American College of Physicians
Leading Internal Medicine, Improving Lives

September 11, 2023

Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: 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 [RIN 0938-AV07]

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of proposed rulemaking regarding changes to the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP), and other federal programs for Calendar Year (CY) 2024 and beyond. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Detailed recommendations and explanations are included in the main text of this letter. The College is confident that these recommended changes would strengthen these proposals and help promote both access to affordable care for Medicare patients and health equity, while also supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We appreciate the opportunity to offer our feedback and look forward to continuing to work with the Agency to implement policies that support and improve the practice of internal medicine.

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Regulatory Impact Analysis

Conversion Factor

ACP remains concerned about the continued financial instability of the Medicare program and the risk it poses to patients' access to care. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with rising practice expenses and inflation. Physicians and their practices have been faced with decades of flat payment and the College is disappointed that the proposed CY24 conversion factor further cuts payment for all physicians' services by 3.36%. The zero-sum system that is budget neutral continues to disrupt CMS' ability to advance reform and invest in physicians, populations, and services that have long suffered from disinvestment. As evidenced by the past several decades, the current Medicare payment system is a defective approach that cannot be preserved with short-term fixes. While we recognize that we are strongly supportive of other proposals herein included which impact the adjustment, it is disappointing that worthy revisions and new investments take away from other Medicare priorities.

The College strongly recommends CMS and Congress work in collaboration with ACP and other interested stakeholders to progress long-term reform – including advancing health equity, enhancing access to care, and improving the health and well-being of everyone enrolled in Medicare. ACP has supported recently introduced legislation, the *Strengthening Medicare for Patients and Providers Act*, that would serve as a first step in correcting the issues with Medicare physician payments, but this alone will not be sufficient to solve the problem.

In considering complementary actions to inflationary updates or addressing budget neutrality, ACP encourages CMS to move forward with an approach to improve the global surgical package valuation. In its analysis using 2019 claims data, RAND found:

> *"...96.5 percent of procedures with 10-day global periods did not have an associated post-operative visit. Approximately two-thirds of procedures with 90-day global periods had an associated post-operative visit; however, the ratio of observed to expected post-operative visits provided for 90-day global period procedures was only 0.38 percent. These findings are very similar to those from earlier reports analyzing 2018 claims data and mid-2017 to mid-2018 claims data."*

In a separate analysis, RAND estimated the net reduction in RVUs was 2.6% across all PFS services, equaling $2.5 billion in Medicare-allowed amounts at the 2019 conversion factor. While the College understands this amount does not represent the actual potential savings to Medicare, if CMS implemented these or similar RVU reductions, the conversion factor would increase due to CMS' budget neutrality requirement and result in further redistributive implications for payments. We strongly encourage CMS to accelerate next steps to identify and redistribute potential savings across all services.

Rebasing and Revising the Medicare Economic Index; RFI re: Strategies for Updates to Practice Expense Data Collection and Methodology

The College is pleased with the agency's proposal to continue to postpone implementation of the updated MEI weights to balance payment stability. However, we are concerned about the viability of these short-term decisions and encourage CMS and Congress to partner with a broad coalition to advance structural resolve for a fragmented system. While the agency has updated the direct PE inputs, including supply/equipment pricing updates, the indirect PE inputs remain tied to legacy information

primarily from the Physician Practice Information Survey (PPIS). This survey was fielded by the AMA in 2007 and 2008 and reflects 2006 data. The AMA is currently fielding a survey to update these inputs, expecting results in advance of CY26 rulemaking.

We agree with CMS that additional efforts should be postponed until completion of the AMA survey. But while the College is appreciative of this, we also agree that waiting only compounds the issue because the current data used to inform indirect PE inputs for services in the PFS are nearly 20 years old. These inputs are directly used to set reimbursement rates and as additional time passes, reimbursement rates in the PFS continue to move further from the actual costs. These disparities disproportionately impact specialties who spend significant time providing direct patient care, such as internal medicine and other primary care physicians. With nearly one third of Americans lacking access to primary care, the chronic lack of adequate support, including adequate reimbursement, drives burnout and contributes to nationwide shortages. While the AMA PPIS is underway, we encourage CMS to invite discussions with interested parties to identify a more standardized and routine approach to updating these inputs. In doing so, particular attention should be made to alternative ways to collect data. Surveys, particularly if done too frequently, can be laborious and burdensome, often yielding less-than-favorable response rates. This is almost always true for small and independent practices that provide care for the most vulnerable populations. As CMS considers its options, we encourage an open forum to share feedback and assess potential options.

Clinical Labor Pricing Update

As discussed in our CY23 comments on the PFS final rule, the College is pleased that CMS has implemented a four-year transition to update clinical labor pricing. We are also pleased that CMS has continued with that update for CY24, to be completed in CY25. This update is long overdue and most appropriate as wage rates are inadequate, do not reflect current labor rate information and result in distortions in the allocation of direct PE. We remain encouraged that those physicians who rely primarily on clinical labor rather than supplies and equipment will receive relative increases that are commensurate with their true costs. ACP encourages CMS to partner with physician organizations to determine how to update the cost data more frequently and fairly compensate physicians for rising costs, including the impact of inflation and increased staffing needs due to demand.

Potentially Misvalued Services Under the PFS, and Valuation of Specific Codes

General Behavioral Health Integration Care Management (CPT Code 99484)

ACP supports CMS' proposal to refine CPT code 99484 by increasing the work RVU to 0.93 from the current 0.61 and increasing the work time of 21 minutes to match the results of the surveyed work time. The College agrees that a work RVU of 0.93 is more appropriate than the RUC-recommended value of 0.85. However, we also echo the agency's concern about the continued undervaluing of care management services under the PFS given the variability of costs involved with these evolving models of care. We further agree that while there is a proposed increase for CPT code 99484, there is a systemic undervaluation of work estimates for behavioral health services. In its consideration of alternative or complementary means to our current process of valuing services, particularly E/M services, we strongly encourage the agency to simultaneously assess the current approach to valuing the behavioral health integration and management services.

Advance Care Planning (CPT Codes 99497 and 99498)

The College supports CMS' proposal to adopt the RUC-recommended work RVU of 1.50 for CPT code 99497 and 1.40 for CPT code 99498, which are the current values for these codes.

Pelvic Exam (CPT Code 9X036)

ACP supports the agency's proposal to adopt the RUC-recommended direct PE inputs for CPT code 9X036. The College believes this refinement will better capture the direct expenses associated with performing a pelvic exam in the non-facility setting.

Services Addressing Health-Related Social Needs (Community Health Integration services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)

Community Health Integration (CHI) Services (HCPCS Codes GXXX1 and GXXX2)

ACP is greatly supportive of the agency's proposals to expand equitable access to care and link underserved communities with critical social services in the community. CMS' proposal to create separate coding and payment for CHI services closely aligns with the principles and recommendations in our 2022 policy paper on *Reforming Physician Payments to Achieve Greater Equity and Value in Health Care*, as well as our 2022 policy paper on *Addressing Social Determinants to Improve Patient Care and Promote Health Equity*.

CHI services help address unmet social drivers of health (SDOH) needs that affect a patient's diagnosis and treatment. To ensure these needs are considered across the continuum of patient care, we recommend these needs be documented in the medical record. For purposes of data standardization, the College recommends that physicians and other practitioners be encouraged to use the ICD-10 codes from categories Z55-Z65 in the medical record and on the claim. ACP additionally agrees that a substantial portion of the work involved in furnishing these services, as well as the SDOH risk assessment, could be in-person but some could also be performed over the phone. For this reason, the College recommends CMS permit for patient consent for CHI services to be obtained via telephone.

ACP is also supportive of CMS' proposal to include coding and payment (HCPCS code GXXX5) for SDOH risk assessments. By providing for separate coding and payment for these services, physicians and other practitioners will be able to better account for the time and resources spent on assessments that ultimately impact patient care. Since SDOH needs undoubtedly impact patient care, the College also supports the agency's recommendation to make the SDOH assessment optional in a patient's annual wellness visit.

Principal Illness Navigation Services (HCPCS Codes GXXX3 and GXXX4)

ACP is highly supportive of CMS' proposal for inclusion of Principal Illness Navigation codes GXXX3 and GXXX4. In alignment with the Administration's shared commitment to improving care management and coordination, these codes would support physicians and other trained auxiliary personnel in improving critical transitional care for patients with serious illnesses. In the College's recent paper *Beyond the Discharge*, ACP highlighted the impact of care coordination efforts on improving the quality of patient care, particularly for those with multiple chronic conditions.

