GREATER NEW YORK HOSPITAL ASSOCIATION
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September
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The Honorable Chiquita Brooks-LaShure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P

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-LaShure:

Greater New York Hospital Association (GNYHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the fiscal year (FY) 2024 physician fee schedule (PFS). GNYHA represents 222 voluntary and public hospitals and health systems throughout New York, New Jersey, Connecticut, and Rhode Island.

This letter includes our comments on proposed telehealth payment and related resident supervision. We also include comments on services addressing health-related social needs and changes to the basic health program regulations.

If you have any questions or would like further information on GNYHA's comments, please contact me at tjohnson@gnyha.org.

Sincerely,

Tim Johnson
Senior Vice President

GNYHA Comments on the FY 2024 PFS Proposed Rule

Comments on Telehealth Proposals

Section II.D.1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

The COVID-19 pandemic spurred an unprecedented increase in telehealth visits in GNYHA member hospitals and their physician practices. Some GNYHA member hospitals reported that for a period in 2020, telehealth comprised upwards of 70% of patient visits. While GNYHA member hospitals and physician practices currently report a smaller percentage of telehealth visits, this modality has become an important component of ambulatory care delivery. According to GNYHA ambulatory care leaders, many patients appreciate the option to see their provider virtually. This is particularly helpful for patients who may have transportation challenges or limited time due to personal, professional, and childcare responsibilities. Hospitals have noted a significant decrease in "no-shows" for ambulatory appointments when using telehealth, which means community members are more likely to get the care that they need without their conditions potentially deteriorating because of delay in care.

Section II.D.1.b. Requests to Add Services to the Medicare Telehealth Services List for CY 2024;
(7) CMS Proposal to Add New Codes to the Telehealth List

GNYHA member hospitals and their physician practices are increasingly screening their patients for health-related social needs (HRSNs) with the understanding that it is an important component of whole-person health. GNYHA appreciates CMS's recognition of the time and effort for this work and further appreciates the ability to assess for social needs via telehealth. Additional comments on GNYHA member activities related to HRSN screenings are included in the below section on social needs risk assessment and including HRSN screening as part of the annual wellness visit (AWV). **GNYHA supports CMS's proposal to add Healthcare Common Procedure Coding System code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment) to the Medicare Telehealth Services List on a permanent basis.**

Section II.D.1.e. Implementation of the Provisions of the CAA, 2023

GNYHA members continue to advance care provided via telehealth and are increasingly incorporating quality measures and process improvement strategies to this modality. They also provide significant supports to patients who may need technology assistance and internet access. **GNYHA urges CMS to work with Congress to ensure that the telehealth flexibilities included within the Consolidated Appropriation Act (CAA), 2023 that are scheduled to end on December 31, 2024, are made permanent, allowing this critical component of health care access to continue. GNYHA will continue its advocacy in this regard.**

Section II.D.2. Other Non-Face-to-Face Services Involving Communications Technology Under the PFS
(a) Direct Supervision via Use of Two-Way Audio/Video Communications Technology
(1) Supervision of Residents in Teaching Settings

GNYHA appreciates the opportunity to comment on CMS's proposal regarding physical presence requirements for teaching physicians in residency training sites that are located within an Office of Management and Budget (OMB)-defined metropolitan statistical area (MSA). GNYHA includes among its member hospitals some of the finest academic medical centers and teaching hospitals in the world. These organizations train future physicians for New York's member states and the rest of the country. During the height of the pandemic and continuing to this day, GNYHA member teaching hospitals availed themselves

of all available telehealth opportunities to ensure patients received needed care while the medical residents who put themselves in harm's way during their training years were guaranteed the medical education they deserved. The teaching physicians who worked tirelessly to ensure these residents' education was not disrupted invested time and effort to create new protocols for effective supervision, including implementing new supervision protocols that relied on audio/video technologies. GNYHA and its member teaching hospitals are grateful that these new supervision protocols were continued through December 31, 2023. In the CY 2024 PFS proposed rule, CMS proposes to allow teaching physicians to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually by the resident. This proposed policy would be effective through December 31, 2024. CMS is also soliciting comments and information so that the agency can consider policies for residency training sites that are located within an OMB-defined MSA.

