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September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2024 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)

Dear Administrator Chiquita Brooks-LaSure:

The Association of American Medical Colleges (the AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year 2024 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule published August 7, 2023 (88 *Fed. Reg.* 52262).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 12 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers. Learn more at aamc.org.

Through their mission of providing the highest quality patient care, teaching physicians who work at academic health systems provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans," because many of these physicians teach and supervise medical residents and medical students as part of their daily work. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Care is often multidisciplinary and team based. These practices are frequently organized

under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 115 individual national provider identifiers (NPIs) to a high of 3,694 NPIs, with a mean of 1,258 and a median of 1,088.¹ These practices support the educational development of residents who will become tomorrow's practicing physicians.

Teaching physicians are vital resources to their local and regional communities, providing significant primary care services and other critical services, including a large percentage of tertiary, quaternary, and specialty referral care in the community. Their patient base may span regions, states, and even the nation. They also treat a disproportionate share of patients for whom issues associated with social determinants of health, such as stable housing, food security, and transportation, contribute significantly to additional health challenges, adding greater complexity to their care.

The AAMC strongly supports CMS's efforts to allow telehealth services to be available to patients in all regions of the country and to patients in their homes and other locations. We believe it is important, and support steps enacted by Congress at the end of the 117th Congress, to continue many of the telehealth flexibilities allowed during the COVID-19 public health emergency (PHE) in the future to continue providing greater access and improved care to patients.

The AAMC commends CMS for its commitment to promoting health and health care equity and expanding patient access to comprehensive care. We share CMS's goal to reduce disparities in health care and support initiatives to close the health equity gap. Our members have been working to implement new strategies aimed at promoting health and health care equity. We were pleased to see CMS's proposal to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Navigation services to account for resources involved in providing these important services. The AAMC also applauds CMS for its proposals in this rule to expand access to vital medical services, such as behavioral health services. These efforts will improve the health of Medicare beneficiaries and reduce costs in the long term.

While we support the direction CMS has taken on a number of issues, we are alarmed by the payment cuts for physicians in the proposed rule, including the significant reduction to the Medicare conversion factor in 2024. There is a discrepancy between the cost of running a physician practice and actual payment for physician services. These reductions in payment would have a devastating impact on physicians and other health care professionals and jeopardize patients' access to care. We are also concerned with proposed policies in the regulation that would make Merit-Based Incentive Payment System (MIPS) more challenging, significantly increase the number of eligible clinicians who would receive a penalty under the MIPS program (to 54%) and reduce incentives for clinicians to participate in advanced alternative payment models.

¹ AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

We are committed to working with CMS to ensure that Medicare payment policies support access to high quality care for patients, accurately reflect the resources involved in treating patients, are not overly burdensome to clinicians, and reduce health care disparities.

The following summary reflects the AAMC's key recommendations on CMS's proposals regarding physician payment updates, telehealth payment policy, Medicare Shared Savings Program (SSP) accountable care organizations (ACOs), the QPP, requests for information (RFIs), and other issues in the Calendar Year (CY) 2024 PFS Proposed Rule:

PHYSICIAN FEE SCHEDULE

- ***Payment Updates:*** Given the unprecedented challenges faced by physicians and the critical importance of patient access to health care services, the AAMC encourages CMS to support stakeholders' efforts to have Congress pass legislation that would provide an annual inflation-based payment update based on the Medicare Economic Index (MEI). We recommend that budget neutrality policies be revised to ensure that utilization estimates are accurate, certain categories of services are exempt from future budget neutrality adjustments, and the \$20 million threshold that triggers budget neutrality is raised.
- ***Rebasing and Revising Medicare Economic Index (MEI):*** The AAMC supports CMS's decision to delay the finalized 2017-based MEI cost weights, pending the completion of the American Medical Association's (AMA) Physician Practice Information (PPI) survey, given the significant impact of rebasing and revising the MEI and the importance of using valid and reliable data on physician practice costs.
- ***Split (or Shared) Visits:*** The AAMC supports a delay in implementing the time-based definition of substantive portion for split (or shared) visits. We urge CMS to finalize an alternative policy that would allow billing of split (or shared) visits based on who performs more than 50% of the time or who performs the key medical decision-making component of the service.
- ***Complexity Add on Code (G2211):*** Given this major impact of the implementation of G2211, the AAMC recommends that CMS provide further clarification on how the utilization assumptions were derived, and more specific education and guidance to practitioners on circumstances when this code should be reported, and the documentation needed to support payment. Further, we recommend that the agency not apply budget neutrality to G2211 since it is a new service not previously paid for by Medicare.
- ***New Payment Codes for Addressing Health-Related Social Needs:*** The AAMC supports proposals to adopt new billing codes and payment to support risk assessments, community health integration, and principal illness navigation services and we recommend CMS explore policy options to waive beneficiary cost sharing to ensure broad and equitable access to these services.
- ***Telehealth 2023 Consolidated Appropriations Act (CAA, 2023) Extension:*** The AAMC supports the extension until December 31, 2024, of the COVID-19 flexibilities provided for in the CAA, 2023 including:
 - payment for telehealth services in any geographic location including the patient's home,
 - payment for services furnished via audio-only technology,

- the expanded definition of eligible providers to include physical therapists, occupational therapists, speech-language pathologists, and audiologists of telehealth services,
- payment for telehealth services provided by FQHCs and RHCs, and
- the delay of the in-person requirement for mental health services.
- **Telehealth Services Furnished by Institutional Staff:** The AAMC supports the extension of payment for Outpatient Therapy (including physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and audiology), Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT) when furnished by institutional staff through December 31, 2024. We recommend that CMS create new remote codes for these services to be billed through the Outpatient Prospective Payment System (OPPS), beginning on January 1, 2025.
- **Telehealth Frequency Limitations:** The AAMC supports the removal of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services furnished via telehealth through December 31, 2024.
- **Telehealth Payment Rates:** The AAMC supports CMS' proposal to pay the same amount for in-person services (non-facility-based rate) when a practitioner is providing telehealth to the patient at home, beginning January 1, 2024.
- **Telehealth List:** The AAMC supports the extension of services on the telehealth list; we applaud CMS for responding to previous feedback by establishing a provisional category for services on the telehealth list.
- **Telehealth: Enrolling Practitioners' Home Addresses:** The AAMC recommends that CMS not require the Medicare enrollment application to include practitioners' home addresses when providing telehealth from their homes if there is a valid reassignment relationship between the remote practitioner and a Medicare-enrolled practice with a physical office location where care is delivered in-person to patients.
- **Virtual Direct Supervision of Clinical Staff:** The AAMC encourages CMS to continue to allow direct supervision of clinical staff through virtual supervision on a permanent basis.
- **Virtual Supervision of Residents:** The AAMC supports CMS's proposal to allow virtual supervision of residents for telehealth services in all residency training locations through the end of CY 2024. However, we urge CMS to allow virtual supervision of residents for both in-person and telehealth services in all residency training locations permanently when clinically appropriate.
- **Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM):** The AAMC supports CMS's proposal to allow FQHCs and RHCs to furnish RTM and RPM services. We oppose the 16-day monitoring requirement to bill these services, and we recommend that CMS allow the provider to determine the appropriate duration for monitoring based on the clinical needs of the patient. We recommend that CMS allow both new and established patients to receive RTM and RPM services.
- **Advancing Access to Behavioral Health Services:** The AAMC supports CMS's effort to increase access to behavioral health care services by increasing payment for general behavioral health services and psychotherapy codes and allowing Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHC) to independently bill Medicare services. We encourage CMS to promote the use of interprofessional consults for behavioral

health by eliminating barriers, and to make changes to increase access to behavioral integration services.

- ***Treatment of Opioid Use Disorder:*** The AAMC supports extending the COVID-19 flexibilities for the Opioid Treatment Programs, including allowing periodic assessments to be furnished via audio-only technology for patients who are receiving treatment, such as buprenorphine.