Evaluation and Management (E/M) Visits

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation, HCPCS Code G2211

ACP strongly supports CMS' proposal to implement the Medicare billing code, G2211. The G2211 code will improve Medicare beneficiaries' access to high-quality, continuous care and help sustain the physician practices beneficiaries rely on for comprehensive health care. Specifically, the College believes the following.

- **G2211 will help promote beneficiaries' timely access to primary care and other continuous services that promote better health care outcomes and help reduce spending.** The add-on code would strengthen the patient-physician relationship as it directly supports physicians' ability to foster longitudinal relationships, address unmet social needs, and coordinate patient care across the team. Evidence indicates increasing payments for these types of services reduces patient appointment wait times and supports the provision of services that improve patient health and can reduce costs.[1][2][3] Perhaps most importantly, studies also found that better continuity in primary care reduces mortality, health care expenditures, and hospitalizations.[4][5]
- **G2211 will advance more appropriate payments for primary care and other longitudinal, continuous care under the Medicare PFS.** Existing billing codes in the PFS do not account for the care coordination services or complex care provided by physicians longitudinally. Studies confirm that office visits provided by internal medicine and family medicine physicians are more complex than those provided by other specialties.[6] This complexity includes management of multiple interdependent conditions, balancing multiple clinical guidelines, registries, and coordination of care across a large team. Existing processes for creating and valuing office visits and other codes fail to account for this additional complexity because they consider the "typical" patient and office visit across all medical specialties. Thus, G2211 fills a gap left by the current Medicare PFS coding and billing structure that is straining physician practices and is not duplicative of other codes. The financial struggles that currently exist because of gaps in current payment codes harm patients, as practices are forced to shorten office visits or accept fewer Medicare beneficiaries.
- **By advancing fair and accurate payment in Medicare, G2211 will help sustain primary care and other physician practices Medicare beneficiaries rely on and bolster the physician workforce.** Over time, the addition of many new procedural codes with higher values to the PFS has

[1] Increased Medicaid Reimbursement Rates Expand Access to Care. National Bureau of Economic Research. 2019. Available at: https://www.nber.org/bh-20193/increased-medicaid-reimbursementrates-expand-access-care.

[2] Candon M, Zuckerman S, Wissoker D, et al. Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients. JAMA Intern Med. 2018;178(1):145–146. doi:10.1001/jamainternmed.2017.6302.

[3] Williams MD, Asiedu GB, Finnie D, et al. Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives. BMC Health Serv Res. 2019;19(1):92. Published 2019 Feb 1. doi:10.1186/s12913-019-3916-5.

[4] Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH. Primary medical care continuity and patient mortality: a systematic review. Br J Gen Pract. 2020 Aug 27;70(698):e600-e611. doi: 10.3399/bjgp20X712289. PMID: 32784220; PMCID: PMC7425204.

[5] Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL Jr. Higher Primary Care Physician Continuity is Associated With Lower Costs and Hospitalizations. Ann Fam Med. 2018 Nov;16(6):492-497.

[6] Katerndahl, D; Wood, R; Jaén, CR. Complexity of ambulatory care across disciplines. Healthcare. 2015, Available at: https://doi.org/10.1016/j.hjdsi.2015.02.002.

resulted in a devaluing of primary care and other cognitive services.[7] This devaluation has led to lower compensation for cognitive care physicians despite the vital role they play in managing chronic conditions and coordinating patient care across a large team. As a result, the interest in pursuing primary care and other cognitive specialties has declined, exacerbating physician shortages in rural and other underserved areas across the nation.[8] While CMS recently updated the office visit codes to address this devaluation, the new codes do not fully account for the complexity or unique costs of providing longitudinal primary care.[9] Implementing G2211 will help to close these compensation disparities and bolster patient access to a physician workforce that better meets the needs of our aging population.

Increased Complexity of Primary Care Office Visits/Work Not Currently Accounted For

Primary care office visits include the provision of patient-centered, integrated, and community-aligned services to achieve better health and better care at lower costs. Evidence clearly demonstrates that primary care O/O E/M visits are more complex, comprehensive, and impactful than other E/M visits. ACP goes into greater depth in the forthcoming section, *Request for Comment About Evaluating E/M Services More Regularly and Comprehensively*, but we strongly believe the existing CPT and RUC methodologies and processes for describing and valuing E/M services do not adequately account for the complexity and intensity of E/M visits. G2211 is intended to be billed with codes for O/O E/M visits to better account for the unique and inherent complexity of services provided through longitudinal patient care that is based on a physician or clinician's ongoing relationship with a patient. While the revisions to the O/O E/M codes better account for the work in these services, the CPT and RUC processes focus on the "typical" patient prohibits the capture of added complexity beyond the typical. Accordingly, the College believes there remains a gap in office-based coding in the PFS that can be filled by implementation of G2211.

ACP is confident G2211 will help in capturing the added complexity of primary care O/O visits. The increased complexity of care provided by internal medicine and family medicine physicians is consistent with their expanding role in managing multiple chronic problems, working with limited evidence, balancing multiple guidelines, and coordinating care with multiple physicians. A 2015 study found that primary care specialties uniquely experience increasing numbers of chronic medical problems, complexity of medication regimens, numbers of guideline-indicated services, demand for preventive services, and pressures for accountability and performance. Managing the overall health of a patient requires coordinating care with various specialists. This coordinated care is the crux of primary care and can lead to unique costs. In these instances, the additional complexity is not captured in the current E/M code structure.

It has also been argued that the work of G2211 can be captured by TCM, CCM, and PCM codes. But as CMS acknowledges in the CY21 PFS final rule, G2211 reflects the time, intensity, and PE when primary care physicians and their clinical care teams furnish services that enable them to build longitudinal

[7] Linzer M, Bitton A, Tu SP, et al. The End of the 15-20 Minute Primary Care Visit. J Gen Intern Med. 2015;30(11):1584-1586. doi:10.1007/s11606-015-3341-3.
[8] Berenson and Rich, "US Approaches to Physician Payment." 2010. Available at: https://pubmed.ncbi.nlm.nih.gov/20467910/.
[9] Berenson, Shartzer, and Murray, "Strengthening Primary Care Delivery through Payment Reform.

relationships with all patients and to address patients' health needs with continuity and consistency over long periods of time. Contrarily, PCM codes are limited to patients with a single high-risk disease; CCM codes are limited to patients with two or more chronic conditions; and TCM codes are limited to patients experiencing a discharge from the hospital/facility setting and focus on care management for 30 days following a discharge, rather than on an ongoing basis. G2211 is needed to better account for the unique and additional costs of providing continual, longitudinal care for all patients.

The College would additionally be remiss to not acknowledge and express our support for the revisions made by the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) to revise the O/O E/M code set. As an active participant in the CPT/RUC E/M workgroup, ACP joined several other medical societies in what ultimately led to some of the most consequential changes to E/M services. However, two things can be true at the same time: we appreciate the effort put into refining the E/M services and believe the work captured by G2211 is not currently accounted for.

Utilization Estimates

ACP is pleased that CMS refined the utilization estimates for G2211. Though we agree that the utilization estimates the agency originally used were inflated, we are still concerned with the proposed 38% projected utilization and then 54% years later. As the College has previously pointed out, similar codes implemented in recent years, such as chronic care management (CCM) and transitional care management (TCM) services, have had lower-than-expected utilization rates. Although two-thirds of Medicare beneficiaries are eligible for CCM services, these codes accounted for only 2.3% of all claims. Similarly, TCM services were only found on 9.3% of claims for the total eligible population of 22%. This is a strong indication that a more accurate estimate for G2211 would be considerably lower than 38%.

ACP further offers that CMS consider making the add-on code G2211 incident-to a physicians' service. About 25% of the utilization estimate is attributed to nurse practitioners (NPs) and physician assistants (PAs). We believe making this change will lower the utilization estimate and help account for patients that are truly complex while positively adding to the longitudinal relationship of the patient and physician.

Impact Analysis

Though ACP is strongly supportive of the implementation of G2211, we acknowledge the challenges presented by the Medicare payment system. Since policy changes in the PFS are mandated to be budget neutral, payments must be reduced for some other services. Unfortunately, this mandate pits specialties against one another, sometimes resulting in disagreement regarding investment in efforts that are long overdue, investments that would result in significant long-term benefits for physicians and patients. The College disagrees, however, with opposition to the implementation of G2211 on the basis of its impact to the conversion factor. We believe that efforts are better spent addressing the more pervasive dilemma of budget neutrality and the unfortunate fact that improvements cannot be made without cuts elsewhere.

