September 11, 2023

Chiquita Brooks-LaSure
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: CMS–1784–P: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure,

On behalf of our over 5,000 members and partners including mission-driven organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge is pleased to offer the following comments in response to the proposed rule concerning CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies.

Extension of Telehealth Policies and Flexibilities

LeadingAge supports the continued extension of the COVID-19 Public Health Emergency telehealth flexibilities. These flexiblities have been invaluable to our members providing services to Medicare beneficiaries throughout the pandemic but have also contributed greater access to critical post-acute and other services.

Due to the continued workforce shortage our members are experiencing, as are many healthcare practitioners with which our members partner or coordinate in delivery of care, we support the proposal to extend the definition of direct supervision to permit virtual presence beyond December 31, 2024. Allowing physicians and other approved practitioners to virtually supervise telehealth visits allows for better coordination between teams and provides more flexibility to beneficiaries in scheduling virtual visits with their care team.

LeadingAge further supports CMS continuing to allow outpatient therapy services delivered by institutional providers – including skilled nursing facilities, and home health agencies (to individuals who are not homebound) – to be furnished via telehealth through the end of 2024, including to beneficiaries in their homes.

LeadingAge also supports CMS's proposal to remove the frequency limitations through 2024 for certain inpatient visits, nursing facility visits, and critical care consultation services. This would align with other telehealth-related flexibilities extended by the 2023 CAA and allow CMS further time to gather more information about telehealth practice patterns.

Payment for Caregiver Training Services

LeadingAge strongly supports the activation of caregiver training services (CTS) codes for the physician fee schedule. Informal, unpaid caregivers are critical members of the interdisciplinary team for older adults and play an increasingly important role in supporting older adults who choose to age at home. In the most recent update to AARP's seminal report, Valuing the Invaluable, there are roughly 38 million family caregivers in the United Staes providing about 36 billion hours of care.[1]

Recognizing the value of the interdisciplinary team, including family caregivers, we strongly encourage CMS to expand the CTS codes to include delegation of training by non-billing staff including nurses, certified nurse assistants, home health aides, medical assistants, and community health workers, under the supervision of a billing practitioner. Adding the ability of physicians and other approved practitioners to delegate, as appropriate, but still bill for CTS would be more useful to practitioners and provide greater accessibility and flexibility to family caregivers. Physician and other approved providers are consistently stretched to their limit and rely extensively on their extended teams to provide support to patients and families currently.

In addition, many tasks that family caregivers could be trained for do not require physician-level knowledge. We would argue these codes should be extended to other practitioners who can bill for certain services like social workers. A recent study found that antipsychotics were increasingly overused in the home health space and advocated for more training of caregivers in behavioral health support for individuals with Alzheimer's and related dementias (ADRD). [2] Unfortunately, under current home health billing, social workers are not able to provide family caregiver training. And while a physician or other billing clinician could very well provide this training to under CTS coding, a social worker would also be an extremely valuable part of this service to help family caregivers understand how to understand and implement non-pharmacological interventions for loved ones with ADRD.

Regarding CMS' seeking comment on the frequency of CTS, we believe that limiting the use of these codes to once a year per caregiver, per patient is insufficient to meet many patients' and caregivers' ongoing needs. Nearly 80 percent of older adults have two or more chronic conditions, and those with more chronic conditions often have greater physical limitations and fewer financial resources, leading them to rely heavily on support from unpaid caregiving.[3] For many of these individuals, educating their informal caregivers on how to manage and support each of the chronic conditions could take more than the time allotted in the proposed CTS codes, therefore it would be best if instances of CTS could be billed more frequently than annually . Additionally, many older adults experience sudden changes to their plan of care due to any number of circumstances from critical incidents like falls, heart attack, or stroke, to progressions in their disease like dementia, COPD, and Parkinson's. In each of these circumstances, if the CTS codes were limited to once a year, providers would not be able to bill for additional new education for caregivers on how the plan of care will need to be adjusted in the wake of critical events or

---

[1] AARP, and National Alliance for Caregiving. Caregiving in the U.S. AARP (Washington, DC: 2020).