MEDICARE SHARED SAVINGS PROGRAM (SSP) ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

- ***Adding a Medicare Clinical Quality Measure (CQM) Reporting Option:*** The AAMC supports the permanent adoption of the new Medicare CQMs reporting option to allow SSP ACOs to meaningfully report quality performance.
- ***ACO Specialists and Reporting MIPS Value Pathways RFI:*** The AAMC urges CMS to consider quality reporting incentives for continued SSP participation that focus on meaningful measures, appropriate performance standards and comparisons, and reducing burden relative to participation in MIPS.
- ***Requiring ACOs to Report the MIPS Promoting Interoperability Category:*** The AAMC encourages CMS to not add burdensome measure reporting without demonstrated benefits to value-based care delivery.
- ***Creating a New Step for Claims-Based Assignment to Expand Patient Access to Accountable Care Relationships:*** The AAMC believes that expanded definitions and steps for claims-based attribution should reflect meaningful care relationships with ACO professionals.
- ***Financial Benchmarking Modifications:*** The AAMC supports the adoption of a cap to risk score growth in an ACO's regional service area as part of the regional adjustment to the benchmark, allowing all ACOs to benefit from the proposed alternative approach to use of CMS-HCC risk score models, and supports the elimination of a negative regional adjustment to benchmarks to encourage greater and continued participation in the program.

QUALITY PAYMENT PROGRAM (QPP)

- ***Improving the QPP:*** The AAMC encourages CMS to work with key stakeholders to identify longer term policy solutions in the future that would improve quality, attain health equity for all beneficiaries, improve patient outcomes, and reduce burden.
- ***Traditional Merit-based Incentive Payment System (MIPS):*** Given the challenges physician practices face in the aftermath of the COVID-19 pandemic, the AAMC urges CMS to support efforts in Congress to give the agency more flexibility to set MIPS performance thresholds based on current circumstances, rather than a preset formula. Additionally, we recommend CMS convene stakeholders to better understand the challenges with the removal of quality measures and ensure appropriate risk adjustment and patient attribution for all cost measures.
- ***MIPS Value-based Pathways (MVPs):*** The AAMC supports retaining voluntary reporting of MVPs for the foreseeable future to ensure MIPS reporting options are the most meaningful, clinically relevant, and least burdensome for multispecialty groups and beneficiaries.

- **Alternative Payment Model (APM) Performance Pathway (APP):** The AAMC supports a new Medicare CQM reporting option for SSP ACOs and encourages CMS to make it a permanent reporting option.
- **Advanced APMs (AAPMs):** The AAMC urges CMS to support legislative efforts to continue the bonus payment and eliminate high participation thresholds for clinicians in AAPMs to encourage participation in AAPMs. Additionally, we recommend that CMS calculate QP thresholds at both the APM entity and individual level and allow either to satisfy QP determinations to encourage AAPM participation by both primary care providers and specialists.
- **Public Reporting:** The AAMC supports the addition of Medicare Advantage data to the procedure utilization data that CMS is sharing with the public. For the information to provide a more accurate representation of the procedures performed by physicians, we believe that this data would also need to include utilization data from Medicaid and private payors. While we support transparency, the AAMC is concerned that cost measure performance information that would be reported on the *Care Compare* website might be unhelpful or misleading to consumers given the challenges with risk adjustment and attribution.

PHYSICIAN FEE SCHEDULE

PAYMENT UPDATES

Update to the Physician Fee Schedule Conversion Factor for 2024

CMS Should Work with Congress to Increase the Medicare Payment Update

In the proposed rule, CMS sets forth the dollar conversion factor that would be used to update the payment rates. For 2024, the conversion factor (CF) would be \$32.7476, which is a 3.6 percent reduction from the 2023 conversion factor. This reflects the expiration of the 2.5% increase for services furnished in 2023,² the -1.25 percent reduction in the temporary update to the conversion factor, and a budget neutrality (BN) adjustment of -2.17 percent. Physicians also face a statutory freeze in annual Medicare PFS updates until 2026, when updates will resume at a rate of only 0.25 percent, which is well below the rate of inflation. In addition to these reductions, we are alarmed by CMS estimates in the rule that approximately 54 percent of MIPS eligible clinicians will receive a payment penalty of up to -9 percent in performance year 2024 (payment year 2026) with its proposals to increase the performance thresholds under the program.

Physician payments have failed to keep pace with rising inflation and practice costs. AMA analysis found that from 2001-2023, Medicare physician payments have increased only nine percent, while the cost of running a medical practice has increased 47 percent.³

We are deeply concerned about the impact of these significant cuts. Payment reductions of this magnitude would pose a major problem at any time, but to impose these cuts at a time when

² Consolidated Appropriations Act, 2023

³ AMA Snapshot, [Medicare updates compared to inflation \(2001 – 2023\)](#) (2023)

teaching physicians and other health care professionals are still recovering from the financial impact of the COVID-19 pandemic, experiencing historic workforce shortages, and record-setting inflation and rising practice costs, will be extremely harmful. Prior to the pandemic there were major concerns about physician well-being, and the pandemic, financial pressures, and administrative burdens only increased those concerns.

This year, MedPAC recommended that Congress increase the 2024 Medicare physician payment rate above current law with an inflation-based payment update tied to the MEI. According to MedPAC, of those Medicare beneficiaries looking for a new primary care physician half had difficulties finding one, and of those beneficiaries looking for a new specialist, one-third had difficulties finding one.⁴ In the 2023 Medicare Trustees Report, the trustees also expressed concern with the failure of Medicare payments to keep pace with the cost of running a practice and warned that they expect access to Medicare-participating physicians to become a significant issue in the long-term.⁵ According to the AAMC's projections, by 2034 the country could experience a shortfall of between 37,800 and 124,000 physicians.⁶ These shortages may be exacerbated if physicians face these cuts in payment.

We are concerned that the additional reductions in revenue for physicians combined with workforce shortages could result in even greater access problems for patients. A cut in physician payment will add to the stress and is likely to trigger further retirement or reduction in physician services during a time when physicians are needed the most in their communities. **Given these unprecedented challenges and the critical importance of patient access to health care services, we encourage CMS to support stakeholders' efforts urging Congress to pass legislation, including H.R. 2474 (The Strengthening Medicare for Patients and Providers Act) that would provide an annual inflation-based payment update based on the Medicare Economic Index (MEI).** This would help to ensure that physicians and other health care providers can continue to provide high quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Looking ahead, we believe that there are ongoing structural problems with the Medicare PFS that need to be addressed. Medicare provider payments have been constrained for many years by the budget neutral system, which has led to arbitrary reductions in reimbursement. The updates to the conversion factor have not kept up with inflation, while the cost of running a medical practice has increased significantly. **At a minimum, we recommend that budget neutrality policies be revised to ensure that utilization estimates are accurate, that certain categories of services (e.g., newly covered Medicare services, health professions added, new technology, etc.) are exempt from future budget neutrality adjustments, and the \$20 million threshold that triggers budget neutrality is raised to at least \$100 million.** We welcome an opportunity to work collaboratively with CMS, Congress, and other stakeholders to address these long-term challenges in the future.

⁴ MedPAC, [Report to Congress, Medicare Payment Policy, Chapter 4](#) (Mar. 2023)

⁵ [2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds](#) (Mar. 2023)

⁶ AAMC, [The Complexities of Physician Supply and Demand: Projections From 2019 to 2034](#) (Jun. 2021)

REBASING AND REVISING THE MEDICARE ECONOMIC INDEX (MEI)

In the 2023 PFS rule, CMS finalized a policy to rebase and revise the MEI weights for the different cost components of the MEI to reflect more current market conditions, beginning in 2024. The current MEI weights are based primarily on results from the AMA's PPI survey, which is based on 2006 data. CMS had planned to use data from the Census Bureau's 2017 Service Annual Survey (SAS) as the primary source for the new weights and to supplement the SAS data with other sources when SAS does not provide the necessary detail. The MEI is used to proportion the components of the resource-based relative value scale (RBRVS) between work, practice expense, and professional liability insurance and to update the Geographic Practice Cost Indices (GPCIs). The use of this new data to determine the MEI weights would result in significant specialty redistribution of payments, in addition to geographic redistribution.

