PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

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September 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

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]

Dear Administrator Brooks-LaSure:

The Post-Acute and Long-Term Care Medical Association (PALTmed) (formerly known as AMDA-The Society for Post-Acute and Long-Term Care Medicine) appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) on the 2025 Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies proposed rule, published in the *Federal Register* on July 31, 2024.

PALTmed is the only medical association representing the community of medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. PALTmed's members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings. In serving this population, these clinicians care for the most high-risk and costly group of beneficiaries covered by Medicare and Medicaid programs.

We would like to offer the following specific comments and recommendations in response to the CMS proposals:

CY 2025 PFS Rate Setting and Medicare Conversion Factor

The 2025 Medicare conversion factor is proposed to be reduced by 2.80 percent from $33.2875 to $32.3562. This cut comes at a time when there is an increased need for clinicians to enter the PALTC settings. The cut to Medicare physician payments starting January 1, 2025, along with the estimated rise in costs of practicing medicine, as measured by the Medicare Economic Index (MEI), will increase by 3.6 percent. In other words, while the costs of paying clinical and administrative staff, and purchasing equipment and supplies are projected to rise by 3.6 percent, physicians'

payments will decrease by nearly three percent. Yet, this proposed rule is silent on the impact of the growing gap between what Medicare pays for care and what it costs to provide that care. It is past time for CMS to join the chorus of authorities on the Medicare program in expressing concern about the ability of patients to continue receiving high-quality care as physician payments erode. We urge CMS to call on Congress to enact a permanent, annual inflation-based update to Medicare physician payments tied to the MEI. At a minimum, CMS must be fully transparent with the public about the impact of these payment cuts by including the expiration of temporary statutory increases to the conversion factor in the specialty impact table.

According to the Medicare Trustees and the Medicare Payment Advisory Commission (MedPAC), if physician payment does not change, access to Medicare-participating physicians will become a significant issue in the future. In their 2024 report, the Medicare Trustees again reiterated their concern that, without Congressional action to change the delivery system or level of payment update, "the trustees expect access to Medicare participating physicians to become a significant issue in the long-term." In the June 2024 Report to Congress, MedPAC specifically addresses the gap between the costs of providing care and Medicare payment and states, "[t]his larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat or stop participating in Medicare entirely." MedPAC also expressed concern about how the lack of an inflation-based update for physician payment is exacerbating the site of service differential, which distorts competition and could increase vertical consolidation, increasing spending by the Medicare program, patients, and taxpayers. As a result, organized medicine strongly supports the swift passage of H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," bipartisan legislation that would provide an annual physician payment update in Medicare tied to the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care. We hope the agency will work with PALTmed and Congress to seek this legislative relief. This would enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care. These concerns stem from the disparity between Medicare physician payment rates and the actual costs associated with delivering high-quality care.

Telehealth

Frequency Limitations on Certain Medicare Telehealth Services

PALTmed supports CMS' proposal to remove the frequency limitations for subsequent nursing facility visit codes (99307-99310) for CY 2025. While CMS continues to gather more data on how practice patterns are evolving, we continue to recommend that CMS permanently remove the frequency limit on physicians furnishing subsequent nursing facility visits via telehealth.

These routine medically necessary visits should not have any form of arbitrary limitation and be solely based on medical necessity. If a patient requires a follow-up visit that would be the second

visit within that 14-day window, it is likely that the patient will end up in the hospital if the telehealth option is not permitted. Telehealth has been shown as an important modality in many value-based care models that have reduced rehospitalization rates and CMS should look to that experience to remove barriers to its use.

Furthermore, limitations on the number of nursing facility visits that can be provided via telehealth are unnecessary as the visits that are required by regulation must already be provided in-person. Amid workforce shortages of physicians and other health professionals who treat nursing facility patients, it has become difficult in some communities to find nursing facilities where hospital patients can be discharged. Continuing to allow telehealth visits to nursing facility patients can allow their physicians to practice more efficiently and allow them to be available for in-person visits with those patients who cannot be effectively treated in a telehealth visit.