[2] Azermai M, Petrovic M, Elseviers MM, Bourgeois J, Van Bortel LM, Vander Stichele RH. Systematic appraisal of dementia guidelines for the management of behavioural and psychological symptoms. Ageing Res Rev. 2012; 11(1): 78-86.

[3] National Council on Aging. Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. Page 5, Figure 2. April 2022. Found on the internet at https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults

progression in the individual's disease. It is critical that family caregivers not only remain informed during these events, which can happen multiple times a year, but be trained in what to expect and how to support the new circumstances their loved one's face.

CMS also requested feedback on how these clinician and caregiver interactions typically occur. The fact of the matter is the majority of family caregivers work either full-time or part-time, with nearly half working in hourly wage positions.[4] Many family caregivers miss work in order to accompany their loved ones to doctors' visits or support them during hospitalization, which has a significant impact on the caregiver themselves. Additionally, nearly 11 percent of caregivers live up to a mile away if not further from the patient, making it more difficult to join conversations for care planning purposes and receiving necessary education. Due to these factors, we strongly encourage CMS to add these codes to be included in the Medicare Telehealth Services List. Since the patient is not present, these codes are a good fit for telehealth. Also, this would provide more flexibility to working caregivers as well as caregivers who do not live close to their loved ones and their care networks.

We understand CMS' concern that CTS may be covered by another Medicare benefit category or Federal program. Currently, the only part A Medicare benefit that allows billing for family education and training is the home health benefit, and that is only allowed for skilled nursing, not any of the other three therapies identified in this rule. We, therefore, do not believe it would be an overlapping of services to allow a patient and their caregiver on home health to receive CTS from a therapy professional outside the home health benefit.

While we understand that CMS' goal with these codes is to support family caregivers who are the primary care source, we do believe there is an opportunity for clinicans in skilled nursing facilities to utilize these codes when educating family caregivers during transitions both to and from their settings. Many family caregivers are responsible for moving their loved ones to a facility-based setting and often pick up the slack in the hand offs between settings of care. Allowing for part A setting clinicans to bill for these codes would improve the discharge planning process considerably and recognize informal caregivers as a critical partner of all healthcare settings not just once the patient returns to their home.

CMS also requested feedback on the overlap of Medicaid services that may provide CTS. Again, we understand CMS would like to avoid duplication of services, we encourage CMS to implement the same standards applied to other services which attempt to prevent billing more than one payer for the same service on the same day. We do not believe CMS needs to exclude Medicare CTS billing in states with Medicaid CTS benefits but instead simply prohibit billing Medicare and Medicaid to train someone for the same task.

LeadingAge strongly supports the activation of caregiver training services (CTS) codes for the physician fee schedule and encourage CMS to finalize the codes with the following considerations:

- Expand the CTS codes to include delegation of training by non-billing staff including nurses, social workers, and community health workers, under the supervision of a billing practitioner.
- Allow codes to be billed quarterly and/or when there is a change in the plan of care.

[4] AARP, and National Alliance for Caregiving. Caregiving in the U.S. AARP (Washington, DC: 2020).

- Add these codes to be included in the Medicare Telehealth Services List to support the majority of caregivers who work full time or part time jobs and for caregivers living away from their loved ones.

Community Health Integration Services and Principal Illness Navigation Services

LeadingAge applauds CMS for proposing the creation of new billing codes for community health integration (CHI), social determinants of health (SDOH) risk assessment, and principal illness navigation (PIN) services. This would create pathways to sustain the essential contribution community-based efforts to address health related social needs as part of implementing a whole person model of care. This is critical in the care of older adults and something LeadingAge members work to achieve throughout the continuum of care.