We support CMS's announcement in the proposed rule to delay the finalized 2017-based MEI cost weights, pending the completion of AMA's PPI survey. While the AAMC recognizes that the data currently utilized for the MEI is outdated and that there is a need to update this data, we had serious concerns with the use of the 2017 SAS data from the "Offices of Physicians" industry, which was not designed for the purpose of updating the MEI. As a result, there are key areas, including physician work, nonphysician compensation, and medical supplies, where CMS would need to use data from other sources. Along with 173 health care organizations, the AAMC supports the AMA's PPI survey, which was launched on July 31, 2023, and will provide more than 10,000 physician practices (including both small practices and large health systems) with the opportunity to share their practice cost data and number of direct patient care hours provided by both physicians and qualified health professionals.

Given the significant impact of rebasing and revising the MEI, we recommend that CMS collaborate with the AMA and other physician organizations on this extensive effort to collect new data to ensure that the data used for physician payment is valid and reliable, and postpone any updates to the MEI weights using other practice cost data until this new survey data is available for consideration.

IMPLEMENTATION OF THE COMPLEXITY ADD-ON CODE (G2211)

In 2021, CMS created add-on code G2211 that could be reported in conjunction with outpatient/office E/M visits to account for resources related to medical care that serves as the continuing focal point for all needed health care services and/or medical care services that are a part of ongoing care related to a patient's single, serious, or complex condition. The CAA, 2021 imposed a moratorium on Medicare payment for G2211 before January 1, 2024. In this year's rule, CMS proposes to pay for this code, effective January 1, 2024, and proposes several refinements from the policies it finalized in 2021 based on feedback it received from stakeholders.

Specifically, CMS proposes that the G2211 would not be payable when the E/M visit is reported with a payment modifier -25 and proposes to refine its previous utilization assumptions. CMS agreed with prior commenters that many practitioners delivering care in settings designed to address acute health care needs, without coordination or follow-up, will regularly have encounters with patients that are not part of continuous care, and therefore would not report this

code. CMS also gave examples of encounters provided by a professional who would not bill this code because their relationship is discrete and time-limited, such as mole removal or treatment of a fracture. With these clarifications, CMS estimated that HCPCS code G2211 will initially be billed with 38 percent of all outpatient/office E/M visits and when fully adopted will be billed with 54 percent of all outpatient office E/M visits.

This add-on code would increase spending significantly, contributing to a significant portion (about 90%) of the -2.17 percent budget neutrality adjustment proposed by CMS. **Given this major impact, we recommend that CMS provide further clarification on how the utilization assumptions were derived, and more specific education and guidance to practitioners on circumstances when this code should be reported.** Specifically, we urge CMS to provide more transparent information regarding how it derived its utilization assumptions that the code would be billed 38 percent in the initial year and 54% in subsequent years. CMS's utilization file provided with the proposed rule provides utilization information for G2211 by specialty and facility/non-facility. However, we do not know CMS's assumptions that underlie the specific utilization estimates provided in that file.

In the past, CMS made assumptions regarding the utilization of Transitional Care Management (TCM) Codes (99495 and 99496) that were much higher than the actual utilization that occurred. At that time, CMS estimated that there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and still less than one million after three years of implementation. As a result, CMS implemented budget neutrality adjustments that were too high in 2013. Similarly, CMS overestimated Chronic Care Management (CCM) utilization when adopting those codes (99487-99489) one year later, estimating utilization of 4.7 million claims when the actual amount was 954,000 in the first year. These overestimates for TCM and CCM resulted in budget neutrality adjustments that made permanent reductions in payments to physicians across the board. We caution CMS against making similar assumptions this time about codes that involve ongoing care and that would result in a significant permanent reduction in the conversion factor.

While we agree with the importance of ensuring physicians that provide primary and other similarly longitudinal medical care are adequately reimbursed, the E/M codes were revalued in 2021 to account for the complexity and resources required to provide these services. In addition, since the E/M code level can be determined by time, we assume that the complexity will be reflected in additional time needed for providing the service and consequently a higher E/M code level for the visit. Therefore, we urge CMS to provide clear guidance and education to practitioners regarding when this add-on code should be reported and what documentation would be required to support payment. Until such time as there is clear guidance on when this code can be used and the documentation to support its use, CMS should be conservative in its utilization estimates to avoid another permanent cut in physician payments as occurred with TCM and CCM.

The AAMC also recommends that the agency not apply budget neutrality to G2211 since it is a new service not previously paid for by Medicare. CMS does not apply budget neutrality for services not previously paid or when it makes a policy change that will increase service utilization. For instance, CMS is expanding its policy on Medicare payment for dental services

that are inextricably linked to covered medical services. In the proposed rule, CMS indicates it is not appropriate to incorporate budget neutrality adjustments into the PFS conversion factor when proposing to pay for additional dental services. Here, the argument is whether G2211 is being unbundled from E/M or a new service not previously paid by CMS. AAMC would assert that CMS did not recognize or pay for E/M complexity previously, and for this reason, budget neutrality should not apply. A lower budget neutrality adjustment benefits all physicians.

SPLIT/SHARED VISITS

CMS Should Allow Billing of Split (or Shared) Visits Based on Who Performs the Key Medical Decision-Making (MDM) or Who Performs More than 50% of the Total Time

CMS proposes another one-year delay of its policy that for a split (or shared) visit the physician or nonphysician practitioner (NPP) who performs the “substantive portion” (which would be defined as more than 50 percent of the total time of the visit) would bill for the service over concerns that were raised by commenters that this policy would disrupt team-based care. A split or shared visit refers to an E/M visit performed by both a physician and a NPP in the same group practice in the facility setting where “incident to” billing is not available. Under this proposal through calendar year 2024, physicians could continue to bill split or shared visits based on the current definition of “substantive portion” as one of the following: history, exam, MDM, or more than half of total time.

We appreciate CMS listening to our concerns that the time-based definition of substantive portion would disrupt team-based care in the facility setting, and we support the delay. However, we urge CMS to finalize an alternative policy that would allow billing of split (or shared) visits based on who performs more than 50% of the time or who performs the key MDM component of the service.

Our members regularly engage in team-based care and believe that patients benefit from the collaboration of physicians and non-physician practitioners who provide services to them. We are concerned that billing based on whomever provided more than 50% of the time will discourage the continuation of team-based care.

Time is not necessarily the essence of patient care. Medical decision making is a critical element in managing the patient’s care; however, it does not typically require the most time. Physicians are compensated for their ability to synthesize complex medical problems and undertake appropriate treatment actions. An NPP may be involved in tasks that require significant time, such as preparing the medical record, taking a history, performing a physical exam, placing orders, obtaining lab or test results, requesting consultations, and doing preliminary documentation. Synthesizing the patient’s symptoms and other information such as test results and then devising the plan of care are the substance of the visit and typically are done by a physician and are critical to the patient’s diagnosis and treatment. In many instances, the activities performed by the physician, which are the key portion of the visit, take less time than the activities that are required to provide the additional information needed for MDM and the plan of care. This lower physician time is likely related to the fact that the NPP gathered the disparate data for careful review or because of the experience and training of the physician. For example, if an NPP and surgeon both see a patient after surgery, the NPP may spend more time

gathering information, but it is only the physician who can make the critical decision to return to the operating room. In another example, for patients with cancer the oncologist (not the NPP) makes the key recommendations of chemotherapy and radiation protocols. **Time is not the most critical component of a complex medical decision.**

Beginning in 2023, CMS changed its policies to allow practitioners to select the visit level for inpatient E/M encounters based on either time or medical decision-making. To maintain consistency in coding policies, we recommend that either time or MDM should also be used to determine the substantive portion of the split (or shared visits). Currently, the vast majority of physicians are selecting the E/M visit level based on medical decision-making. Therefore, most physicians have not been tracking and documenting their time. Tracking the precise time spent by the physician and NPP (including time when it is spent simultaneously), and summing it together to determine the total time, and the 50% threshold, would be extremely burdensome to physicians and NPPs, particularly when they are not using time to select the visit level. Tracking the time does not benefit patient care and is only important for the inpatient hospital billing purposes when selecting E/M level based on time. Requiring this tracking would place a significant regulatory burden on both the physician and NPP.