Challenges with the Medicare payment system are compounded by the lack of any annual updates. Adjusted for inflation, physician payment has declined 26% from 2001 to 2023. There is no question that there must be an inflationary update if we are to protect access to high-quality care for patients covered by Medicare, but there must also be integrity restored to the systems that we currently have. Though

ACP is disappointed that G2211 will impact the conversion factor, there currently exist significant distortions in the PFS that have existed for many, many years. The College believes it could be argued that the impact from G2211 would be substantially outweighed by addressing the fact that the majority of visits in the global period are not being furnished but are paid for, nonetheless.

As evidenced by the 2019 RAND report, the vast majority (ratio = 0.04) of expected post-operative visits for procedures with 10-day global periods are not delivered. Among procedures with 90-day global periods, the ratio of observed to expected post-operative visits provided was 0.38. In an additional analysis of the 2019 claims data, RAND's adjustment to work RVUs, physician time, and direct PE inputs resulted in a 2.6% net reduction in RVUs across all PFS services. At the 2019 conversion factor, this reduction equals $2.5 billion in Medicare allowed amounts. Though several factors impact what the true cost savings would be, at a minimum the conversion factor would increase, and payments could be redistributed across all physicians' services.

ACP understands that there are several important distributional implications with this revaluation approach. The College is careful to not diminish these, but the resounding point is that the overvaluation of procedures with 10-day and 90-day global periods leads to overpayment by Medicare, inflated beneficiary cost-sharing burden, and distorted incentives for practitioners to overprovide these services, with further implications for Medicare payments and beneficiary costs and health. The College commends CMS for initiating discussions regarding the global periods and we strongly encourage the agency to improve the accuracy of valuation of these global periods and redistribute potential savings to Medicare by moving forward.

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

It is clear that the Medicare physician payment system needs repair. Rethinking how Medicare determines payment amounts for physicians' services is a longstanding debate with significant and far-reaching impact. Given Medicare's size and role as a public program, reforms to improve its value have tremendous potential to improve care quality and health outcomes throughout the country as well as to generate savings for beneficiaries and taxpayers. Unfortunately, the system's shortcomings are just as substantial.

For years, physicians have struggled with an annual cycle of Medicare payment cuts and the absence of any inflationary updates that has put seniors' access to care at risk. While ACP is encouraged by the introduction of legislation in Congress to help ensure that Medicare payments to physicians begin to keep up with inflation, we strongly believe it is essential be maintain integrity in the Medicare PFS, ensure patients receive high-quality care, and determine accurate payment rates for physicians' services. ACP believes that part of this objective is to make sure we utilize and refine the most appropriate and adequate processes for doing so.

The RUC provides relative value recommendations to CMS annually. Along with several other medical societies, ACP is an active participant in the RUC process. Accordingly, we provide robust input into the CPT and RUC processes, including engagement in the CPT/RUC E/M workgroup to study the issue of documentation requirements in the O/O E/M code set and develop recommendations for improvement. The College is most appreciative of these opportunities and the incredible work that has resulted in positive changes for physicians and patients across the country. To support the RUC's work, ACP has also published and made available to members numerous educational materials to discuss the importance of internal medicine physicians' participation in the RUC process and determining fair values.

These processes are not without their flaws, however. While ACP supported the RUC's 2011 decision to expand its membership to include more representation of primary care and geriatrics, we acknowledged more needed to be done to ensure the RUC has the necessary expertise from physicians with the training, skills, and experience in comprehensive and longitudinal care of patients, especially those with complex illnesses. Due to the RUC's tendency to value codes primarily on the basis of the physical skill involved, cognitive services (i.e., critical thinking involved in data gathering and analysis, planning, management, decision making, and exercising judgment in ambiguous or uncertain situations) are routinely undervalued. In fact, one study found that Medicare reimburses physicians 3 to 5 times more for common procedural care than for cognitive care. In that study, the authors demonstrated that two common specialty procedures, cataract extraction and screening colonoscopy, can generate more revenue in one to two hours of total time than a primary care physician receives for an entire day's work. Though cognitive services are not procedure-intensive (e.g., spinal tap), with technological innovations, mass amounts of data to review, and the role of team-based care, internal medicine physicians and primary care physicians' services (e.g., care coordination for a high-risk patient) are increasingly labor-intensive. The College understands that physicians who primarily provide procedural services also provide a degree of cognitive care, but those physicians who almost exclusively provide cognitive care are deprived of an appropriate accounting due to the RUC's reliance on the metrics of time, intensity, and practice expense alone.

Importantly, these fundamental biases are averse to the critical role that primary care plays in health care and necessary reform to support the provision of continuous, patient-centered, relationship-based care. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels. As the NASEM report points out, the nation's health is directly linked to the strength of its primary care delivery system and workforce. As the current payment system drives down the value of primary care, there has been a resulting shortage of primary care physicians. This shortage will, and has had, a profound impact on the quality of care and patient health outcomes, particularly for our most vulnerable populations. Accordingly, the systemic undervaluing of cognitive, including primary care, services is problematic and widespread.

CMS must implement a supplement or complement to the RUC, as a one-size-fits-all approach to assign value to physicians' services is unworkable and fails to serve subsets of physicians' services, particularly E/M. ACP believes that it is unfortunate that the current payment system pits specialties against one another due to budget neutrality. However, those providing the nation's primary care needs should not pay the price. The College does not believe that the RUC is not effective or should be replaced in its entirety. The RUC's history demonstrates that it serves the other subset of physicians' services well. The College recommends that, for E/M services in particular, the valuation process is supported by an independent, wholly separate entity. In doing so, ACP believes it is imperative that the physician community is involved in this process, specifically medical specialty societies and physicians that perform the majority of E/M services.

In ensuring the physician community is adequately involved and represented, the College strongly recommends the RUC perform an assessment of its current methodologies. As ACP has expressed to both the RUC and AMA, the current survey process is laborious, burdensome, and regularly yields poor response rates from specialties that, for example, provide the majority of primary care and other E/M

services. The data, therefore, is less than informative and riddled with representational issues. ACP's experiences have demonstrated that since this data is used to support the RUC's recommendations to CMS, and ultimately informs reimbursement rates and downstream coverage and access decisions by private payers, unfruitful valuation efforts have a widespread impact. It is necessary that the recommended assessment particularly addresses the ways in which the RUC can improve its processes to ensure there is proportional representation and participation across all medical specialties. There should also be attention given to the survey design itself and whether the standard information collected, as well as the way it is collected, is the most appropriate for each service, particularly E/M, and is not burdensome to communities that are already resource deprived. ACP strongly encourages the RUC to collaborate with the participating medical specialty societies to imminently refine the process, and the College continues to welcome the opportunity.

ACP strongly believes there are refinements needed to the RUC process and methodology, but we would be remiss to not also acknowledge the challenges presented by a supplementary or complementary approach to the RUC process. Creation of an alternative panel could be labor and resource intensive and may ultimately result in the same pitfalls that currently exist. As a launching point, ACP recommends CMS explore the possibility of the Medicare Payment Advisory Committee (MedPAC) providing such advisory responsibilities. In addition to advising Congress on payments to private health plans participating in Medicare and practitioners in Medicare's traditional FFS program, MedPAC provides information on access to care, quality of care, and other issues affecting Medicare. Since the RUC advises on only the relative resources to furnish a service, without consideration for the tertiary impacts, the College believes the MedPAC is uniquely situated to enhance the RUC's work. As recent as May 2023, the Commission conducted a review of Medicare payments for primary care services and the impact to beneficiary access to care. While the College understands that there may need to be revisions to the MedPAC and its processes to assume this responsibility in either the long- or short-term, we believe it critical that CMS begin exploring alternative or complementary approaches.

Medicare's relative values not only inform the PFS but are also used by Medicaid and private insurers. Due to the widespread implications, ACP is greatly supportive of the agency's efforts to improve the accuracy of valuing services. We encourage CMS to provide additional opportunities to engage with the agency on this subject and look forward to refining current processes to ensure resources are well accounted for in the inputs for certain services, particularly E/M.