Qualifying for CHI and PINs

Include all care management codes as eligible for initiating visit: A transitional care management visit is a type of E/M visit that should be explicitly included in the eligible initiating visit services for CHI/PIN services. Complex medical conditions are often identified during an acute hospitalization, and HRSNs, such as housing insecurity, can directly impact hospital length of stay. Providers of transitional care management services must be cognizant of HRSNs in developing the transition plan after an acute care hospitalization. Furthermore, a post-discharge medical visit would be a transitional care management encounter that could indicate a need for further CHI/PIN services. There should be no wrong door for entry into the suite of available Medicare care management services – these are services that CMS is encouraging because they are good for the beneficiary and the Medicare program. Therefore, we urge CMS to include an explicit reference to transitional care management visits being a qualifying encounter for CHI/PIN services.

Recognize the reality of practice today and honor the policy recognizing that within a group practice, there may be more than one provider conducting the initiating visit and engaging in subsequent general supervision delivery of CHI/PIN services and PIN services. The proposed rule states that the same practitioner that conducts the initiating visit would furnish and bill for both the CHI/PIN initiating visit and the CHI/PIN services. However, this provision does not reflect reality. In many health care settings, physicians, APRNs, physician assistants, therapists, and others operate as care teams. This is particularly true in health professional shortage areas (HPSAs) where the beneficiary may be seen by more than one provider in a group practice, but each provider adheres to a shared care plan within the group practice or provider organization.

Include social workers, including BSWs, in CHI and PINs auxiliary workforce definition. Similarly, to our request to include social workers in the caregiver training services, we ask that social workers be included as eligible auxiliary workforce for CHI and PINs under the general supervision of a Medicare Part B billing provider.

CHI and Part B Home Health Services: In relation to Community Health Integration, CMS is proposing that these services provided to an individual could not be billed while the patient is under a home health plan of care under Medicare Part B. CMS believes there would be significant overlap between CHI and services furnished under a home health plan of care, particularly in relation to medical social services and comprehensive care coordination. We disagree with this assumption and encourage CMS to allow for concurrent CHI Services while the patient is under a home health plan of care under Medicare Part B. Because many CHI services would address complex needs, they often require multiple interventions over

time. During the time that CHI services are being provided, the beneficiary may require home health services such physical therapy. The proposal to prohibit concurrent provision of CHI services and home health plan of care could cause a disruption in the continuity of care for addressing HRSNs because the social service component is very limited during home health services, which are generally only sixty (60) days in duration. In addition, this would place the beneficiary in a position to have to choose between receiving services addressing multiple complex needs–for example housing assistance/services versus ongoing physical therapy–because it is extremely unlikely that the social service component of a limited-duration home health benefit would provide continuous social care interventions initiated by auxiliary personnel at the Medicare provider practice.

LeadingAge has many members that serve as community-based organizations including a growing contingency of adult day programs, which could be exceptional partners in these programs. To assist CBOs with evaluating and seeking opportunities for partnership, we request that CMS provide additional detail and clarification in its final rule or related guidance regarding:

- What arrangement would be needed to involve non-profit, community-based organizations, including to show sufficiency of clinical integration?
- Who bills Medicare for the service and how would the contracted CBO/CHWs be paid? Would they be paid separately by Medicare, or would the billing practitioner pay them?

PINs and Palliative Care: Our members that deliver palliative care are excited to see the principal illness navigation services proposal and note the need for these services for those with serious illness. However, adding PINs to the existing suite of care management services is not sufficient to make palliative care in the community sustainable under Part B – which is much needed.

LeadingAge asks that CMS work to improve access to Part B palliative care through assigning adequate payment to an existing CMS comprehensive management and care coordination methodology. This structure could also be used for palliative care services across the continuum as well as a response to live discharge from hospice, with hospice teams focused on providing continuity of care for people with conditions that cause them to intermittently graduate from and return to hospice eligibility. LeadingAge recommends CMS assign a payment rate to CPT code S0311 and to CPT/Revenue Code S0311/069x combination for all Medicare beneficiaries. CMS should also assign covered services to be associated with S0311 to ensure consistency.