In the 2022 PFS final rule, CMS justified its decision that the practitioner responsible for more than half of the time should bill for the visit, by stating that “no key or critical portion of MDM is identified by CPT [Current Procedural Terminology[®] by the AMA]. Therefore, we do not see how MDM (or its critical portion, or other component part) can be attributed to only one of the practitioners.” The AAMC believes that this concern can be addressed using attestations and documentation. For example, CMS could require that the physician or NPP attest in the medical record that he/she performed all aspects of the MDM for the service as follows:

“I saw and evaluated the patient with ___ (insert name of NPP) ___. I provided a substantive portion of the care for this patient. I personally performed all aspects of the medical decision making for this encounter. I have reviewed and verified this documentation and it accurately reflects our care.”

In addition to the attestation, the physician or NPP is required to include in the documentation pertinent elements of his/her MDM/Assessment and Plan. This includes documentation about the patient’s presenting acute and/or chronic problem(s)/condition(s); pertinent data reviewed; and assessment/plan. CMS has a long history of auditing E/M services by examining the documentation in the medical record to ensure that it supports appropriate billing. CMS could continue to use its program integrity levers to audit split (or shared) visits billed on the basis of MDM.

As stated earlier, at a minimum, we support a continued delay in implementation of the 50 percent time threshold for billing and urge CMS to reconsider this proposal. Physicians and NPPs need time to adapt to these significant changes. Additional time is needed to educate and raise awareness and implement these changes. Providers also need additional time to assimilate this policy into clinical workflows in team-based environments.

SERVICES ADDRESSING HEALTH-RELATED SOCIAL NEEDS: SOCIAL DETERMINANTS OF HEALTH (SDOH) RISK ASSESSMENT, COMMUNITY HEALTH INTEGRATION (CHI) SERVICES, AND PRINCIPAL ILLNESS NAVIGATION (PIN) SERVICES

CMS discusses how it is working to better identify and value practitioners' work for the additional time and resources used to help patients with serious illnesses navigate the health care system or remove health-related social barriers that interfere with the practitioner's ability to implement a medically necessary plan of care. Specifically, CMS proposes to pay separately for SDOH Risk Assessment, Community Health Integration, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists. We support CMS's commitment to health care equity and its proposal to establish codes and payment for these services to facilitate practitioners' ability to allocate additional resources to assist patients with health-related social needs that impact their care.

Our members are dedicated to addressing social risk factors that impact healthcare and reducing health disparities. They are meaningfully investing in talent, time, and technology needed to identify best approaches to address patients' social needs, working with community organizations. Academic health systems are uniquely positioned to contribute to approaches to addressing social risk factors because of their integrated delivery models across the continuum of care. Additionally, the AAMC supports academic medicine's commitment to reducing health inequities through collaboration with multisector and community partners through the AAMC Collaborative for Health Equity: Act, Research, Generate Evidence (AAMC CHARGE).⁷ Our specific comments on the SDOH Risk Assessment, Community Health Integration, and PIN Services payment policies follow:

CMS Should Establish a New Code for SDOH Risk Assessment with Modification to Address Service Timeframes and Beneficiary Cost Sharing Obligations

CMS proposes a new code to bill an SDOH risk assessment that includes administration of a standardized evidence-based tool that includes food insecurity, housing insecurity, transportation needs, and utility difficulties. The SDOH risk assessment must be furnished by the practitioner on the same date they furnish an E/M visit and is considered reasonable and necessary when used to inform the patient's diagnosis and treatment plan established during the visit.

We commend CMS for recognizing the work involved in administering a SDOH risk assessment as this will enable practitioners to gain a more thorough understanding of the patient's full social history and determine whether social needs are impacting medically necessary care. If health-related social needs are identified, we believe that appropriate follow-up as part of the care plan is critical to address the impacts of the identified, unmet needs on overall health. Although it would be beneficial to have the capacity to furnish CHI, PIN or other care management services, or have partnerships with community-based organizations, we do not believe that this should be a requirement as a condition of payment given the challenges with building this capacity, including the significant upfront investments that would be necessary. **Instead, we recommend**

⁷ <https://www.aamchealthjustice.org/get-involved/aamc-charge>

that to bill for these services, the billing practitioner must incorporate information from the SDOH screening into the care plan, if an unmet health-related social need is identified.

We recommend that CMS expand the timeframe to complete the SDOH risk assessment for carrying out the screening so that it is not limited to the same day as the E/M visit and expand the methods for completing the assessment to include patient portals and phone. This would benefit both providers and patients by providing more opportunities to complete the assessment and inform the treatment plan. **To ensure continuity of care and that the risk assessment is reasonable and necessary to inform the patients' diagnosis and treatment, we recommend CMS require that the practitioner review and revise (as needed) the SDOH risk assessment on the same day as the E/M visit.** We support CMS's proposal to add this code to the Medicare Telehealth Services list to accommodate scenarios in which the practitioner (or their auxiliary personnel under their supervision) complete the risk assessment in an interview format.

Building on these proposals, CMS also proposes to add other elements to the annual wellness visit (AWV) by adding a new SDOH Risk Assessment as an optional additional element (at beneficiary discretion) with an additional payment. The new SDOH Risk Assessment would be separately payable with no beneficiary cost-sharing when furnished as part of the same visit with the same data of service as the AWV. We support adding this assessment to the AWV as it could inform the care the patient receives and encourage partnerships with community-based organizations. It can help to reduce barriers, expand access, promote health care equity for underserved patients, particularly those with unmet health-related social needs. As stated earlier, we recommend CMS allow the SDOH risk assessment to be completed prior to the AWV and require that the **practitioner review and revise (as needed) the SDOH risk assessment on the same day as the AWV.** If the AWV includes the SDOH risk assessment, we believe it should be considered a CHI or PIN initiating visit if it is provided by a billing practitioner who is able to bill for CHI or PIN services.

We support the proposal that there be no cost-sharing for the SDOH Risk Assessment provided as an additional element of the AWV, as AWVs generally do not include beneficiary cost-sharing. **Given the preventive nature of the SDOH Risk Assessment, we urge CMS to waive cost-sharing for the SDOH Risk Assessment in all cases when it is billed (not just limited to the add-on element to an AWV).** If patient cost-sharing is required when provided as part of an E/M visit, there is concern that it will erode patient trust or willingness to share sensitive personal information with a provider. It will be important to obtain patient consent, which would include informing the patient about applicable cost-sharing and the right not to receive services. This could in turn reduce overall impact of the new code on addressing unmet health-related social needs if patients refuse service due to the cost-sharing obligation.

CMS Should Adopt New Billing Codes and Payment for Community Health Integration Services and Principal Illness Navigation Services

CMS proposes two new G codes for the provision of CHI services to address the health-related social needs that present a barrier to patient care as identified during an initiating visit. Additionally, CMS proposes two new G codes for the provision of PIN services to help Medicare patients diagnosed with high-risk conditions (e.g., chronic obstructive pulmonary disease,

congestive heart failure, dementia, cancer, severe mental illness, substance use disorder, etc.) identify and connect with appropriate clinical and support services. PIN services are designed in parallel to CHI services, but focused on patients with a serious, high-risk illness who may not have health-related social needs. Similar to other care management services, CHI and PIN services would be furnished monthly, and provided by certified or trained auxiliary personnel, including community health workers, under the general supervision of the billing practitioner as “incident to” the professional services. To bill for CHI or PIN services, there must be an initiating CHI or PIN visit with the billing practitioner. CMS clarifies that the auxiliary personnel may be employed by Community-Based Organizations (CBOs) as long as there is the requisite general supervision by the billing practitioner for these services, similar to other care management services. If the services are provided by auxiliary personnel under a contract with a third party, there must be sufficient clinical integration between the third party and the billing practitioner, and they must communicate regularly and ensure proper documentation in the medical record. CMS is not proposing to require consent for CHI or PIN services because it believes these services typically involve direct patient care and are largely provided in person. However, there would be patient cost-sharing for these services.