In discussing its proposal, CMS notes that in the CY 2021 PFS final rule, it implemented a policy whereby teaching physicians may meet the requirement to be present for the key or critical portion of services when furnished by residents through audio/video real-time communications technology (virtual presence) but only for services furnished in residency training sites located outside of an OMB-defined MSA. According to CMS, it made this "location distinction" to "increase beneficiary access to Medicare-covered services in rural areas" and to "expand training opportunities for residents in rural areas." 88 *Fed. Reg.* 52302 (Aug. 7, 2023). CMS also stated that it had "concerns about patient populations that may require a teaching physician's experience and skill to recognize specialized needs or testing and whether it is possible for the teaching physician to meet these clinical needs while having a virtual presence for the key portion of the service." 88 *Fed. Reg.* 52302 (Aug. 7, 2023).

GNYHA appreciates that CMS has these concerns, and we comment on them in detail below. First, the accreditation requirements with which residency programs and hospitals must comply, and the overall approach of these national accreditors guarantee the safeguards around teaching physician's experience and skill and patient populations that CMS is seeking as the agency considers the clinical needs of patients. Second, the beneficiary access issue that drove CMS to permit the use of virtual presence is also of concern in many non-rural areas for many specialties, and the access needs of other underserved populations that are not Medicare beneficiaries should also be considered in the context of CMS's policy deliberations.

Accreditation Requirements for Supervising Physicians of the ACGME and TJC

The Accreditation Council for Graduate Medical Education (ACGME) and The Joint Commission (TJC) have set requirements that teaching hospitals and residency programs must comply with to remain in good standing. Both organizations have set these requirements and evaluate residency programs and hospitals to ensure that patient safety is not at risk. As stated within their respective accreditation standards, both organizations recognize that a single physical presence standard is not appropriate, and hospital and residency program leadership must exercise professional judgment in determining the proper level of supervision given the amount of training residents have previously received and the type of patient care setting where the service is being provided. Resident supervision requirements can be found in ACGME's Institutional Requirements and Common Program Requirements (CPR) and TJC's Comprehensive Accreditation Manual for Hospitals.

<u>ACGME Requirements</u>

Section VI.A.2.a).(2) of the ACGME CPR states, "The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation." For this requirement, the ACGME follows that requirement with an explanation of its intent that emphasizes the responsibility of the residency program to determine the level of supervision for particular residents and settings based on the various factors appropriate for the situation.

> "Supervision is also contextual. There is tremendous diversity of resident-patient interactions, training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables."

Section VI.A.2.c) of the ACGME CPR further states, "The program must define when physical presence of a supervising physician is required."

ACGME also has a system in place to identify any concerns of residents regarding proper supervision. To ensure that residents are comfortable that they are being provided with the appropriate level of supervision, the ACGME includes a section, "Faculty Teaching and Supervision," within the confidential surveys administered to residents by the ACGME on an annual basis. Each residency program must have a minimum 70% completion rate, or the program will be flagged as out of compliance. No individual responses are shared with the program or the institution sponsoring the residency program. If a residency program is found by ACGME to not be providing the proper level of supervision, the program is required to immediately address the deficiency. Failure to do so would result in an escalating sequence of corrective actions, up to and including loss of accreditation. Loss of accreditation would be a catastrophic disaster for the program and the hospital and would almost certainly result in the immediate closing of the residency program.

<u>TJC Requirements</u>

Subsection 04.01.01 (MS.04.01.01) of the *2022 Comprehensive Accreditation Manual for Hospitals* of the TJC states, "In hospitals participating in professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out their patient care responsibilities." Within the section defining "Elements of Performance," the required written descriptions of the roles, responsibilities, and patient care activities of the participants of residency programs, TJC states, "The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities."

As with the ACGME, the key point is that the hospital leadership and residency program director must have a system in place that ensures that—rather than requiring that a monolithic standard be applied to all resident

supervision situations—the residents are supervised based on their experience and progressive development through the course of their training.

Access to Services for Medicare Beneficiaries, Medicaid Consumers, and Underserved Communities
As stated above, CMS has implemented a policy whereby teaching physicians may meet the requirement to be present for the key or critical portion of services when furnished by residents through audio/video real-time communications technology to "increase beneficiary access to Medicare-covered services in rural areas." GNYHA believes this same concern for beneficiary access holds for non-rural areas, particularly for primary care services, other services common to ambulatory settings, and especially, behavioral health services. According to an analysis of federally designated health professional shortage areas (HPSAs) conducted by GNYHA in 2022, 21% of primary care and mental health geographic area and population HPSAs were non-rural and an additional 15% were partly rural and partly non-rural. And for many settings that are not geographically located in a HPSA, the demand for physician services in many specialties has become equally overwhelming.