CMS indicates that Medicare data show that less than five percent of these services have been provided via telehealth during the period that the frequency limits have been lifted, but this does not mean the service or policy is unimportant or unnecessary. Instead, it indicates that the flexibility is not being abused and that the more frequent telehealth visits are most likely being provided to the subset of patients who really need them. It is likely that greater use of the flexibility may be needed in the future, particularly given the increasing frequency of severe weather events across the country and the growing shortages of physicians in many communities. Moreover, continuing the uncertainty about whether the policy will be made permanent or terminated could result in the loss of programs and services that are only viable in an area that has a shortage of physicians because the available physicians know they will have the flexibility to use virtual visits for a greater portion of patient care. As a result, rather than protecting patients, continuing the temporary status of the policy could harm them.

Advance Primary Care Management (APCM) Codes

For CY 2025, CMS is proposing to establish coding and make payment under the PFS for a new set of Advance Primary Care Management (APCM) services described by three new HCPCS G-codes. The proposed APCM services would incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management.

PALTmed seeks clarification from CMS on sites of services where these codes are billable. It has often not been clear whether newer codes are billable in PALTC settings – nursing facilities, home health, and assisted living. We understand that these are to be considered a “designated care management service” under § 410.26(b)(5) and, as such, could be provided by auxiliary personnel under the general supervision of the billing practitioner. However, given the unique nature of the PALTC setting, it is not clear if these can be utilized and how best to utilize them.

Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or a Medicare Advantage Prescription Drug Plan

CMS proposes to extend the date after which prescriptions written for a beneficiary in a long-term care (LTC) facility would be included in determining the CMS EPCS Program compliance from January 1, 2025, to January 1, 2028, and that related non-compliance actions would commence on or after January 1, 2028. PALTmed strongly supports this proposal.

By 2028, the National Council for Prescription Drug Programs SCRIPT standard version 2023011, which includes three-way communication functionality to improve communication between pharmacies and LTC facilities, will also be required.

PALTmed appreciates this proposed extension of the EPCS compliance date for controlled substance prescriptions issued to patients in LTC facilities. CMS correctly identifies the barriers that physicians with patients in LTC facilities currently face in adopting EPCS. Physicians may be responsible for covering multiple LTC facilities, each with different electronic medical record systems, and they need to rely on LTC nursing professionals to communicate prescriptions to the pharmacist on behalf of the physician. Under SCRIPT version 2017071, physicians can submit EPCS to the pharmacy but would need to then contact the LTC facility to separately give an order for the facility staff to administer the medication to the patient. As SCRIPT version 2023011 is expected to resolve these issues and this standard version will be required by January 1, 2028, it makes sense to align the LTC compliance date with the SCRIPT requirement.

O/O E/M Complexity Add-on Code

CMS is proposing to allow payment of the O/O E/M visit complexity add-on code when the O/O E/M base code is reported by the same practitioner on the same day as any Medicare Part B preventative service furnished in the office or outpatient setting such as an annual wellness visit, vaccine administration. CMS does not assume any additional spending beyond its original utilization projections for G2211 associated with this new proposal for CY2025.

PALTmed requests that CMS add PALTC settings (home care, assisted living, and nursing facilities as sites of service to bill code G2211 for the following reasons.

We appreciate CMS developing an additional Frequently Asked Questions (FAQ) document outlining specific requirements for use of the code. In the document CMS states:

> "Continue to use the codes in this family to report E/M services you provide to a patient in the office or other outpatient facility. HCPCS code G2211 is separately payable to the billing physician or practitioner in both facility and non-facility settings and is not limited to any physician specialties. HCPCS code G2211 cannot be billed with code sets for other E/M

> services (e.g., hospital inpatient, emergency department, home or residence, and nursing facility)."

In the PALTmed White Paper Whom Do We Serve? Describing the Target Population for Post-Acute and Long-Term Care, Focusing on Nursing Facility Settings in the Era of Population Health, we describe the complex nature of patients and residents in the nation's nursing homes for whom physicians have a longitudinal relationship. This same relationship exists in both home health and assisted living settings.

We strongly believe that this type of relationship is exactly what is described by the code. The CMS document states:

> "No specific diagnosis is required for HCPCS code G2211 to be billed. For the billing practitioner, it would be appropriate to report a health condition that is a single, serious condition and/or a complex condition for which the billing practitioner is engaging the patient in a continuous and active collaborative plan of care related to an identified health condition—the management of which requires the direction of a practitioner with specialized clinical knowledge, skill, and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals."