Split/Shared Visits

In response to both the CY22 and CY23 PFS, ACP has urged CMS to refine its policy regarding split (or shared) visits. Though ACP is pleased the agency is proposing to delay implementation of its policy finalized in CY22, the College has recommended the agency transition to using either MDM or time to determine the substantive portion of the visit. We believe this approach will recognize physician contributions and provide appropriate compensation for the time it takes to supervise and furnish these services. It would also promote consistency across the E/M code family by aligning with the 2021 O/O E/M changes and revisions to the inpatient codes.

The College recommends that when the physician participates and meaningfully contributes to the MDM – even if the physician does not perform the MDM in its entirety – or when the physician meets the time threshold, then the physician should be considered to have performed the substantive portion of the visit. ACP believes this would best account for the physician's contributions in collaborating with

the AP, particularly when involved in cases with greater complexity. The recommended approach also encourages APs to work to the top of their license, consulting with the physician when the situation is particularly difficult. In these situations, the physician is performing the key component of the visit and has meaningfully contributed, though not necessarily spending more than half of the total time.

The MDM components to support the billing of the split/shared visit should also align with the key elements finalized with the 2021 O/O visits. MDM, provided by the physician, is what determines the plan of care. Simultaneously, the concept of collaborative practice is preserved and the negative downstream impact on the patient experience is removed. We encourage CMS to work with specialty organizations to determine appropriate steps to facilitate the recommendation.

Medicare Telehealth Services

Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List, and Consolidation of the Categories for Services Currently on the List

ACP is pleased that CMS has proposed to streamline the code-coverage process for future rulemaking cycles, revising the Category 1-3 taxonomy to a simpler permanent or provisional code status. The College agrees that the move toward a binary classification approach could address the confusion from interested parties submitting requests. We further believe this revision better recognizes that evidence development for code coverage does not happen on an annual timeline.

Implementation of Provisions of the CAA, 2023

In-person Requirements for Mental Health Telehealth

ACP is pleased that CMS is proposing to delay the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunications technology under Medicare until January 1, 2025, rather than until the 152nd day after the end of the PHE in accordance with the CAA, 2023. However, the College is disappointed that CMS is not proposing to permanently eliminate the in-person requirements for mental health visits, and certain other health care services.

The College believes that there are many positive aspects of both phone and video visits that benefit patients (i.e., access to other family members, transportation issues, the ability to check medications, etc.) and sees no solid rationale or clinical application for requiring a physician to see a patient in person for a mental health exam. This requirement is not based on medical necessity, and the College is opposed to imposing regulations that do not improve patient safety or outcomes. This policy would additionally hamper many psychiatrists who care for patients outside of their locality from continuing to care for many of their patients, unless the in-person visit could be local for the patient and conducted in partnership with a primary care physician. If CMS' imposition of this requirement is based on fraud and abuse concerns for audio-only visits, the Agency should consider the many informatics solutions that could be implemented to eliminate such concerns.

Originating Site Requirements

The College was pleased that in the 2023 Final Rule, CMS finalized proposals to continue to allow telehealth originating sites for any service on the Medicare Telehealth Services List to include any site in the U.S. where the beneficiary is located at the time of the telehealth service, including an individual's home, beginning on the first day after the end of the PHE for COVID-19 through December 31, 2024. ACP has been a proponent of expanding access to mental and behavioral health services, including

allowing beneficiaries to access services from home, or if the technology is not available at home, from a rural health clinic or hospital. However, the College continues to recommend that CMS permanently extend the policy to waive geographical and originating site restrictions for *all* telehealth services.

Telehealth Practitioners

As discussed in greater depth in the forthcoming section, *Advancing Access to Behavioral Health Services*, ACP is very supportive of CMS' proposal to recognize marriage and family therapists and mental health counselors as telehealth practitioners whom Medicare payment may be made for their services. Adding these professionals to the list of practitioners will advance access to behavioral health services and help better support the care provided for a person's emotional and mental well-being. The College continues to encourage CMS to implement changes that help close the access gap by expanding the behavioral health workforce and paying more accurately for behavioral health services.

Place of Service for Medicare Telehealth Services

ACP is strongly supportive of CMS' proposal to pay the non-facility rate for telehealth services provided to a patient when they are at home. Since many physicians offer hybrid telehealth and in-person visits, it is essential that physicians and other practitioners maintain a physical office. The College additionally believes that the value of the physician's time remains consistent for the same service, whether delivered in-person or virtually, even if the cost of the infrastructure utilized for the visit varies. Providing telehealth services is as labor and time intensive as an in-person visit, so it simply is not the case that telehealth is a less expensive way of treating patients. It is evident that the cost of treating patients through telehealth does not differ from an in-person visit, and ACP is pleased that CMS' proposal reflects this fact and builds on the lessons learned from the COVID-19 public health emergency, which demonstrated how vital telehealth care is to providing access to high-quality health care.

Direct Supervision via Use of Two-way Audio/Video Communications Technology, including Supervision of Residents in Teaching Settings

The College is disappointed that CMS is not making the direct supervision flexibility permanent and is instead proposing to cease defining direct supervision to allow the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications after December 31, 2024. Disappointingly, CMS is also proposing to revise regulatory text so that, after December 31, 2024, the presence of the physician (or other practitioner) will not include virtual presence through audio/video real-time communications technology.

There are a number of robot-assisted surgeries that are performed with the surgeon sitting at the console manipulating robotic arms (attached to the surgical instruments) with the use of hand and foot controls. These procedures are much more invasive than supervising residents via real-time two-way audio/video communications.

In previous comments to CMS, ACP advocated for permanency of the direct supervision flexibility based on our belief that doing so would support the expansion of telehealth services and protect frontline health care workers by allowing for appropriate social distancing measures. While social distancing may no longer be a chief concern, the College still believes that clinicians should feel empowered to supervise clinical staff virtually, at their discretion, regardless of whether there is a PHE, as we previously stated.

The College remains concerned that the expiration of the direct supervision flexibility means that supervision will be required to happen synchronously, which the College continues to oppose. Such a requirement places an extra onus on the preceptor/supervisor to be in the same vicinity as the supervisee (i.e., the resident or fellow the physician is supervising). ACP strongly believes that direct supervision does not have to be synchronous and there is no reason to require synchronous direct supervision.

Clarifications for Remote Monitoring Services

Use of Remote Patient Monitoring, Remote Therapeutic Monitoring, in Conjunction with Other Services

ACP is disappointed that CMS is proposing to clarify that RPM and RTM may not be billed together, so that no time is counted twice by billing for concurrent RPM and RTM services. CMS clarified that in instances where the same patient receives RPM and RTM services, there may be multiple devices used for monitoring, and in these cases, the services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary. However, different clinicians and specialists are using RTM and RPM for different reasons. If a patient has a continuous glucose monitor for type 2 diabetes (with endocrine) and a scale for heart failure (with cardiology). This will put an undue burden on the different specialists or primary care physicians. Therefore, ACP opposes this proposal.

Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy

ACP supports regulatory changes that cater to a patient's individual needs and improve access to services if the services are appropriately performed via telehealth and are compliant with the latest clinical standards, guidelines, and best practices. The College believes these conditions are met in these proposed changes and therefore, ACP is supportive of the proposed changes to expand telehealth flexibilities for outpatient therapy services, DSMT and MNT.

Caregiver Training Services

ACP recognizes that the caregiver's role is an important aspect in improving patient outcomes. CMS is proposing to make payments when practitioners train and involve caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan. Payment for this important aspect of whole-person, coordinated care has significant implications for health equity as many patients who receive care through their Medicare plan have caregivers who would benefit. However, ACP encourages CMS to consider making payments only to those who provide such training have a longitudinal relationship with the patient in order to provide continuity of care. This important service should not be let to those who do not share such a relationship with the patient.

Advancing Access to Behavioral Health Services

Proposed Changes to Regulations

ACP is very pleased with CMS' intent to finalize proposals that support a person's emotional and mental well-being through their behavioral health care. Specifically, the College is supportive of the agency's proposals to allow licensed professional counselors, including additional counselors, and marriage and family therapists to enroll in Medicare and bill for their services for the first time. We strongly believe this proposal will advance access to behavioral health services and expand the types of practitioners

that can furnish these services as part of primary care. We are further supportive of CMS' proposal to increase payment for crisis care, substance use disorder treatment, and psychotherapy. Individually, the College strongly believes that each of these proposed changes would help to make an essential contribution towards strengthening behavioral health care for people with Medicare. Taken as a whole, we further believe these proposals can make a profound and sustained difference in the behavioral health treatment of millions of people across the U.S.