We also note that in New York, as we believe is the case in many states, the Medicaid requirements for teaching physicians around supervision and ability to bill for professional services generally follows the Medicare standards. We highlight this issue to note that the decisions that CMS makes for resident supervision and the need for physical presence in non-rural areas has immediate implications for state Medicaid programs also and access to services for the individuals enrolled in those state programs.

What this means is that access to patient care services for Medicaid beneficiaries could be limited if, within the Medicare PFS rulemaking, CMS does not fully recognize the use of virtual presence for supervision of resident services. GNYHA understands that the state Medicaid programs could independently change their supervision requirements for teaching physicians. However, such a change for Medicaid while Medicare has a differing standard would be unworkable for hospitals and other clinical settings and overly complex to operationalize. We respectfully request that CMS keep this issue in mind as it contemplates what its policy should be under the Medicare PFS.

In summary, GNYHA supports CMS's proposal to allow teaching physicians to have a virtual presence in all teaching settings located within an OMB-defined MSA in clinical instances when the service is furnished virtually by the resident. We also are supportive of the more expansive flexibility CMS provided for teaching physicians in rural areas and urge the agency to extend that sensible policy for all clinical instances to all residency training sites.

Section II.E.27.a Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)
GNYHA agrees with CMS's recognition that HRSN screening and related navigation activities are undervalued, and strongly supports CMS's proposal to develop coding and payment for these activities. GNYHA also agrees with CMS's analysis of community health workers (CHWs), their value to the health care system, and the importance of coding and reimbursing for this work. CHWs are valuable members of the care team who help patients navigate complex systems of care while addressing social needs.

Section 2.E.27.b.; e. Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

GNYHA believes that Medicare coverage for CHI and PIN services will help increase access to important CHW services, address social care needs, and reduce health disparities while contributing to workforce capacity building in local communities. In terms of the structure CMS proposes for CHI and PIN services, GNYHA agrees that an evaluation and management (E/M) visit could be used to initiate the service period. We recommend that a practitioner who identifies a social determinants of health need—for example, a physician treating a patient in the emergency department who is experiencing food in security—be permitted to refer to a CHW for both a comprehensive assessment and ongoing CHI and PIN services. That patient's primary care provider or the provider managing their complex illness could provide the general supervision necessary for the CHW. This will help ensure that Medicare beneficiaries who end up in the hospital—in part because they do not have an engaged primary care provider willing/able to refer them to a CHW—will have an opportunity to access the benefits of CHI and PIN services. **GNYHA urges CMS to allow other professional services other than E/M to qualify as the initiating visit, including the AWV. We also encourage CMS to consider alternative referral pathways to allow patients in the inpatient or emergency room setting to be referred to CHI or PIN services.**

Request for Clarification on Allowable CHI and PIN

On behalf of its members, GNYHA seeks clarification from CMS on whether CHI and PIN services can focus on HRSNs that are discovered outside of the initiating visit. Often, HRSNs are not identified all at once, and individual needs can change over time. For example, an individual experiencing food insecurity may receive CHI services that facilitate the receipt of Supplemental Nutrition Assistance Program benefits or access to a food pantry. While these may alleviate the specific food insecurity need, the CHW may, in the process, identify a transportation insecurity need that was not discovered during the initiating service, but that still may interfere with the diagnosis or treatment of the patient's problem. **As CMS considers additional guidance, GNYHA urges the agency to provide reasonable flexibility to ensure that as many needs as possible can be met in the context of CHI care, and to reimburse for all CHI and PIN services that address HRSNs impacting a patient's condition.**

CHW or Auxiliary Staff Training Requirements

We appreciate that CMS seeks comment on training requirements and agree with CMS that there is a strong need to ensure CHI services are high quality and consistent with evidence-based best practices. We respectfully disagree that the best way to achieve this aim is through an individual training requirement for auxiliary personnel. As training, licensure, and certification requirements vary across states, GNYHA urges CMS to allow certain flexibilities regarding how CHW and auxiliary staff workers are trained when performing CHI and PIN services. Many hospitals, health systems, and provider organizations in GNYHA's membership have already developed robust training programs that they believe meet the needs of their patients and that ensure a high quality of service. GNYHA is concerned that a training standard from CMS could create barriers for individuals entering the CHW workforce, particularly if they cannot afford the fees or tuition related to education and certification. The CHW workforce should be comprised heavily of individuals from the communities they serve and people with lived experience. These characteristics help make them relatable to patients from the community and help them establish relationships and trust. Licensure or certification requirements could make it difficult for certain individuals to enter this workforce.