Nursing facilities, assisted living, and home health care are the perfect match for this description. In nursing facilities, physician services are not covered by Part A consolidated billing, and given that virtually all patients and residents in nursing homes have multiple complex co-morbid conditions that require "the direction with specialized clinical knowledge, skill and experience" and "shared decision-making", we believe it is appropriate for CMS to make these codes available for use in the nursing facility setting particularly for patients who are place of serve (POS) 32 – the long-term nursing facility care side.

The CMS document further explains the definition of a long-term longitudinal relationship:

> "... HCPCS code G2211 can be billed to recognize the services that enable practitioners to build longitudinal relationships with their patient and address the majority of patient's health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that results in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape."

This is exactly the type of relationship physicians have with residents in the long-term care side of the nursing facility described by POS 32. Very often these patients are not able to travel to the

office, but the care provided at the nursing facility is exactly the care described by this code. Therefore, it would be consistent with the intent of this code to allow it to be billed for patients in the nursing facility.

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

We appreciate CMS addressing this important topic. Issues surrounding opioid use disorder treatment in nursing facilities are often overlooked. PALTmed recently adopted a policy to advocate for expanded access to skilled nursing facility services for patients with OUD.

Opioid use disorder (OUD) in older adults is one of the fastest-growing health problems that continue to go underrecognized and undertreated. There is an increasing number of older adults with a history of OUD or on medications for OUD (MOUD; i.e., methadone, buprenorphine, and naltrexone) who are hospitalized and require discharge to skilled nursing facilities (SNFs), but face disproportionate harms when they are not able to access SNF care.

There is a pervasive practice of screening patients for admission to SNFs (i.e., 80% of referrals being denied and 40% of patients being denied SNF admission) leading to longer hospital lengths of stay awaiting disposition and discharge to self-care despite being recommended for SNF care. Care provisions in SNFs based on a patient's history of OUD and being on MOUD leads to unnecessary and potentially unsafe changes, interruptions, and discontinuations of medications for MOUD.

We ask that CMS take regulatory action to ensure patients cannot be denied appropriate admission to skilled nursing facilities based on blanket policies denying admission based solely on the diagnosis of OUD or active MOUD use.

We look forward to working with CMS to address barriers in the prescribing, dispensing, and administration of MOUD by skilled nursing facilities and long-term care associated pharmacies.

Calendar Year 2025 Updates to the Quality Payment Program (QPP)

Physician practices participating in the MIPS program face penalties that can cut their Medicare payment by as much as negative 9 percent. Yet, research shows that the program is about as good as a random chance at identifying high-quality care; disproportionately penalizes small, rural, and independent practices; and exacerbates health inequities. The cost measures hurt specialists whose patients incur higher spending when they receive evidence-based care, like oncologists, and the inadequate number of specialty-specific quality measures artificially limits the scoring potential of specialists whose services are vital to diagnostic accuracy, such as radiologists and pathologists, among others. While Congress recognized the importance of timely feedback to

physicians participating in MIPS, CMS does not provide initial performance feedback for six to 18 months after the performance is measured, when the physicians are already well into the subsequent measurement year and have no opportunity to modify their performance on the measures. Without timely feedback, MIPS cannot work as intended because physicians need data to monitor their ongoing performance and identify gaps or variations in care that can be addressed to improve quality of care and reduce avoidable costs.

We appreciate that CMS proposes a couple of policies that have the potential to improve MIPS, such as changing the cost measure scoring methodology to increase physicians' final scores. However, this proposed rule does not resolve many of the root causes of the problems in the MIPS program as they require statutory remedies. To fix this problem, PALTmed is joining many other specialty societies in calling on Congress to replace key elements of MIPS with a new Data-Driven Performance Payment System (DPPS) that:

- Freezes performance thresholds for three years to allow recovery from the COVID-19 pandemic and Change Healthcare cyberattack.
- Eliminates the current tournament model and replaces corresponding payment penalties of up to nine percent with payment adjustments assessed as a percentage of statutorily mandated payment updates (i.e., 0.25 percent or MEI).
- Ensures CMS provides quarterly feedback reports by holding physicians harmless from penalties should the Agency fail to provide this data.
- Aligns program requirements with other CMS nursing facility value-based programs, simplifies reporting by allowing cross-category credit, and enhances measurement accuracy.