The College continues to encourage CMS to implement changes that help close the access gap by expanding the behavioral health workforce and paying more accurately for behavioral health services. Another strategy to expand access to behavioral health services is for CMS to enable continued use of telehealth for such care, including through audio-only modalities for patients and localities where audio-visual capabilities do not exist. In addition to this strategic policy, CMS can also work with other agencies, such as the FTC, in efforts to expand broadband access across the U.S., to allow for improved access to audio-visual tele-behavioral health services.

Updates to the Payment Rate for PFS Substance Use Disorder (SUD) Bundle (HCPCS codes G2086-G2088)
The U.S. is in the midst of a drug overdose epidemic. According to the Centers for Disease Control and Prevention, 106,699 people died from a drug overdose in 2021, a 14% increase from 2020. Over 15% of adults aged 12 and older needed substance use disorder treatment in the past year in 2021 but few received it. ACP strongly supports action to facilitate access to substance use disorder treatment, including medications for opioid use disorder, like buprenorphine. In-office substance use disorder treatment can help achieve these goals and enable patients to receive care for co-occurring conditions. The Office-Based Substance Use Disorder (SUD) Treatment Bundle (HCPCS Codes G2086-G2088) covers overall management, care coordination, individual and group psychotherapy, and substance use counseling. Inadequate reimbursement is among the significant barriers to accessing psychosocial care in medication-assisted treatment. ACP believes the proposed payment increase for the in-office SUD bundle will help ensure the complex care needs of patients receiving in-office treatment for substance use disorders are addressed and that the complexity of delivering office-based SUD treatment is accurately reflected.

Comment Solicitation on Expanding Access to Behavioral Health Services
The College appreciates the agency's request for feedback on ways to increase utilization of the psychiatric collaborative care model. Medicare's 2016 decision to cover and reimburse for integrated behavioral health services marked important policy progress. Unfortunately, the actual utilization of these codes has lagged far behind the need for integrated care.

We additionally recommend the following.

- Allow clinical staff to obtain consent under general supervision of the treating physician. Once consent is given there should be no need to re-obtain consent from a patient during that episode of care. Consent should be tied to inclusion in the program within the practice and not to the identified treating clinician.
- Eliminate limitations on billing CPT code 99494 related to Medically Unlikely Edit policies. Under current policy, practices cannot bill more than two instances of CPT code 99494 code a month. When managing a patient requires additional time, that additional care goes unreimbursed.
- Allow FQHCs and RHCs to bill the existing CPT codes (99492-99494, G2214). Most payers, including many Medicaid plans, use the CPT codes to bill for CoCM services. Consistency across

payers will reduce the administrative burdens and potential errors that occur when required to do something differently for what is likely a small subset of patients.

- CoCM services often include crisis services. New HCPCS codes specific to CoCM crisis services should be created, with higher rates, given the intensity of the services. This is similar to the approach taken for the enhance psychotherapy codes.

RFI re: Digital Therapies, such as, but not limited to, Digital Cognitive Therapy

ACP agrees that the physical safety and privacy of beneficiaries using digital cognitive behavioral therapy or other digital therapeutics for behavioral health are important issues and that measures must be taken to ensure the physical safety and privacy of patients using these technologies. In a 2021 position paper on health information privacy, ACP acknowledged that such digital health products pose significant privacy risks because the data they collect are typically not covered by HIPAA and lack the robust legal protections of traditional health information. In the paper, ACP recommends that a comprehensive federal privacy statute that protects sensitive health information that falls outside of the scope of HIPAA would be a step in the right direction when it comes to protecting the privacy of beneficiaries' health information.

Physical safety is another major concern, given that many digital health products are not sufficiently vetted by health care practitioners and the medical information or guidance dispensed may not be evidence-based nor in accordance with established medical standards of care. Furthermore, with medical device hacking and the proliferation of malicious software ("malware") and ransomware attacks on the rise, cybersecurity measures are also urgently necessary to protect beneficiaries' physical safety along with the privacy of their health information.

Barriers to digital CBT reaching underserved populations include the widespread lack of broadband in certain areas across the U.S., particularly in rural areas. Improving broadband access through efforts such as the Federal Trade Commission's Affordable Connectivity Program will have a significant positive impact on high-speed internet access, and therefore digital CBT access, across the nation. In addition to broadband, the continued ability to provide digital behavioral and mental health services (e.g., those provided through telehealth) through audio-only technology is another major factor in improving access to such services. These measures, in turn, are likely to have a positive impact on behavioral and mental health care equity.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Implementation of the CAA, 2023

ACP is pleased that CMS is proposing to make conforming regulatory text changes based on CAA, 2023 to the applicable RHC and FQHC regulations in 42 CFR part 405, subpart X to include the delay of the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology under Medicare beginning January 1, 2025. However, as stated above, the College is disappointed that CMS is not proposing to permanently eliminate the in-person requirements for mental health visits, and certain other health care services.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

ACP is pleased that for RHCs and FQHCs, CMS is proposing to continue to define "immediate availability" as including real-time audio and visual interactive telecommunications through December 31, 2024. However, as noted above, the College is again disappointed that CMS is not making the direct

supervision flexibility permanent. In previous comments to CMS, ACP advocated for permanency of the direct supervision flexibility based on our belief that doing so would support the expansion of telehealth services and protect frontline health care workers by allowing for appropriate social distancing measures. While social distancing may no longer be a chief concern, the College still believes that clinicians should feel empowered to supervise clinical staff virtually, at their discretion, regardless of whether there is a PHE, as we previously stated. Furthermore, the College believes that this provisioning should extend to all health care professionals and not just RHCs and FQHCs. Given that many health care professionals can be in dual locations (e.g., an FQHC and an academic health system or an RHC that is affiliated with a larger center) the restriction to RHCs and FQHCs will create confusion and added clinician burdens related to remembering to follow different procedures depending on location. It will also create a differential in-patient experience, which is a cause for concern.

The College remains concerned that the expiration of the direct supervision flexibility means that supervision will be required to happen synchronously, which the College continues to oppose. Such a requirement places an extra onus on the preceptor/supervisor to be in the same vicinity as the supervisee (i.e., the resident or fellow the physician is supervising). ACP strongly believes that direct supervision does not have to be synchronous and there is no reason to require synchronous direct supervision.

Updates to Supervision Requirements for Behavioral Health Services furnished at RHCs and FQHCs
ACP is pleased that in order to be more consistent with applicable policies under the PFS, for CY 2024, CMS is proposing to change the required level of supervision for behavioral health services furnished "incident to" a physician or NPP's services at RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS for CY 2023. ACP is similarly pleased that CMS is proposing to revise the regulations at §§ 405.2413 and 405.2415 to reflect that behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or another practitioner).

RHCs and FQHCs Conditions for Certification of Coverage (CfCs)
ACP supports CMS's proposals to modify the existing RHC and FQHC CfCs to include MFTs and MHCs as part of the collaborative team approach to provide services under Medicare Part B and to include definitions of other healthcare professionals who are already eligible to provide services at RHCs and FQHCs. These changes would help resolve lingering questions and lack of clarity on the eligibility of certain health care professionals to provide services in various contexts. ACP also supports adding conforming changes to the CfCs to include MFT and MHC services to indicate that RHC and FQHCs can offer these services under their Medicare certification. Furthermore, these changes will advance access to behavioral health services and better support whole-person care, inclusive of patients' emotional and mental well-being.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Program (OTPs)
Underserved populations are more likely to have access to audio-only, telephonic communication technology than audio-video technology. ACP supports the proposal to permit audio-only periodic assessments for patients receiving buprenorphine treatment via opioid treatment programs when audio-video communication capabilities are not available to the Medicare enrollee if SAMHSA and DEA

requirements are met, through the end of CY2024. This extension will help promote health equity and address health care disparities by ensuring services are accessible following the end of the COVID-19 public health emergency.

Medicare Sharing Savings Program (MSSP)
Modifications that grant certain participants more time within upside-only arrangements could potentially boost participation in the MSSP, aligning with the administration's objectives. Assessments of the adjustments made to benchmarking and risk adjustment should be conducted through modeling to ascertain their alignment with stakeholder requirements.

Qualifying Participant (QP) Determination
ACP is discouraged that CMS is proposing to calculate QP determinations at the individual level (previously at the entity/group level) for each unique NPI associated with an eligible clinician participating in an Advanced APM MSSP. While ACP recognizes that the intent of the proposal was to encourage specialty participation, this change may result in the opposite outcome while increasing the administrative burden on the physician.