We support CMS’s proposal to pay for CHI and PIN services that are billed “incident to” a professional’s services. In addition, we support the proposal for general supervision of these services and allowing billing providers to have contracts with third parties, such as community health organizations, whose staff provide these services. This will improve access to these important services.

Whole person care is critical for treating illness and injury and community health workers are an important part of teams by providing social care assistance and peer support to improve health. Community health workers help to address social needs by identifying appropriate health care providers, scheduling appointments, finding and applying for necessary resources in the community, providing education, making sure medical recommendations are understood and through other services. They engage with individuals for a varying amount of time depending on the individual’s need.

It is important that academic health systems interact regularly with the community health organizations to stay abreast of the patient’s care and know the outcome of the referrals made. Improving patient outcomes is a key driver of adoption of social needs interventions. To facilitate care, it will also be important to identify ways to exchange health information about the patient among health care providers and community-based organizations that are secure and protect the patient’s privacy, without requiring CBOs invest in expensive electronic health records systems.

Given the populations that would benefit from CHI and PIN services and their focus on prevention, we urge CMS to waive cost-sharing for these services. Cost-sharing requirements would be a barrier to receiving these important services. If cost-sharing is not waived, then patient consent, which would include informing the patient about the applicable –cost-sharing, the right to discontinue services, and any limitation on payment, would be necessary.

MEDICARE TELEHEALTH AND COMMUNICATION TECHNOLOGY BASED-SERVICES

The AAMC appreciates the work that CMS has done to provide important flexibilities around telehealth during the COVID-19 PHE. The AAMC strongly supports the telehealth waivers and regulatory changes established by CMS in response to the PHE that have facilitated the widespread use of telehealth and other communication technology-based services that have improved access to health care. For the 2024 PFS, we strongly support CMS's proposal to implement provisions in the Consolidated Appropriations Act (CAA), 2023 to ensure patients can continue to have access to telehealth services through the end of December 31, 2024; however, we urge CMS to make the waivers and flexibilities permanent. These waivers and flexibilities have increased patient access to care and allowed for a more efficient use of in-person resources. The expiration of these flexibilities and waivers would result in reduced access to care, particularly impacting patients in rural and other underserved areas, those with lower socio-economic status, those with disabilities, and those from certain racial and ethnic backgrounds that have historically experienced limited healthcare access.

CAA, 2023 COVID-19 Flexibilities Extension

CMS Should Implement the COVID-19 Flexibilities Provided for in the CAA, 2023 Through December 31, 2024; We Strongly Recommend That CMS Permanently Implement These Policies

AAMC strongly supports the extension of payment for telehealth services in any geographic location including the patient's home through the end of December 31, 2024. We urge CMS to work with Congress and other stakeholders to permanently eliminate the geographic and patient location restrictions. During the PHE, CMS paid for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home. This has allowed patients to remain in their home, reducing their exposure to COVID-19 and reducing the risk that they expose another patient or their physician. It also means that patients who find travel to an in-person appointment challenging can receive care, which may be particularly important to patients with chronic conditions or disabilities who need regular monitoring. It also helps those who, because of their job, lack of care for dependents, transportation issues, and other limitations, find it difficult to attend an in-person visit to receive care. The AAMC acknowledges that CMS does not have the authority to make permanent the changes related to geographic locations and originating sites. We encourage CMS to work with Congress and other stakeholders to permanently eliminate the geographic site requirements and allow the home to be an originating site.

AAMC strongly supports the extension of payment for audio-only services through December 31, 2024; however, we recommend that CMS permanently allow payment for audio-only services. The AAMC commends CMS for extending payment for audio-only technology through December 31, 2024, and permanently allowing payment for audio-only technology for mental health services. However, we strongly believe that payment for Audio-only services (including telephone E/M Codes) should be permanently extended. In the first COVID-19 PHE interim final rule with comment, CMS established separate payment for audio-

only E/M services, CPT[®] codes 99441-99443.⁸ CMS recognized these services as telehealth services and added them to the Medicare telehealth list for the duration of the PHE. CMS will not allow payment for these codes under the PFS after December 31, 2024, following the end of the PHE.

Eliminating coverage for these important audio-only services will result in inequities in access to services for specific populations. Coverage of these audio-only services is particularly important for Medicare beneficiaries who may not have access to, or may not feel comfortable with, interactive audio/video technologies. Reports suggest that lack of video services or discomfort regarding the use of video may particularly affect certain populations, some of whom have high-risk and chronic conditions, including older adults, those with low socioeconomic status, those in rural communities, and certain races and ethnicities. Data from the Clinical Practice Solutions Center (CPSC),¹ which contains claims data from 90 physician faculty practices, shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient, with 17% of visits delivered via audio-only interaction for patients 41-60 years of age, 30% for patients 61-80 years of age, and 47% of visits for patients over 81.⁹ CMS also released data showing that nearly one third of Medicare beneficiaries received telehealth by audio-only telephone technology.^{10, 11} This demonstrates the importance of continuing to allow equitable coverage and payment for audio-only services to Medicare beneficiaries.

In addition, patients in rural and other underserved areas and those with lower socio-economic status are more likely to have limited broadband access, making it more difficult to receive telehealth services by audio and video interactions. For these patients, their only option to receive services remotely may be through a phone. Not only is audio-only access a health disparities issue, covering audio-only visits is an important recognition of the value of provider effort. Many services can be provided in a clinically appropriate way via an audio-only interaction, and patients and practitioners should be able to choose this option when clinically appropriate.

AAMC supports the delay of the in-person requirement for mental health services through December 31, 2024. We recommend that the in-person visit requirement for mental health services be eliminated permanently. AAMC commends CMS for providing coverage and payment of telehealth for mental health services. In previous rulemaking, CMS implemented provisions in CAA, 2021 that removed geographic restrictions and permitted the home to be an originating site for telehealth services for the treatment of mental health disorders, as long as the practitioner furnishes an initial in-person visit 6 months prior to the first telehealth visit as well

⁸ CMS, Medicare and Medicaid Programs; Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency,” 85 FR 19230 (Apr. 6, 2020)

⁹ AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

¹⁰ HHS ASPE Issue Brief: [Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic](#) (July 2020)

¹¹ S Verma, [Health Affairs Blog: Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19](#). (July 2020)

as a subsequent in-person visit at an interval to be determined by the Secretary of Health and Human Services. During the PHE, the removal of Medicare's geographic and site of service limitations for services furnished via telehealth have significantly increased access to care, particularly for behavioral telehealth services. In April 2020, at the height of the COVID-19 PHE, telehealth visits for psychiatry and psychology surpassed 50% of the total services. According to data from faculty practices included in the CPSC, the use of telehealth for mental health services remained consistent throughout 2020 and 2021.¹² And the use of telehealth services by behavioral health providers has remained high. In addition, there has also been a reduction in missed appointments for behavioral health services because telehealth expansion has made it easier for patients to access care. This is particularly important in mental health because there is a shortage of providers.

We recognize that the statute requires an initial in-person visit prior to the telehealth visit, as well as a subsequent in-person visit at an interval to be determined by the Secretary; however, we believe that an in-person requirement acts as a significant barrier to care for mental health services. Continuation of care is crucial for mental health services, and this in-person visit requirement may result in a lapse of care and ultimately negative clinical outcomes for patients. Mental health services are the only type of service provided by telehealth that would require an in-person visit at a specific interval, which is arbitrary and discriminatory against this particular type of service. Furthermore, the in-person requirement will increase wait times for those in need of an in-person visit due to workforce shortages. It also adds an additional burden of commuting to see the provider. This burden will disproportionately affect those in underserved communities or rural areas and anyone who does not have reliable transportation. AAMC acknowledges that CMS does not have the authority beyond December 31, 2024, to eliminate the in-person requirements; therefore, we encourage CMS to work with Congress and other stakeholders to permanently remove the in-person requirements.

