress how these changes might lead to health care systems deciding that the program is no longer advantageous and that other models, like REACH, would be a better alternative. While we understand that CMS is intending to strengthen the program, these new requirements may inadvertently backfire and degrade the MSSP program.

Historical Data to Establish the 40th Percentile MIPS Quality Performance Category Score

CMS proposes to establish the 40th percentile MIPS quality performance category score by using a three-year average of historical data, beginning for PY 2024. Specifically, for a given performance year, CMS

would average the 40th percentile scores from three consecutive prior performance years with one lag year. For example, PY 2024 would be based on the average of MIPS performance category scores from PYs 2020-2022. Under the proposal, CMS would provide ACOs with this threshold prior to the start of the performance year.

AHPA does not support the establishment of the 40th percentile MIPS quality performance category score. We believe that this will make it increasingly difficult for ACOs to participate in the program. Instead, we recommend that CMS maintain the current threshold.

Align Certified EHR Technology (CEHRT) Requirements for MSSP ACOs

MSSP ACOs are currently required to certify at the end of each performance year the use of CEHRT by their participating clinicians. These requirements differ depending on if an ACO is in a track of MSSP that meets the financial risk standards to be considered an Advanced APM.

In this year's rule, CMS proposes that MIPS-eligible clinicians, qualifying APM participants (QPs) and Partial QPs participating in an ACO, regardless of track, would be required to meet and report the MIPS Promoting Interoperability (PI) performance category requirements. Under this policy, CMS would sunset the current MSSP requirements at the end of PY 2023 and would instead require reporting of the MIPS PI performance category measures (and scoring) either at the individual, group or virtual group level or by the ACO as an APM entity, beginning with PY 2024. CMS also seeks comment on an alternative policy of requiring ACOs to report on the PI performance category at the APM entity level.

AHPA opposes this proposal as it would add undue burden on ACOs that are already overburdened and facing upcoming changes which will impact their stability, including the expiration of Advanced APM Incentive Payments at the end of CY 2023. Additionally, QPs in an Advanced APM are exempt from MIPS, which is a valuable incentive for clinicians to join an Advanced APM. Removing this incentive and requiring these clinicians to meet MIPS PI requirements would be counter to CMS' overall stated goal for all Medicare fee-for-service beneficiaries to be part of care relationships with accountability for quality and total costs by 2030.

Cap Regional Services Risk Score

CMS proposes to make two changes to how it applies its risk adjustment methodology. First, CMS now accounts for changes in the demographic risk score for the ACO's beneficiary population from BY 3 to the performance year prior to applying the 3 percent cap. Second, CMS now applies the 3 percent cap in aggregate across the four Medicare enrollment types, which will allow the risk score for individual enrollment types to increase by more than 3 percent, so long as the ACO does not hit the cap in aggregate.

AHPA urge CMS to increase the risk score cap to 5 percent and to apply a symmetrical cap on decrease in risk score. Increasing the cap to 5 percent will better account for changes in risk score over the agreement period. The current methodology of normalizing risk adjustment in a region can penalize ACOs that have been coding accurately and that maintain the same level of risk over their agreement period. Under this scenario, an ACO could see a decrease in their risk score if others in their region increase their coding intensity. This issue is further exacerbated for ACOs that include a large number of specialists, since they have less opportunities to increase their risk score. CMS has previously indicated that it is hesitant to introduce a cap on decreases in risk score because it is concerned it could create a gaming opportunity for ACOs.

AHPA continues to implore CMS to let ACOs identify participant providers at the NPI/TIN combination level in the MSSP program, rather than at the TIN level. This is how programs like ACO REACH and Primary Care First operate. As a healthcare system that participates in multiple CMS value-based programs, AdventhHealth desires consistency in the program specifications, including this one, to allow for large systems to participate without needing to create different legal entities for participation and allow for systems to use their models that may include primary care providers, specialists, APPs and others who operate under one TIN as the current structure results in the inadvertent inclusion of providers who are not the target of our primary care education and initiatives designed to drive better MSSP performance

Further, in the MSSP program, APPs that work for specialty practices are treated as though they are primary care providers, resulting in attribution of oncology and transplant patients who should be receiving evidence-based care for their diagnosis, not care dictated by efficiency standards. This is due to CMS's inability to identify APPs at a taxonomy level that specifies if they do primary care or specialty work.

The inability of CMS to identify APPs at the primary care or specialty line of work has negative implications to the Primary Care First model as well, which counts, for example, dermatology services performed by an APP as a primary care service, whereas dermatology services performed by a dermatologist are counted as specialty services. This results in the PCF practice being negatively impacted with a leakage adjustment over a service that cannot be redirected in house to the attributed primary care provider. This penalty does not exist in the ACO REACH model, and demonstrates another area where consistency is needed across the models.

Appropriate Use Criteria

CMS proposes to pause implementation of the AUC program for re-evaluation, and to rescind the current AUC regulations. CMS notes that the agency feels it has exhausted all reasonable options for fully operationalizing the AUC program consistent with the statutory provisions requiring real-time claims-based reporting to collect information on AUC consultation for advanced diagnostic imaging services. Further, CMS states that it expects the program reevaluation to be difficult and time-consuming and thus does not propose a timeframe for recommencing implementation.

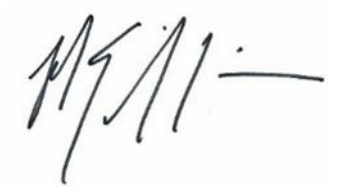
AHPA recognizes the challenges that CMS faces with operationalizing the real-time claims processing aspect of the AUC program. However, providers have already made significant financial investments to comply with the AUC program. **Rescinding this program could set the precedent that the agency can reverse course at any time and negate the significant investments that providers have made to achieve compliance before the enforcement deadline. Therefore, we recommend that CMS not rescind the current AUC regulations and opt to delay implementation until a viable solution can be achieved.**

We recommend that CMS explore the possibility of contracting with a third-party to help operationalize the AUC program and ensure compliance with statutory requirements. There is no apparent statutory provision precluding CMS from seeking proposals from the private sector to develop a claims processing system that does what the statute requires, which the agency may later incorporate into its rulemaking as a proposal subject to public comment. We encourage CMS to work with Congress to advance legislation to enable implementation of a Medicare payment model for advanced diagnostic imaging based on the use of AUC embedded in clinical decision support software.

Conclusion

AHPA welcomes the opportunity to discuss further any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Susana Molina, Director of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,



Michael E. Griffin
President
The Adventist Health Policy Association