Risk Adjustment Methodology
ACP is pleased with proposed changes aimed to encourage participation by ACOs caring for medically complex, high-cost beneficiaries including the elimination of a downward adjustment for ACOs that would face a negative overall adjustment with the previous methodology. Due to the impacts of proposed changes including new codes added to the Primary Care calculation and an extended 24-month lookback window, CMS projects a 2.9% increase in beneficiary participation which supports ACP and CMS shared interest in increasing access while shifting to value. ACP is interested to know what percentage of new participants are new to value-based care arrangements and serve medically complex beneficiaries (looking at dual eligibility could be a way to do this).

Certified Electronic Health Record (CEHRT) Threshold
The College is pleased with CMS' proposal to remove the MSSP Certified Electronic Health Record Technology (CEHRT) 70% threshold requirement beginning PY24. However, ACP does not agree that a reasonable replacement is a new requirement for all MIPS eligible clinicians, QPs, and Partial QPs to report Promoting Interoperability (PI). The College is concerned that this requirement would effectively disincentivize AAPM participation as a significant incentive is the exemption from traditional MIPS reporting. ACP encourages CMS to look for an alternative solution that neither increases administrative burden nor disincentives AAPM participation.

Medicare Clinical Quality Measure (CQM)
ACP highly supports CMS' proposal which specifies that ACOs that report Medicare CQMs would be eligible for the health equity adjustment to their quality performance score.

Hybrid Model
The College is pleased to see the highlighting of a potential hybrid model within the MSSP. ACP, alongside other groups interested in appropriate payment for primary care, have outlined various principles that we believe would promote success in such program. These principles include that:

- Equity considerations must be embedded in the hybrid payment option.
- There will be added value for the Medicare beneficiary.

- The option must result in increased investment in primary care.
- The option must be fully voluntary.
- The option must be available rapidly and in all geographies.
- Implementing this option will create additional value for Medicare.

ACP strongly encourages CMS to continue to engage with patients, physicians, and other health care professionals when moving forward with the design and implementation of a hybrid approach to paying for primary care in the MSSP. To promote the widest participation, the model's design must provide primary care practices with assurance that they will share directly in additional financial incentives. Meaningful participation of *primary care* clinical leaders in ACO governance is one powerful means to that end and should be incorporated into the model. We thank CMS for the acknowledgment of the value of prospective population-based payment and look forward to working with the Agency on developing this model further.

ENHANCED Plus Track

ACP is supportive of increasing opportunities for physicians and other health care professionals to enter into value-based care arrangements. A higher risk track needs to be simultaneous with other, lower risk tracks in order to create a glide path to value which ensures that all types of practices are able and incentivized to participate. ACP believes sufficient guardrails should be included to best protect physicians and their patients including assurance that these investments reach the primary care practices.

Medicare Diabetes Prevention Program (MDPP)

The College is supportive of the major proposed changes to the MDPP including the proposed new G-codes for MDPP services provided in a virtual setting, which creates a greater opportunity to gain additional insights on the effectiveness of virtual services. Additionally, ACP supports the increased flexibilities extended through the elimination of the cap on the number of services that may be provided virtually and the allowance of alternatives for in-person weight requirements. CMS also proposes to streamline the MDPP payment structure from a performance-based attendance and weight loss structure to a hybrid structure that pays for attendance on a fee-for-service basis and diabetes risk reduction (i.e., weight loss), on a performance basis.

Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan

ACP is pleased that CMS is proposing to integrate the Medicare Part D regulation that permits the use of either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the beneficiary are part of the same legal entity while still maintaining the requirement for e-prescribing into the CMS EPCS Program. As CMS notes, this change will provide alignment across electronic prescribing policies for prescriptions prescribed and dispensed within the same legal entity without forcing these entities to adopt the NCPDP SCRIPT standard for these transmittals. ACP likewise supports the removal of the same entity exception.

ACP supports the proposal to modify the definition of "extraordinary circumstance" to mean a situation outside of the control of a prescriber that prevents the prescriber from electronically prescribing a Schedule II-V controlled substance that is a Part D drug and to drop the restriction "other than an

emergency or disaster." As CMS notes, this modification would allow prescribers the ability to request a waiver regardless of whether CMS triggers the recognized emergency exception. ACP also supports the proposal that as a default, prescribers impacted by the CMS EPCS Program recognized emergency exception would be excepted for the entire measurement year, and not just for the duration of the emergency. ACP is also pleased that CMS is proposing to continue the practice of issuing a prescriber notice of non-compliance as a non-compliance action for subsequent measurement years.

Updates to the Quality Payment Program (QPP)

APMs

ACP calls on Congress to pass legislation that would extend the APM Incentive Payment, freeze the QP payment threshold at its current level, and replace these differential CF updates with an inflation-based update for all physicians.

Traditional MIPS

ACP strongly opposes CMS' proposal to raise the performance threshold for avoiding MIPS penalties from 75 points to 82 points. ACP has previously advocated against increasing these threshold requirements, emphasizing that the 75-point threshold was established using 2017 claims data, a year marked by the transition to MIPS. The new threshold is derived from an average of claims data spanning 2017 to 2019. According to CMS' own projections, this adjustment could lead to a higher number of MIPS-eligible clinicians facing penalties, potentially resulting in payment reductions of up to -9 percent.

Performance Measures

New Quality Measures Proposed for the CY24 Performance Period

Preventive Care and Wellness (composite)

ACP agrees that measures assessing prevention and early identification of disease are an essential component when evaluating physicians, particularly primary care physicians. However, we do not support the combination of individual MIPS preventive measures into a composite measure. The benefit of this measure is questionable. There has long been an argument in the performance measurement community about the value of composite measures in both assessing performance and identifying areas for improvement. While composite measures gained favor because they offer the promise of providing a clearer picture of overall performance, they should not be used alone. Rather, they should be a complement to individual measures when profiling and creating incentives for improvement. Each one of the measures assess important aspects of prevention and detection of disease (i.e., addressing influenza immunization, pneumococcal immunization, breast and colorectal cancer screening, body mass index screening, tobacco use screening and cessation intervention, and screening for high blood pressure with follow-up). While all of them were reviewed by ACP's Performance Measurement Committee (PMC), four out of seven measures were supported by the PMC. The most common reasons that the other three measures were not supported included concerns related to evidence, feasibility, and unintended consequences.

ACP is pleased to see that the composite measure specifications have been improved since previous versions of the measure and now include the use of a denominator-weighted score. However, it is unclear if the results of the seven components will be made available to those reporting on the measure. CMS has not done so in the past with multi-component/composite measures. If this is the

case, the opportunities for improvement will be unclear and it will defeat CMS' stated intent to assess performance and to *support performance improvement.* ACP strongly recommends that CMS not move forward with the proposal to add this measure to MIPS and removing some of the individual measures that are part of it.

Gains in Patient Activation (PAM) Scores at 12 Months

There are several concerns about the broad applicability of the measure as well as the feasibility and implementation burden the measure would pose. The PMC describes some positives about the design of the measure including looking at a change score and excluding patients who would clearly not be eligible for the measure. However, PMC feels that the measure would be better if it applied to a narrower set of patients. As it is, the measure does not account for patient preference and the instances where a patient may not need activation such as a sore throat or a sprained ankle. This can be burdensome to operationalize and would be very difficult to adopt into a practice that does not already have a robust system to support patient engagement, patient activation, and patient-centered experiences. It can be difficult for physicians to integrate this into their workflow. In addition, the developers state that PAM scores are higher for people who have good to excellent health. They also acknowledge lower scores for a vast majority of patients that make up an internal medicine physician's patient population (i.e., sicker patients, patients older than 75, the uninsured, Medicaid and Medicare patients). As a result, the performance scores would likely skew lower for internal medicine physicians.

ACP recommends that CMS not move forward with the proposal to add this measure to MIPS.

Quality Measures Proposed for Removal in the CY24 Performance Period

While ACP understands it is CMS' preference to combine measures and use broader measures, where possible, we oppose removal of Q107 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment and Q110 Preventive Care and Screening: Influenza Immunization. These measures are evidence-based, methodologically sound, and clinically meaningful.

ACP supports the removal of Q111 Pneumococcal Vaccination Status for Older Adults, Q324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients, and Q391 Follow-Up After Hospitalization for Mental Illness (FUH). These measures were not supported by the PMC for a number of reasons including reliability and validity concerns as well as unintended consequences.