AAMC supports the extension of the expanded definition of eligible telehealth providers to include physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), and audiologists through December 31, 2024, and strongly recommends CMS permanently allow these practitioners to receive payment for telehealth services. The COVID-19 pandemic has contributed to the already strained workforce shortages. Addressing the workforce shortage will require a multipronged approach, including innovation in care delivery; greater use of technology; as well as improved, efficient use of all health professionals on the care team. PTs, OTs, SLPs, and audiologists have proven throughout the PHE that they are able to furnish high-quality care via telehealth effectively, safely, and efficiently to patients. Expanding the definition of eligible providers has resulted in increased access to care, making it obtainable to those who might not otherwise be able to receive it. Patients have come to rely on being able to obtain these services virtually. If PTs, OTs, SLPs, or audiologists are no longer able to furnish telehealth services to patients after December 31, 2024, it will result in lapses in care that may negatively impact patient health. AAMC acknowledges that CMS does not have the authority outside of the PHE beyond December 31, 2024 to make

¹² AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

changes related to which providers can furnish telehealth services. We encourage CMS to work with Congress to permanently expand the definition of eligible telehealth providers.

AAMC supports the extension of payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for telehealth services through December 31, 2024; however, we strongly recommend that CMS permanently allow payment for telehealth services furnished by FQHCs and RHCs. During the PHE, the CARES Act established Medicare payment for telehealth services when RHCs and FQHCs serve as the distant site. RHCs and FQHCs were able to effectively furnish telehealth services and treat patients via telehealth during the PHE and should be allowed to continue to do so. If FQHCs and RHCs are no longer able to furnish telehealth services to patients after December 31, 2024, this will limit access to care, which may negatively impact patient health. AAMC acknowledges that CMS does not have the authority outside of the COVID-19 PHE beyond December 31, 2024, to make the changes related to payment of FQHCs and RHCs for telehealth services. We encourage CMS to work with Congress to permanently continue payment for telehealth services furnished by FQHCs and RHCs.

AAMC supports CMS proposals to implement provisions in the legislation that recognize marriage and family therapists (MFTs) and mental health counselors (MHCs) as telehealth practitioners, effective January 1, 2024. The COVID-19 pandemic exacerbated and exposed the critical shortage of behavioral and mental health providers. The PHE highlighted telehealth as an effective way to expand access to care, in particular for mental health services. According to data from the Health Resources and Services Administration (HRSA), as of September 10, 2023, approximately 164 million people currently reside in Mental Health Professional Shortage Areas (HPSAs), and there is a shortage of 8,289 practitioners¹³. Around 32% of Mental Health HPSAs are located in non-rural areas, and 7.5% are in partially non-rural areas. Currently, around 100 million people reside in Primary Care Shortage Areas, with a need for 17,303 more primary care practitioners.¹⁴ Both MHCs and MFTs are qualified to evaluate, diagnose, and create treatment plans for their patients through telehealth. They are trained to treat a range of mental health conditions, striving to resolve issues and develop effective strategies to address these challenges. The AAMC supports this proposal and commends CMS for allowing MFTs and MHCs to provide telehealth services, leveraging their expertise to address the current mental health crises.

¹³ HRSA Data on Health Professional Shortage Areas by Discipline can be found here:
<https://data.hrsa.gov/topics/health-workforce/shortage-areas>

¹⁴ Designated Health Professional Shortage Areas Statistics, Bureau of Health Workforce, HRSA (Mar. 2023)
<https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>

Telehealth Services Furnished by Institutional Staff

CMS Should Extend Payment for Outpatient Therapy, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT) When Furnished by Institutional Staff Through December 31, 2024 and Create New Remote Codes for These Services to be Billed through the Outpatient Prospective Payment System (OPPS) Beginning January 1, 2025.

During the PHE, hospital outpatient departments could provide services billed on institutional claims forms virtually (via telemedicine) to a patient while the patient is a registered outpatient, and the home is considered an “expansion site” under the Hospitals Without Walls program. This included physical therapy, occupational therapy, speech language pathology, and audiology, DSMT, MNT, when furnished by institutional staff. Through December 31, 2023, CMS is exercising enforcement discretion, allowing hospitals to continue receiving payment for telehealth services provided by hospital-employed PTs, OTs, SLPs, and clinical staff providing DSMT or MNT services, when billed through the institutional claims form (UB-04). CMS proposes to continue payment for these services when furnished by institutional staff to patients in their homes until December 31, 2024. **The AAMC strongly supports this extension, as it promotes continuity of care.** During the PHE, patients have come to rely on the ability to receive these services virtually, while providers have demonstrated that these services can be provided safely and effectively through audio-video technology. We urge CMS to permanently allow payment for these services provided by institutional staff and billed by the hospital, similar to a policy finalized in last year’s OPPS rule that allows payment for mental health services provided by institutional staff employed by hospitals to beneficiaries in their homes.

Telehealth Frequency Limitations

CMS Should Remove Frequency Limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services Furnished via Telehealth through December 31, 2024

Before the COVID-19 PHE, telehealth services were restricted to once every 3 days for subsequent inpatient visits, once every 14 days for subsequent nursing facility visits, and once per day for critical care consultation services. CMS temporarily lifted these limitations during the COVID-19 PHE and then announced the use of enforcement discretion to waive these frequency limitations through December 31, 2023. In the 2024 PFS, CMS proposes to extend the removal of these telehealth frequency limitations through December 31, 2024.

The AAMC strongly supports the removal of these frequency limitations through December 31, 2024, as it promotes continuity of care. These frequency limitations would result in decreased access to care, potentially leading to negative clinical outcomes. We believe that providers are best situated to determine when subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services furnished via telehealth are medically necessary.

Telehealth Payment Rates

CMS Should Pay the Non-Facility-based Rate for Telehealth Services When a Practitioner is Providing Telehealth to a Patient at Home

During the COVID-19 PHE, CMS recognized that the cost of furnishing telehealth services may not significantly differ from resource costs involved when those services are furnished in-person.¹⁵ As a result, CMS instructed the use of the CPT® telehealth modifier '95' and the Place of Service (POS) code of where the service would have taken place if the telehealth service had been provided in-person. This policy allowed telehealth services to be reimbursed at the non-facility rate, which is the same as the in-person rate, for office-based services provided via telehealth. In its rationale in the interim final COVID-19 rulemaking, CMS stated “we expect that physician offices will continue to employ nursing staff to engage with patients during telehealth visits or to coordinate pre- or post-visit care, regardless of whether or not the visit takes place in person, as it would have outside of the PHE for the COVID-19 pandemic, or through telehealth in the context of the PHE for the COVID-19 pandemic.”¹⁶ Despite this reasoning, in the 2023 PFS, CMS finalized a policy to pay the facility-rate instead of the non-facility rate for telehealth services beginning January 1, 2024.

CMS is proposing a change to the policy finalized in the 2023 PFS to pay the same amount as in-person services (non-facility-based rate) when a practitioner is providing telehealth to the patient at home beginning January 1, 2024. **The AAMC strongly supports the proposed policy because it acknowledges and reimburses for the infrastructure and staffing costs for telehealth care, beyond the clinicians’ time and clinical expertise.** For example, providers must establish a video platform that is HIPAA compliant, accessible, user-friendly, and compatible with patient-owned devices, and that integrates with EMR scheduling and enables multiple concurrent participants (e.g., learners, patients’ family members). Providers must ensure that both they and their patients have sufficient internet access and bandwidth, and in some instances must supply the appropriate devices, for example webcams, headsets, smartphones, for patients and clinicians. They must establish workflows and staffing to ensure effective appointment scheduling, notifications, reminders for providers and staff, and learner supervision, as necessary. Protocols and infrastructure must be in place for managing patients’ emergencies. Providers must also offer effective technology training for providers and staff, including real-time technical support for providers and patients, with contingency plans in place for when failures occur, as well as private locations where others cannot hear or see the patient during the video visit. Providers also need to employ nurses, medical assistants, and other staff to engage patients before, during, and after telehealth visits to coordinate care pre- and post-visit and ensure a seamless experience. We refer CMS to an AAMC resource document which further describes these costs.¹⁷ CMS’s proposal to provide adequate payment for these services will help ensure that practitioners can continue to provide telehealth services and increase patient access to care.