MIPS Value Pathways (MVPs)

PALTmed appreciates the ongoing dialogue with CMS on MIPS Value Pathways (MVPs), and we support the American Medical Association's (AMA) recommendation of an alternative framework. This alternative framework addresses many of the pitfalls of the current CMS approach to MVP and is based on consensus gathered with input from other specialty societies. We are hopeful CMS will finally address these concerns and recommendations in response to this RFI.

PALTmed along with other medical specialty societies continue to believe that the best way to address the problems with CMS' existing MVP approach is to create separate MVPs for individual health conditions, episodes of care, and prevailing settings of care such as nursing facilities. We support an alternative framework that categorizes quality and cost measures into condition-specific subdivisions within a broader MVP. Physicians who specialize in treating patients in a particular setting and/or conditions would be able to clearly identify the available measures for that condition and register to be held accountable for those condition-specific quality and cost measures within the MVP. By creating MVPs through the proposed framework, CMS and physicians

could also more easily identify and remedy gaps in measurement and scoring challenges, such as no or limited condition-specific measures or measures without a benchmark. **We believe this framework helps address many of the problems with the current MVPs for many specialists, is feasible for CMS to implement, and helps inform patient decision-making.**

This proposed framework will better ensure that there are applicable MVPs available for all clinicians including those practicing in nursing facilities. We believe CMS could take existing measures that are applicable to the nursing facility setting and create a set of measures in an MVP that would be applicable to the patient population in that setting. We continue to express concerns that the major problem with the "zero-sum" approach to this program makes those who care for the frailest and high-cost patients appear poorly on many quality and cost measures that were designed for other settings of care. Therefore, CMS must use place of service codes or compare similar populations when considering MVPs and tallying performance in the program.

We join many of our specialty colleagues in opposing any mandatory participation in the MVP framework. The MIPS program has and continues to undergo constant changes, and it is difficult for practices, particularly those that practice in the PALTC setting, to continuously adapt to these changes. Simply put, the potential for financial reward in successful participation has not kept pace with the cost and administrative burden it takes to participate in this program. Those practices that have been participating in traditional MIPS should have the opportunity to continue to do so without further penalties for not switching to yet another framework.

We continue to urge CMS to incentivize reporting of MVPs, rather than mandate it. One way to do this would be by providing more frequent, actionable performance feedback and claims data to physicians and groups that opt to report MVPs. While Congress recognized the critical importance of data sharing with physicians in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) statute, which requires timely MIPS performance feedback, CMS has dragged its feet in meeting its statutory obligations to provide timely (e.g., quarterly) MIPS feedback reports and has never provided Medicare claims data to physicians despite this requirement going into effect in 2018. For the growing set of administrative claims measures in MIPS, including every cost measure, physicians do not currently know which patients are attributed to them, which measures they are scored on, and how their scores compare to their peers and the benchmark *until six months after the performance period ends*. Without this information at any point during the actual performance year, physicians have no way to monitor their performance, identify opportunities for efficiencies in care delivery, and avoid unnecessary costs. The lack of timely and actionable feedback contributes to physicians' frustration with MIPS, which they experience as another check-the-box exercise rather than an effort to meaningfully improve quality of care and reduce unnecessary costs. CMS could incentivize reporting of MVPs by making Medicare claims data and meaningful MIPS attribution, measure, and performance data available on a rolling basis or, at a minimum, on a quarterly basis during the actual performance period for MVP participants.

Cost Measures

We continue to be extremely concerned about the Cost Performance Category resulting in MIPS scores that are inequitable for physicians and misleading for patients because of the wide comparison group used to calculate the scores with inequitable risk adjustment. We reiterate that CMS must use alternative ways, such as place of service codes, to compare costs of clinicians that treat similar populations. Comparing PALTC based practices on a bell curve with all internal and family medicine makes every PALTC practice look like a significant high-cost outlier and presents a distorted picture to both patients and the healthcare field now connected through value-based care arrangements. On multiple occasions, we have presented evidence to CMS through practice quality resources use report (QRUR) that clearly demonstrates the real-time impact of these cost measures. Despite previous assurances that CMS is considering alternative ways to deal with this issue, either through the use of place of service codes or better alignment through facility-based scoring, CMS has taken no action on this issue.