As an alternative approach, CMS could encourage best practices in CHW training that could take place

within an individual hospital, health system, or provider organization. The best practices could be based on those set forth by professional groups such as the Community Based Workforce Alliance[1] and National Committee for Quality Assurance (NCQA)[2]. These best practices for CHW programs include recruitment of CHWs based on their lived experience, fair compensation, career ladders, adequate training and supervision, the use of person-centered workflows with reasonable caseloads, and processes for protecting CHW safety. Notably, these domains encompass, but are not limited to, training. The C3 project has also developed a core consensus model for CHW roles and skills.[3] Implementing best practices and evidence-based training within individual institutions would allow the flexibility for organizations with existing CHW programs to continue the great work they have undertaken, while providing standards and guidance for improvement or for those who have not yet incorporated CHW programs.

In summary, GNYHA discourages CMS from setting a single training standard, but asks that the agency rely upon existing best practices and evidence-based training modules, alongside the training programs used by already established CHW programs.

Duplication of Medicaid Services

We do not find CMS's proposal duplicative with current Medicaid coverage of services to address social determinants of health nor those services delivered by CHWs. New York's Medicaid program added a CHW benefit for Medicaid beneficiaries in the FY 2023-24 State budget. Similarly, Connecticut recently passed a bill requiring its Department of Social Services to design and implement Medicaid reimbursement for CHW services. New Jersey's CHW pilots authorized under its Section 1115 Medicaid waiver will help support a more permanent statewide proposal for CHW services under Medicaid. GNYHA believes that Medicare coverage will complement the coverage provided under Medicaid, and it will allow for more seamless workflows in hospital-based, -owned, and -affiliated practices. **GNYHA encourages CMS to finalize its proposal to align with Medicaid-covered CHW services in other states.**

CHI and PIN Policies Under OPPS

Many hospitals that bill under the Outpatient Prospective Payment System (OPPS) have robust CHW programs, and they will be unable to bill for those services under PFS. **To not disadvantage or deter successful CHW models anchored in hospitals, CMS should clarify how this proposal would work in a hospital setting or create a similar pathway under the Hospital OPPS.**

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[1] Community Based Workforce Alliance, Advancing CHW Engagement in COVID-19 Response Strategies. February 2021. Available online https://nachw.org/wp-content/uploads/2021/09/CWBA-Playbook-11421.pdf.

[2] National Committee on Quality Assurance, "Critical Inputs for Successful CHW Programs." November 2021. Available online: https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW- Programs-White-Paper-November2021.pdf.

[3] CHW Common Indicators Project: Proposed Indicators for Priority Constructs. Available online https://www.chcf.org/wp-content/uploads/2021/05/CHWPsMediCalRsrcPkg3CIProposedIndicatorsPriorityConstructs.pdf.

Section 2.E.27.d Social Determinants of Health Risk Assessment

As previously mentioned, GNYHA strongly supports coding and valuation for social needs screening services. GNYHA members have demonstrated their commitment to HRSN screening and collectively screen tens of thousands of patients on a monthly basis, expending significant resources.

GNYHA agrees with CMS that it is important to ensure that patients are referred to appropriate services when a social need is identified. However, GNYHA strongly discourages CMS from applying a condition of payment to the HRSN screening that would require the billing practitioner to furnish CHI or PIN services or have partnerships with community-based organizations (CBOs) to address identified social needs. While these elements are important, many hospitals and health systems and their provider organizations are still establishing the appropriate partnerships and infrastructure to address HRSNs. Additionally, it would be difficult for CMS to establish parameters for reporting the existence of CBO partnerships, particularly in the context of a claim that includes the risk assessment G code.

A thorough social needs screening, documentation, and analysis of the impact of any needs on overall health and treatment takes time and effort on the part of providers and care teams, and thus should be eligible for reimbursement when it is completed according to CMS guidelines. Additionally, CMS has quality measures in place and under development that will place more accountability on providers for screening and addressing social needs. These quality measures put the appropriate checks in place to ensure that patients with HRSNs are appropriately assisted or referred.

GNYHA strongly supports CMS's proposal to provide a reimbursement pathway for social needs screening and urges CMS to finalize this proposal without adding additional requirements to demonstrate CHI or PIN services or CBO partnerships.