¹⁵ *Supra*, note 8

¹⁶ *Id.*, at 19233

¹⁷ AAMC, [Understanding a Video Visit at the Health System Level](#) (2021).

Telehealth List

CMS Should Establish a Streamlined Medicare Telehealth Services List

During the PHE, providers have demonstrated their ability to deliver services safely and effectively on the telehealth list. Currently, the telehealth list is comprised of three categories: services added to the telehealth list based on an evidentiary assessment of their similarity to other already-listed services (Category 1), services added based on an evidentiary assessment of whether they would clinically benefit the patient when provided via telehealth (Category 2), and in 2021, CMS created a new group of services (Category 3). Category 3 services are likely to have clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider them for permanent addition under Category 1 or Category 2 criteria. These services were added temporarily until December 31, 2023.

In the 2024 PFS, CMS proposes to streamline telehealth by creating both a permanent and provisional category, replacing Categories 1, 2, and 3. Services that are currently on the Medicare Telehealth Services List under Category 1 or 2 would be assigned to the new permanent category, while services currently added on a temporary basis under Category 2 or Category 3 would be assigned to the provisional category. **The AAMC commends CMS for adding services that were temporarily included on the telehealth list during the PHE to the provisional category to allow for additional study.** This approach will promote continuity in care and prevent confusion that could arise from various telehealth services that were added to the telehealth list during the PHE expiring at different times.

As proposed, new services can be added to the provisional list when public comments express support for possible clinical benefit, without the required evidence supporting clinical benefit for addition to the permanent list. The provisional list would provide time to gather evidence to determine if a telehealth service can be provided safely, effectively, and efficiently via telehealth. Once there is sufficient evidence, CMS will either add the service to the permanent category or remove it from the telehealth list altogether. This decision to add or remove services is based on evidentiary support instead of assigning an arbitrary deadline. **The AAMC appreciates CMS's responsiveness to previous feedback in proposing a provisional list. Furthermore, we agree with CMS that these proposed changes would effectively streamline the process while promoting the future study of telehealth services.**

Telehealth: Reporting the Home Addresses on Enrollment

CMS Should Not Require the Medicare Enrollment Application to Include Practitioners' Home Addresses When Providing Telehealth from Their Homes if There is a Valid Reassignment Relationship Between the Remote Practitioner and a Medicare-enrolled Practice with a Physical Office Location Where Care is Delivered to Patients In-person.

During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from the location where they had been enrolled. Starting on January 1, 2024, practitioners will be required to report the addresses where they perform telehealth services when enrolling in Medicare.

Requiring reporting of practitioner's home addresses for enrollment is likely to discourage practitioner's from providing telehealth services from their home, limiting access to care. Practitioners have expressed privacy and safety concerns associated with enrolling their home address. They fear the unintended consequences of their personal information becoming available to the public, especially if it is displayed on Medicare websites that included physician look-up features, such as *Care Compare*. In particular, there has been an increased trend toward violence against physicians and other health care professionals in recent years. The inclusion of a physician's home address poses a potential threat for a physician and their family.

In addition to privacy and safety concerns, this requirement poses operational challenges and creates an undue administrative burden to update and change provider addresses. Updating the 855B forms or PECOS to include home addresses of the many practitioners that are employed by large multi-specialty practices would be challenging, particularly as practitioners join and leave the group practice or move to new homes. This policy complicates the Medicare Administrative Contractor (MAC) assignment if the home is located in a different MAC jurisdiction than the practitioner's physical office location. In such cases, the group practice would be required to enroll with multiple MACs to ensure practitioners receive payment at the payment amount for services based on where they are located when performing telehealth services. This policy does not consider where the practitioner performs the telehealth services (i.e., their home) may differ from where the patient is located and from the location where the practitioner generally practices and is licensed.

Removing this requirement would make it more feasible for practitioners to provide safe and effective telehealth services from their homes and expand access to medically necessary care by increasing the availability of practitioners. Practitioners could be available to furnish telehealth services during extended hours and on weekends. Access to specialists for which there are shortages would be improved. Additionally, patients with urgent clinical needs outside of business hours would be able to receive care.

Provider enrollment requirements are designed to protect the Trust Fund by ensuring the accuracy of payments and that providers meet appropriate qualifications and requirements for participation in the Medicare program. We believe that if there is a valid reassignment relationship between the remote practitioner and a Medicare-enrolled practice with a physical office location where care is delivered to patients, safeguards would be in place. The benefits of providing telehealth to patients far outweigh any compelling reason to require enrollment of home addresses.

Given the privacy and safety concerns and operational challenges, if a practitioner is enrolled in Medicare and reassigns payment to a physical office location where he or she practices, CMS should not require that practitioner to enroll other addresses, such as their home, where they provide telehealth services.

If CMS chooses to proceed with this policy, it should delay the requirements until December 31, 2024, to align with the telehealth flexibilities provided for in the CAA, 2023. We are concerned that there is insufficient time for practices to complete and submit enrollment information to the MAC jurisdictions of remote practitioners and for the MACs to process these

enrollments by the end of this year. CMS should also provide guidance on how providers will be required to report addresses, as well as the requirements for updating and maintaining the list of addresses.

Virtual Direct Supervision of Clinical Staff

CMS Should Continue to Allow Direct Supervision Through Virtual Supervision on a Permanent Basis.

During the COVID-19 PHE, CMS adopted a policy on an interim basis that direct supervision for services billed “incident to” a physician service could be met through virtual supervision. Direct supervision generally requires immediate availability within the office suite. We commend CMS for adopting these virtual supervision policies, as they have been critical in reducing exposure to COVID-19 and enabling expanded access to health care services. Continuing these policies will reduce risk of exposure to all infectious diseases (e.g., coronavirus, seasonal flu, and others), and increase access to care for patients. Our members have found virtual supervision of clinical staff to be safe and effective, and improved access to care. For example, virtual supervision allows physicians to supervise Advanced Practice Providers across multiple campuses, which increases patients’ access to care.

Virtual Supervision of Residents for Telehealth and In-Person Services

During the COVID-19 PHE, CMS allowed the supervisory requirement for teaching physicians ‘to be present for the key portion of the service through real-time audio/ video technology’ (herein referred to as virtual supervision) for both services when the resident and patient are together in-person (herein referred to as in-person services) and telehealth services in all residency training locations. In the CY 2021 PFS, CMS finalized a policy to permanently allow virtual supervision of residents in training sites located in non-Metropolitan Statistical Areas (non-MSAs). CMS stated that this policy would improve access to care in these areas. Currently, CMS is exercising enforcement discretion to allow virtual supervision of residents in all residency training sites, as was permitted during the COVID-19 PHE, through December 31, 2023. In the CY 2024 PFS, CMS proposes to allow virtual supervision of residents furnishing telehealth services in all residency training locations through December 31, 2024.

The AAMC strongly supports CMS’s proposal to allow virtual supervision of residents for telehealth services in all residency training locations through the end of CY 2024. However, we urge CMS to allow virtual supervision of residents for both in-person and telehealth services in all residency training locations permanently. At a minimum, CMS should allow virtual supervision of residents for both in-person and telehealth services in underserved areas, as well as in non-MSAs.

Residents have been virtually supervised safely and effectively during the PHE, for both in-person and telehealth services. In both cases, the teaching physician is present virtually during key and critical portions of the service through interactive audio/video real time communications technology, and both the attending physician and resident have access to the electronic health record. Teaching physicians render personal and identifiable physician services and exercise full personal control over the management of the care for which payment is sought. CMS requires

that the documentation in the patient's medical record must clearly reflect how and when the teaching physician was present during the key and critical portion of the service, along with a notation describing the specific portions of the service for which the teaching physician was virtually present. After the visit, if medically necessary, the teaching physician continues to engage with the patient through phone calls, messages, video updates, study reviews, and collaboration with other providers.