MIPS Value Pathways (MVPs) Development and Maintenance

Value in Primary Care MVP

ACP opposes CMS proposal to consolidate the measures in the Promoting Wellness (PW) and Optimizing Chronic Disease Management (OCDM) MVPs into a Value in Primary Care (VPC) MVP. Although primary care clinicians specialize in providing care across the spectrum of wellness to illness, the combination of the two MVPs into one seems to minimize the work of internal medicine physicians and the complexities of both prevention and early identification of disease AND the management of chronic conditions. Preventive services are focused on *living well* and most often provided annually during physical exams or wellness visits. On the other hand, effectively managing chronic disease involves routine visits with a primary care clinician focused on improving symptoms and *getting well*. Given the distinction between these two critical aspects of a primary care clinician's practice, the unique challenges with the focus of each of these services, and their frequency/timing, consolidating the 2 existing MVPs is untenable.

ACP believes primary care clinicians should have a choice between the PW and OCDM MVPs. While ACP has expressed concern with some of the measures in each existing MVP, together these MVPs included 24 measures (14 in PW and 9 in OCDM), based on the recommendations from our Performance Measurement Committee (PMC), from which ACP members could select. The new MVP includes 13 measures, including 2 composite measures. ACP has previously expressed concerns regarding the composite measures that fall under the preventive category that are outlined above. Regardless of the value of the individual measures, the newly proposed Value in Primary Care MVP significantly limits the measure options for a primary care physician to select meaningful measures appropriate to the needs of their practice. The VPC MVP particularly affects the chronic disease aspect of the MVP, which is proposed to only include measures addressing the management of diabetes and hypertension and several broader measures that are patient satisfaction focused. The OCDM MVP includes measures related to coronary artery disease, asthma, and depression - three conditions which are arguably the most common conditions seen in a primary care setting apart from diabetes and hypertension. The VPC measures include 2 composite measures that include overlapping measures (e.g., influenza immunization is both in the adult immunization status measure and the preventive care and wellness composite). It seems that this particular issue could be burdensome to clinicians, who choose to report both measures. If CMS finalizes the Value in Care MVP, ACP recommends weighting the composite measures higher than the other quality measures, i.e., reporting on one composite measure suffice as four quality measures.

Additionally, it is unclear how some of the proposed cost measures apply to the other categories in the Value in Primary Care MVP. There are no asthma/COPD or heart failure quality measures in the proposed MVP, but those conditions are included as cost measures. CMS is also proposing to remove the cervical cancer screening quality measure from this MVP, yet there is a cervical cancer screening improvement activity proposed for inclusion. If CMS moves forward with this MVP, ACP recommends retaining the cervical cancer screening quality measure. ACP also recommends removing the heart failure cost measure. It is out of scope for the conditions listed in the quality measure component. As ACP has advocated previously, it is important that MVPs fulfill their original intent to make participation in MIPS more meaningful by aligning measures across categories. In order for MVPs to truly function as an onramp to value based care, they must be a meaningful deviation from MIPS.

Promoting Interoperability Performance Category

ACP is pleased that CMS is proposing to lengthen the performance period for this category from 90 days to 180 days. The College has some concerns about reporting burden because most organizations need to hire support staff for this considering the necessary information is not directly captured from the EHR, and EHR vendors charge extra for these reporting metrics. However, we believe that a shift from 90 days to 180 days for this performance category is an improvement.

The College is also pleased that CMS is proposing revisions to the CEHRT definitions in the Medicare Promoting Interoperability Program and the Quality Payment Program (on which the MSSP's definition of CEHRT at § 425.20 also relies) to support the proposed transition from the historical state of year themed "editions" to the "edition-less" approach in the ONC HTI-1 proposed rule.

Transforming the Quality Payment Program /Advancing CMS National Quality Strategy Goals

Increasing Alignment Across Value-Based Programs

ACP supports CMS' Universal Foundation initiative. Aligning the most important adult and pediatric performance measures across CMS programs will help to identify measurement gaps and disparities in care. However, some of the adult performance measures in the Universal Foundation are flawed and do not have testing data available. ACP strongly believes a performance measure should be tested at the level of attribution it is applied to when used in accountability and payment programs. ACP's Performance Measurement Committee (PMC) applies a RAND-modified process to evaluate measures based on five criteria: importance, appropriate use, evidence, measure specifications, and feasibility.[10] ACP is hopeful that we will see a more objective process in the selection of measures for CMS programs, including the former MAP process and CBE endorsement. We are encouraged to learn of some of the improvements that are planned which should ensure that measures receive greater scrutiny and that criteria are applied more consistently and without bias.

[10] MacLean CH, Kerr EA, Qaseem A. Time out - charting a path for improving performance measurement. N Engl J Med. 2018;378:1757-1761.

Universal Foundation Measure Name	PMC Level of Support
139: Colorectal cancer screening	ACP does not support this measure at individual clinician level because of uncertain validity. ACP supports this measure at group practice and health plan levels. Colorectal cancer screening is an important clinical area. It is critical to improve access to evidence-based tests to make a meaningful clinical impact. These evidence-based tests should be clearly identified as not all tests have validity to support their use as stand-alone screening tests. The PMC recommends modifying the numerator to include only the types of tests that qualify as colorectal cancer screening, consistent with current guidelines. It would also be beneficial to extend the numerator time interval for performing the colonoscopy from nine years to ten years to ensure the exam is ordered and performed adequately. ACP urges the measure developer to conduct reliability and validity testing at individual physician level.
93: Breast cancer screening	ACP supports this measure at individual clinician, group practice and health plan levels. Current evidence supports the measure. The specification allows for screening done in the last 27 months of the performance year which helps in the implementation of this measure. The measure exclusions are proper; however, they can be challenging to document in the patient's medical record. There are some concerns related to patient attribution to clinicians at the individual physician level, as well as feasibility concerns with outside imaging reports being entered in a patient's medical record to signify that the screening was completed. However, as more organizations move towards team-based care, these issues should be minimal in the future.
167: Controlling high blood pressure	ACP does not support this measure at individual clinician, group practice, and health plan levels because of uncertain validity. The PMC believes that this measure has high impact and there is ample evidence to demonstrate that treating patients towards an appropriate blood pressure goal results in decreased heart attacks and strokes. However, the committee has concerns with the strict BP control across the whole patient population, especially for older patients. The committee feels that the measure denominator age range should either be 18-60 years or there should be different BP targets for stratified age groups. Based on AAFP/ACP guidelines, the PMC does not believe that less than 140 is ideal for every hypertensive patient across all age groups. Moreover, the committee thinks that by assessing the most recent BP from the measurement period, the measure deviates from actual practice. Physicians managing hypertension usually rely on a series of BP readings to make a diagnosis or a treatment decision. To make the measure more meaningful, the measure developers need to

	consider altering that component, and allow the use of either the median or the mode BP during the measurement period. The committee also believes that the numerator should allow the inclusion of home BP readings that are reviewed and entered in the EHR by the patient's clinical team, and that the specifications need to add some additional clarification on what digital transmission of remote BP entails. The committee feels that the measure should allow risk adjustment to include clinical, demographic, and social risks in the calculations, particularly to consider for physicians treating a higher proportion of marginalized patient populations.
204: Hemoglobin A1c poor control (>9%)	ACP does not support this measure at individual clinician, group practice, and health plan levels because of uncertain validity. Measure developers cite a significant performance gap based on data from the 2013 HEDIS reporting year and a large proportion of patients with HbA1c >9% indicates poor quality care. However, there is insufficient evidence to describe an appropriate definition of poor HbA1c control. Furthermore, this measure encourages clinicians to measure A1c in patients with diabetes at least annually while evidence suggests that patients who are well controlled should be re-evaluated every 6 months. The fact that this measure errs on the side of annual evaluation is a conservative treatment approach. Moreover, the measure specifications include several flaws. First, specifications should include appropriate exclusion criteria for patients where the potential harms outweigh the benefits of treating to a target HbA1c (e.g., patients with dementia, patients receiving end of life care, and patients aged > 80 years). Second, developers should consider revising the specifications to include some element of risk-adjustment for socioeconomic status and other unmodifiable risk factors to avoid potentially penalizing clinicians who disproportionately treat a large percentage of patients who cannot easily achieve HbA1c measurements below 9% (e.g., hospice/palliative care clinicians, clinicians who specialize in dementia care). Finally, this measure intends to assess quality performance at the health plan level and implementation at the individual clinician level could unfairly penalize certain clinicians who disproportionately treat a large percentage patients who cannot easily achieve HbA1c measurements <9%.
672: Screening for depression and follow-up plan	ACP does not support this measure at individual clinician group practice levels because of uncertain validity. While the measure aligns with United States Preventive Services Task Force (USPSTF) recommendations on screening for clinical depression, we suggest the denominator specifications exclude patients who are currently under the care of a mental health specialist for comorbid illness or severe cognitive impairment. Furthermore, developers should consider revising the denominator specifications to reflect patients seen in the calendar year instead of all patients. In