Section III.Q. Changes to the Basic Health Program (BHP) Regulations

GNYHA is strongly in favor of the proposal to allow a state to suspend its BHP and maintain the BHP trust fund during a period in which the state enrolls the BHP population in comparable coverage. Permitting BHP suspension and BHP trust fund maintenance will facilitate innovation in coverage expansion while guarding against enrollment disruptions.

New York is one of only two states currently operating a BHP. GNYHA has championed New York's BHP, the Essential Plan (EP), since its inception. The EP has proven to be an invaluable vehicle for providing access to comprehensive coverage for low-income New Yorkers not eligible for Medicaid. Expanding access to coverage has enormous individual and public health benefits and also provides a mechanism for more adequately reimbursing health care providers for the cost of delivering care.

New York is currently working to expand eligibility so that even more New Yorkers can access affordable and comprehensive coverage. Given limitations on coverage expansion under Section 1331 of the Affordable Care Act, the New York State Department of Health (DOH) is seeking Federal authority to expand EP coverage under a Section 1332 Waiver (Waiver). The new expansion EP population will have access to EP plans with lower cost-sharing and premiums relative to plans currently available via the Qualified Health Plan marketplace, and the existing EP population will not experience any changes to benefits, choice of plans, premiums, cost-sharing, eligibility, or enrollment processes as a result of the

Waiver[4, 5]. GNYHA has expressed strong support for the Waiver's proposal to expand eligibility while essentially preserving the status quo for the existing EP population.

As CMS notes[6], there is value in allowing states currently operating BHPs to experiment with other ways of providing coverage that may increase the number of covered individuals while not increasing Federal costs. As further explained below, amending 42 CFR 600.140 to allow a state to suspend rather than terminate its BHP, while ensuring that BHP-eligible individuals receive coverage with BHP comparable benefits, actuarial value, premiums, and eligibility, will serve to encourage such experimentation and further the goal of expanding access.

Currently, states are required to operate a BHP under a certified CMS approved blueprint for as long as the blueprint is in place, and existing regulations set forth a process for full termination of a BHP, including the refund of any remaining balance in the BHP trust fund to the Federal government[7]. DOH has requested a suspension of its BHP during the Waiver and maintenance of the BHP trust fund to be used for currently allowable uses in the interest of reducing coverage disruption and given administrative burdens in conducting a BHP blueprint.[8] Given the inherent risk in experimentation, it behooves a state not to dismantle an already operational BHP, so that if and when the alternative, comparable coverage program, which is time-limited by design, ends enrollees can seamlessly transition back to BHP coverage with minimal disruption.

For these same reasons and to allow maximum flexibility for states to innovate, we suggest permitting a state to negotiate the length of its BHP suspension and BHP trust fund maintenance on a case-by-case basis with CMS. The proposed 42 CFR 600.140(b)(1)(v) contemplates an initial five-year suspension period followed by a five-year extension of a previously approved suspension. CMS could consider allowing multiple five-year extension periods or a more individualized approach rather than fix a 10-year maximum.

Additionally, we encourage CMS to the extent possible to explore mechanisms for permitting states to continue to access BHP trust funds during a suspension period for approved purposes on a case-by-case basis. BHP suspension as proposed is conditioned on a state providing BHP-eligible enrollees with alternative coverage equal to BHP in benefits, actuarial value, eligibility, and premiums. Thus, the goals of the current regulatory requirement to use BHP trust funds to reduce premiums and cost sharing and provide additional benefits for eligible individuals enrolled in BHP standard health plans can seemingly be met through financially supporting the transition to and provision of alternative coverage during suspension.

Finally, with respect to timing, DOH noted in its Waiver application that implementing the Waiver by January 1, 2024, will have the added benefit of smoothing the affordability "cliff" for New Yorkers transitioning from Medicaid as the continuous coverage requirements ends[9]. The proposed revisions

[4] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, page 4.
[5] Appendix B: Public Comment Materials, Full Public Notice, Department of Health, New York Essential Plan Expansion (Section 1332 State Innovation Waiver).
[6] 88 FR 52542.
[7] 42 CFR 600.140.
[8] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, cover letter.
[9] ibid

contemplate CMS reviewing State requests to suspend a BHP only after the rule has been finalized, but also acknowledge the timing constraints for states seeking to suspend a BHP in the first plan year that begins following publication of the rule. Given the timing of New York's waiver and implications for coverage expansions and disenrollment mitigation, we appreciate the flexibility inherent in the proposed language.

In summary, GNYHA urges CMS to finalize its proposal to allow a state to suspend its BHP and maintain the BHP trust fund during a period in which the state enrolls the BHP population in comparable coverage.