Advanced Alternative Payment Models (APMs)

Qualifying APM Participant (QP) Determination and APM Incentive

Recommendation:

- CMS should advance physician participation in Advanced APMs by: 1) taking an active role in educating Congress on the urgent need to freeze QP thresholds and extend the Advanced APM bonus; 2) collaborating with interested parties to design and adopt more Advanced APMs, especially those that fill current gaps; 3) ramping up performance feedback and data sharing in MIPS to prepare physicians for moving to APMs; and 4) reversing policies set to take effect next year that move us backward and will hinder physician participation in APMs.

In the 2022 performance year, the most recent year for which we have data, the total number of QPs in Advanced APMs was 386,263–a 41 percent increase from 2021. QPs accounted for 38 percent of overall QPP participants in 2022, more than ever before. We commend CMS for this important progress, which has been helped largely due to new models that began accepting new participants in 2022, including Primary Care First and the Kidney Care Choices Model. More MSSP participants also advanced to higher risk-bearing tracks, demonstrating the importance of models that offer gradual glide paths to risk.

However, we have significant concerns that this important progress is about to take a significant step backward due to several major changes that are set to take effect on January 1, 2025, under current law. First, Advanced APM lump sum bonuses are set to expire at the end of the 2024 performance year. Second, QP thresholds are set to increase in the 2025 performance year from 50

to 75 percent of payments and from 35 to 50 percent of patients. The partial QP thresholds will also increase from 40 to 50 percent of payments and 25 to 35 percent of patients. Based on the most recently available data from the 2022 performance year, physicians in non-primary care specialty models will significantly struggle to achieve QP status under those higher QP thresholds set to take effect next year.

PALTmed recognizes these changes are set in statute. **We urge CMS to leverage its expertise and authority to educate Congress on the adverse impact that allowing the QP thresholds to rise and the Advanced APM bonus to expire could have on Advanced APM participation.** PALTmed joins many of our specialty society colleagues in strongly supporting S. 3503/H.R. 5013, the Value in Health Care (VALUE) Act, bipartisan legislation that would extend the original five percent APM incentive payments and freeze the 50 percent revenue threshold for an additional two years, among other changes that would stabilize and strengthen APMs.

PALTmed appreciates important progress in the form of new voluntary models, including the Accountable Care Organization Primary Care Flex (ACO PC Flex) Model and the Making Care Primary Model. However, these models are still developed to mainly address the needs of the ambulatory population. Many PALTC-based clinicians have no opportunity to voluntarily participate in an APM focused on the conditions that their patients have and/or the treatments they deliver, there is no nationwide voluntary primary care medical home model, and small, rural, and safety net physicians lack opportunities to transition to APMs.

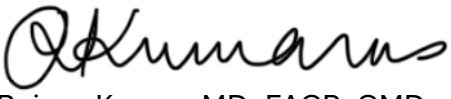
We strongly urge CMS to develop models designed with the specific needs of these unique needs of the PALTC population. One-size-fits-all models will not work to encourage adoption among groups that have so far been left out of APM participation. In addition to a lack of available relevant models, low APM uptake is due to barriers such as high start-up costs and high levels of risk, which disproportionately hinder small, rural, and safety net practices. Clinicians need innovative models that are designed around unique practice and patient needs, that are willing to make front-end investments in technology and other supports and pay for high-value services that have been proven to improve outcomes, and that have a long-term mindset and are sustainable over time. Models cannot simply transfer financial risk to practices and prioritize short-term financial savings above all else.

As CMS looks to bridge the gap between MIPS and APMs, increasing data sharing and performance feedback is paramount for practices to monitor their performance and build confidence to move into APMs. Reducing the administrative burden of MIPS is also critical to allow practices to devote scarce resources to exploring APM opportunities, if available.

Conclusion

We appreciate the opportunity to comment on these proposals. Should you have any questions please reach out to our Senior Director of Advocacy and Strategic Partnerships, Alex Bardakh at abardakh@paltc.org or 410-332-3132.

Sincerely,



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