	addition, measure specifications do not define an appropriate screening frequency. It is not clear whether this measure applies to all patients in a providers' panel or only those seen during the calendar year in a face-to-face visit.
394: Initiation and engagement of substance use disorder treatment	ACP does not support this measure at individual clinician and group practice levels. The specifications are flawed and the measure is not appropriately specified to evaluate performance. Developers should consider dividing the numerator statement to form two discrete measures: 1) initiation of alcohol and other drug dependence treatment; and 2) engagement of alcohol and other drug dependence treatment. Also, it is unclear what constitutes a "new episode of drug or alcohol dependency." While it is appropriate for accreditors and regulators to use this measure in programs designed to assess quality at the level of the health system, regulators should not include this measure in accountability programs designed to assess performance of individual clinicians. It is unclear whether individual clinicians will be able to control the outcomes of this measure. Individual clinicians will likely face interoperability challenges to data collection.
561 or 44: Plan all-cause readmissions or all-cause hospital readmissions	ACP supports this measure at health plan level. Although there is no evidence to demonstrate its impact on health outcomes, there are no concerns regarding the gaming issues that are present with other readmission measures given the level of accountability and the financial alignment. The risk adjustment models have not been provided, but likely do not include social determinants or measures of income. The applicability is reasonable given that the measure intends to assess health plan performance and therefore would be applied by line of business, which includes Medicare but also includes commercial PPO, commercial HMO, and Medicaid.
158: Consumer Assessment Healthcare Providers and Systems	ACP does not support this measure at individual clinician and group practice levels because of uncertain validity. Survey results provide important feedback and enhance the provider selection process for consumers. However, implementation could promote overuse of unnecessary treatments where the potential benefits do not outweigh the risk of harms (e.g., opiate prescriptions, imaging studies). While evidence does not support this claim, we base this assumption on our clinical judgement and personal experiences in clinical practice. In addition, developers do not present any evidence to form the basis of the measure. Improving patient experience is an admirable clinical goal; however, we question the validity of the survey process and the impact of survey results on improving patient outcomes. Also, survey results are likely a poor gauge of clinician performance unless a majority of patients participate in the survey. Finally, individual clinicians

	should not be held accountable to organizational factors beyond their control (e.g., appointment wait times, friendliness of staff).

Advancing Health Equity

ACP applauds the CMS Framework for Health Equity, which outlines five priorities for advancing health equity into new and current CMS efforts. These priorities encompass the use of standardized data, inequities in healthcare policies, healthcare organization capacities, language access and health literacy, and increasing accessibility. There is a need to enhance the collection of social drivers of health (SDOH) data to address health disparities across communities. Improving the collection of SDOH data elements will help CMS identify gaps in care that may have been previously overlooked. By building the capacity of healthcare organizations to collect this important information through funding and grants, CMS can directly impact health inequities.

Additionally, ACP supports the implementation of a health equity adjustment (HEA) to an ACO's MIPS Quality performance category score. This adjustment will motivate organizations to advance their efforts in improving health inequities.

Accelerating Interoperability

ACP supports the transition to a more digitalized health care system. Promoting interoperability is imperative for aligning quality team-based care across practices. However, CMS should address important issues with health information technology (HIT) systems, such as the lack of standardized data entry across vendors. Not all health IT vendors have the same data elements available for data collection. Additionally, some vendors charge fees for modifying necessary data elements needed for quality measure reporting, which can deter some practices from reporting certain quality measures.

QPP Vision and Goals

Emphasizing the Importance of Value-Based Care

ACP is extremely supportive of the vision outlined by CMS for the QPP program. CMS has described the effort as an opportunity to reduce the burden of clinician participation thereby giving clinicians more time to focus on patient-centered care and subsequently improve health outcomes.

The objective of slowly transitioning from traditional MIPS reporting to MVP reporting to APM participation is laudable. The high APM participation rates (42.7%) highlighted in last year's final rule indicated that APMs are gaining traction among eligible clinicians and groups. However, MVP participation rates are projected to be relatively low (14%) for the 2024 reporting year. As a result, we have a long way to go to fully transition to MVPs as the only MIPS reporting option. ACP recommends that CMS carefully consider barriers to MVP participation, including type of practice as well as practice settings, and identify ways to address them.

MVP Reporting in the QPP

CMS has stated that MVPs have been constructed to reflect the team-based healthcare model. They have also noted that MVPs should allow primary care and specialty clinicians the opportunity to report on measures that are directly relevant to their clinical practice.

The existing and newly proposed MVPs are focused on particular conditions or topic areas which are relevant to particular specialties. This approach seems to place greater emphasis on the latter

statement, maintaining the current fragmentation of care rather than supporting a broader, more coordinated approach to patient care. ACP strongly supports the use of clinical care teams which has been reinforced as part of ACP's New Vision for U.S. healthcare and would recommend that CMS consider how best to incorporate team-based care within MVPs.

MVP Development, Maintenance, and Scoring

ACP is pleased to see the operationalization of the policies regarding proposing new MVPs and maintaining existing MVPs finalized in last year's rule.

ACP was disappointed to learn that CMS is proposing to consolidate the measures in the Promoting Wellness and Optimizing Chronic Disease Management MVPs into a Value in Primary Care MVP through the 2024 proposed rule. We understood that if CMS identified any modifications that are potentially feasible and appropriate, CMS would host a public facing webinar through which interested parties may offer their feedback on the potential revisions. The webinar that took place in February 2023 did not indicate that this consolidation was under consideration. ACP recommends that all MVP modifications be shared through public facing webinars. If they are not anticipated at the time of the first webinar, CMS should have a second webinar including additional changes that are being considered.

While we generally support CMS intent to adopt scoring policies from traditional MIPS for MVP participants, we question if the MIPS scoring policy for new measures would be suitable for MVPs.

RFI re: MVP Reporting for Specialists

ACP values CMS' engagement with the specialty medicine community in order to improve participation in MVPs. CMS should ensure that measures within all MVPs are methodologically sound, evidence-based, and address clinical areas of importance. Additionally, CMS should provide incentives for specialties to report MVPs, such as an incentive bonus, or ease the MVP reporting requirements. In order to encourage specialty participation, CMS should ensure measures are more appropriate for the target users of the MVP, halt the removal of measures that are important to specialists, and prioritize that the MVP diverges from MIPS in administrative burden requirements while remaining voluntary. Since most specialty societies report quality measures through their own qualified clinical data registries, CMS should work with specialty societies to incorporate registry reporting as an option if this is not accounted for within reporting methods for MVPs. CMS seeks comment on if and how they should consider assessing overall specialty performance as part of the APP in the future. An assessment of how MVPs are performing by specialty may be helpful in determining MVP participant types and the College is supportive as long as the data collection doesn't increase physician burden.

Episode-Based Payment Model

CMS should ensure that new payment models place physicians at the center of decision making about care coordination and delivery, give them the resources and flexibility they need to deliver services that can achieve good outcomes for all types of patients with lower overall spending for Medicare, and do not place them at risk for outcomes or costs they cannot control. Additionally, CMS should design new APMs to provide adequate payments and flexibility that will ensure access to high quality care for patients with higher levels of need. The best way to ensure that episode payments support appropriate care for underserved beneficiaries is to identify what kinds of beneficiaries are currently underserved, determine what services they need (including non-medical services) and what it will cost to deliver those

services, and then establish payment amounts for those beneficiaries that are sufficient to cover the cost of the necessary services and support. For ACP's full recommendations, please refer to our recent letter to CMS on their Episode-Based Payment Model RFI.

Conclusion

Thank for this opportunity to comment on CMS' notice of proposed rulemaking regarding changes to the Medicare Physician Fee Schedule, Quality Payment Program, and other federal programs for CY24 and beyond. ACP is confident these recommended changes would improve the strength of these proposals and help promote access to affordable and equitable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. The College appreciates the opportunity to offer our feedback and looks forward to continuing to work with the agency to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Ph.D., Director, Regulatory Affairs for the American College of Physicians, at boutland@acponline.org or (202) 261-4544 with comments or questions about the content of this letter.