Composition of Hospice Interdisciplinary Group

LeadingAge supports the addition of Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) to the list of providers eligible to serve on Medicare-certified hospices' interdisciplinary teams (IDTs). However, we have strong concerns with recent CMS staff clarifications on the August 30, 2023, Open Door Forum (ODF) call. CMS personnel, in response to a question about this provision, implied that hospices would be required to employ or contract with all 3 discipline types (social worker, MFT, and MHC). Based on the way the statutory provision is written, as well as communication with Congressional offices, that was not the intent of the legislative language which was passed last year and is not a reasonable interpretation for implementation and enforcement purposes.[5]

[5] Pub.L. 117-328. https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ", marriage and family therapist, or mental health counselor" after "social worker".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2024. 42 USC 1395*l* note.

Additionally, this proposed rule itself states "This statutorily-required modification allows MHCs or MFTs to serve as members of the interdisciplinary group (IDG)". It does not say that these professions are required or mandatory, which would be a significant burden for hospice providers and nearly impossible to comply with.

Our hospice members have reported that it would be extremely difficult to recruit and employ/contract with MHCs and MFTs. For years, many of our hospice members have found it difficult to recruit, hire and retain social workers, and they anticipate that the difficulty will be even more pronounced with MHCs and MFTs. Some hospices will not have any MHCs and MHTs in their geographic area. According to the Bureau for Labor Statistic, some states may only have 40 MFT in the whole state.[6] Additionally, while our members support the option to use MHCs, and MFTs, many do not see MFTs or MHCs being able to substitute for social workers who have extensive training in navigating community resources as well as in counseling. MFTs and MHCs do not receive the same training in resource support. MFTs and MHCs could be a great resource for those beneficiaries with more extensive counseling needs but it should not be, nor was this provision intended to be, a requirement.

The CMS staff person speaking at the Open Door Forum also stated that because MFT and/or MHC services would not be considered "core services", the MFT and/or MHC would not have to be a W-2 employee. It is correct that the statute did not define MFT and/or MHC as a core service, but it also did not define them as "non-core services" like physical therapy, occupational therapy, and speech-language pathology which are defined at 42 CFR 418.70. These "non-core services" have clearly defined expectations for hospices in contracting and providing for services including waivers for when the professionals are not available in a hospice's service area.

We ask that CMS finalize the rule with clear language stating that hospices may use MFTs and MHCs as appropriate but underscore that it is not a requirement to make them available, even when counseling services are in the plan of care. The hospice community interprets the wording in the rule to mean that hospices have the choice of using a SW, MHC, or MFT, and would not be required to employ or contract with an MHC or MFT.

Determining Beneficiary Assignment Under the Shared Savings Program

LeadingAge supports CMS's proposal to assign beneficiaries using evaluation and management codes for nurse practitioners, physician assistants and clinical nurse specialists to determine where a beneficiary receives the plurality of their primary care. We think this is a positive addition and reflects the reality that these practitioners are increasingly the source for individuals to have their primary care needs addressed.

---

[6] Bureau of Labor Statistics. *Occupational Employment and Wages, May 2022: 21-1013 Marriage and Family Therapists.* https://www.bls.gov/oes/current/oes211013.htm

Future Considerations for MSSP

If ACOs are going to be one of the primary accountable care models in traditional Medicare, then we must begin to consider how these ACOs engage non-physician providers in the care of older adults. Some Medicare beneficiaries reside in the community in single family homes and apartments, while others require more assistance with their activities of daily living and chronic condition management. This high-needs population often receives the bulk of their care from nursing staff and aides in residential settings such as long-stay nursing homes and assisted living. Therefore, we think CMS should continue to refine MSSP and other similar accountable care models in the following ways:

1. **Pursue statutory change to permit other provider types to be the accountable entity and coordinator of care in an ACO.** Under the current statutory limitations of the Medicare Shared Savings Program (MSSP), primary care physicians, hospitals and health systems are the only permitted leaders of this model. While primary care and specialty care physicians play an integral part in a Medicare beneficiaries care, we think the law should be revisited to permit a broader array of providers to be accountable for the total cost of beneficiaries' care as leaders of these models. Nursing homes often provide both post-acute care (skilled, short-stay), and long-stay custodial care where the nursing home is the beneficiary's residence. Long-stay nursing home residents are also Medicare beneficiaries even though the bulk of their care is funded through other payor sources. We encourage CMS to explore a residential-based ACO model where the nursing home is at risk for total cost of care and coordination with physicians, hospitals, health systems and other providers. CMS has yet to test such a residential-based hub of accountable care. We believe that economies of scale could be achieved through such an approach especially where the hub of care is where the person resides. In these cases, the individual beneficiary often has daily interaction with their care providers instead of a 20-minute office visit. Assisted living and other senior living communities should be considered for this model in addition to nursing homes. Hospice providers are also engaging in MSSP through the formation of physician practices but are essentially using their core skillsets to manage serious illness – forming a new entity to do so should not be a requirement for entry into the accountable care space.

2. **Develop value-based arrangements that are embedded within the ACO for non-physician participating providers or organizations. (e.g. nursing homes, assisted living, home care, etc.)** As the ACO model expands to more beneficiaries, we believe it is critical for the model to evolve and engage other providers in the work for managing total cost of care and improving outcomes. Most importantly, every provider who is involved in this work should share in the financial rewards of those labors. Accountable care is a team sport and as such, there is less success when all providers involved in a beneficiary's care don't work together. This means all team members must be accountable and appropriately rewarded for their actions. The ACO model as it stands lauds that it reduces Post-Acute Care (PAC) spend to generate its savings. However, another way to look at this is robbing one provider to pay another. It is unsustainable and may ultimately create access issues as the current financing model for these PAC providers is no longer sustainable. CMS could help ensure ACOs adopt more value-based arrangements with PAC and other providers by offering a menu of value-based payments embedded within the ACO such as a nested bundle for SNF, home health, or palliative care/serious illness management services. The GUIDE model is potentially a good precedent for this – though we have to see what the "nesting" looks like in the RFP.

3. **Consider new avenues for beneficiary assignment to ACOs.** As CMS seeks to improve beneficiary assignment, we encourage CMS to explore assigning Medicare beneficiaries who reside in nursing homes for long-stay custodial care (100 days or more). We understand that often residents of long-stay nursing homes are not enrolled in an ACO because they don't receive the plurality of their primary care in the community but instead via the nursing home and/or an affiliated physician practice. We would encourage CMS to explore ways for the nursing home to participate in an ACO that would result in their residents being assigned to an ACO. One possible approach may be to allow nursing homes to exclusively align their tax identification number to a particular ACO and this would assign their Medicare FFS beneficiaries to the ACO. This may require CMS to establish an additional role for nursing homes where this could occur vs. SNF Affiliate roles or preferred providers.

By creating a role for nursing homes and possibly other aging service providers in beneficiary assignment, it also elevates their position within an ACO as a whole, including the possibility of having a seat at the decision-making table for distribution of shared savings and care delivery redesign. This engagement could lead to even greater success at managing Medicare beneficiaries who receive long-term services and supports within nursing homes and assisted living communities.

We cannot leave these providers out of the financial rewards of improving outcomes or these services/providers will cease to exist as their payments and units of services continue to be reduced by ACOs and Medicare Advantage plans. We are always available to discuss these and other options for meaningful participation for PAC and LTSS providers in the MSSP and other models.

We thank you for your consideration of the issues highlighted above. My contact information is below if you wish to discuss any of the recommendations.

Sincerely,

Katy Barnett
Director, Home Care and Hospice Operations and Policy
kbarnett@leadingage.org