The use of telehealth has been of great benefit for patients, both during and after the COVID-19 PHE. It maintains and expands access to safe and effective care, particularly for patients in rural and other underserved areas, those with lower socio-economic status, those with disabilities, the elderly, and those from certain racial and ethnic backgrounds that have historically experienced limited healthcare access. It also helps those who, because of their job, lack of care for dependents, transportation issues, and other limitations, find it difficult to attend an in-person visit to receive care. Furthermore, physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital admissions. Telehealth also protects patients from exposure to infectious diseases, such as COVID-19 and the seasonal flu. Allowing residents to provide these telehealth services while being supervised virtually further expands access and promotes training opportunities.

As part of their training, it is essential for residents to have experience with providing telehealth services, as they will be providing them to their patients independently in the future to ensure that they are adequately trained before they enter the physician workforce. Virtual supervision of residents allows the teaching physician and residents to provide telehealth services safely and effectively from different locations. They interact with the patient virtually, receiving real-time information from the patient simultaneously. This enables the supervising physician to take an active role in patient evaluation and treatment. Video platforms allow the resident and teaching physician to communicate seamlessly by sending real-time private messages to each other and/or by meeting virtually face-to-face in a private breakout room separated from the patient. As a result, the teaching physician and resident do not need to be in the same room. The need and demand for these services is expected to increase as remote digital tools for at-home health monitoring continue to expand, and the population continues to age, resulting in transportation and mobility challenges.

Virtual supervision of in-person services improves access to care by bringing more care directly where patients are and allowing teaching physicians to oversee care across multiple locations. It also offers the added advantage of having residents onsite with the patient to facilitate audio/video communication and observations for the remote teaching physician. An example of the benefits of virtual supervision of an in-person service is where a psychiatric resident is caring for patients overnight in the emergency department and evaluates a patient with the attending psychiatrist remotely supervising through a secure platform. This teaching physician can communicate directly with the patient and the resident and has access to the patient's medical record. Under such an arrangement, the attending psychiatrist would be available in the case of a psychiatric emergency to virtually supervise the resident involved in the patient's care, thereby increasing access.

Additionally, training programs have increased the practice of sending residents to medically underserved areas for rotations. For example, residents may be involved in providing care to patients through mobile treatment units and in hospital at home programs. During the COVID-19 PHE, teaching physicians and residents have demonstrated their ability to effectively provide care through virtual supervision, which improves access,¹⁸ outcomes and patient satisfaction,¹⁹ through these mobile service lines. Not allowing virtual supervision could impact training programs to the extent they will no longer be able to continue if teaching physicians were required to be physically present at mobile locations.

While we appreciate that CMS finalized a policy in the CY 2021 PFS to increase access by allowing virtual supervision of residents for both in-person and telehealth services in non-MSAs, it is important to recognize that significant workforce shortages are also impacting access to care in MSAs. According to data from the HRSA, as of September 10, 2023, 164 million people currently reside in a Mental Health HPSAs and there are 8,289 fewer practitioners than are needed.²⁰ Approximately 32% of Mental Health HPSAs are located in non-rural areas and 7.5% are in partially non-rural areas.²¹ Currently, 100 million people reside in a Primary Care Shortage Area and there are 17,303 primary care practitioners that are needed.²² Additionally, a June 2021 report from the AAMC predicts a shortage of up to 124,000 physicians by 2034.²³

These shortages have a real impact on access to care for all patients. During the COVID-19 PHE, specialties such as Psychiatry and Behavioral Health, Family Medicine, Internal Medicine, Primary Care, Endocrinology, Dermatology, Nephrology, Allergy/Immunology, Radiology, Cardiology, Infectious Diseases, and more have provided high-quality oversight through virtual supervision for both in-person and telehealth to help address the shortage and improve access to care. Teaching physicians have more time to educate residents and provide comprehensive patient care, ultimately improving patient outcomes. For example, allowing teaching physicians to supervise residents virtually increases the availability of the teaching physician, including extended weekday and weekend hours to address patient needs. They can continue to supervise residents even when experiencing periods of quarantine or mild illness. Additionally, this policy helps residency programs access a broader diverse pool of experienced teaching physicians and specialists and reduces provider burnout by allowing them to practice more efficiently, for example, by reducing travel time.

Guardrails exist through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations that have standards and systems that will ensure patient safety and oversight of residents when virtual supervision of residents occurs for both in-person and telehealth services. ACGME sets forth extensive program requirements, including requirements related to supervision. ACGME recognizes that direct supervision occurs when either the supervising physician is physically present with the resident during the key portions of

¹⁸ [How Do Mobile Health Clinics Improve Access to Health Care?](#) Tulane University School of Public Health and Tropical Medicine Blog (Jun. 2021).

¹⁹ Caplan GA, et al, [A meta-analysis of “hospital in home,”](#) Med J Aust. (Nov. 2012)

²⁰ *Supra*, note 13

²¹ *Supra*, note 14

²² *Id.*

²³ *Supra*, note 6

the patient interaction; or the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. The program must also demonstrate that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and ability guided by milestones, as well as patient complexity and acuity. The faculty must assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility, and each resident must also know the limits of their scope of authority. Teaching physicians are ultimately responsible for determining the level of supervision required and any adverse events that occur. ACGME, other accrediting organizations, and the medical education community work hard to monitor, report, and address any issues related to workload, patient safety, medical error, resident well-being and burn-out, professionalism, and resident learning and outcomes.²⁴

The AAMC supports the current exclusion from direct supervision by interactive telecommunications technology of surgical, high risk, interventional and other complex procedures, endoscopies, and anesthesia services. For these services, we believe that the requirement for the physical presence of the teaching physician for the entire procedure or the key portion of the service with immediate availability throughout the procedure, is necessary for patient safety given the risks associated with these services. When providing these types of services, a patient's clinical status can quickly change and there is a need for the rapid onsite decision-making and procedural skills of the supervising physician.

It is imperative that the progress in improving access that has been made during the COVID-19 PHE continue now that the PHE has ended. Therefore, we urge CMS to allow virtual supervision of residents in all geographic regions for in-person services and telehealth services that may be furnished safely and effectively.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

In the proposed rule, CMS made several clarifications on Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) codes and is actively seeking feedback to assist with future policies for remote monitoring services. RPM involves the collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. It allows patients to be monitored remotely while in their homes, and for providers to track patients' physiologic parameters (e.g., weight, blood pressure, glucose) and implement changes to treatment as appropriate. Physicians and practitioners may provide RPM services (CPT[®] codes 99453, 99454, 99091, 99457, and 99458) for patients with acute and chronic conditions. RTM involves utilizing devices to monitor a patient's health or their response to treatment using non-physiological data. This practice includes collecting data related to musculoskeletal and respiratory medication or therapy responses (CPT[®] codes 98975, 98976, 98977, 98980, and 98981).

²⁴ [ACGME Common Program Requirements](#)

CMS Should Allow RPM and RTM Services to be Furnished in RHCs and FQHCs

Health care providers and their patients can experience many benefits from the use of RPM, including reduced readmissions, shortened hospital stays, improvements in quality of life, and lower costs. The continuous monitoring of RPM services is beneficial in academic medical centers since they serve patients who are often more clinically complex. These services allow physicians to track their patients' health metrics without requiring multiple in-person visits from patients whose schedules cannot accommodate greater time commitments. Allowing FQHCs and RHCs to provide RTM and RPM services will expand access to care to these remote services, particularly in rural areas and underserved areas.

CMS Should Allow RPM and RTM Services to be Billed for New and Established Patients

During the PHE, CMS allowed RPM services to be furnished to both new and established patients. Since the PHE ended, RPM services may no longer be provided to new patients. CMS has not clarified whether RTM services can be billed by new patients. We recommend that CMS allow both RTM and RPM services to be billed by new and established patients. In many cases, those who do not have an established relationship with a primary care provider seek care when acute symptoms develop. In the context of the COVID-19 PHE, for example, new patients could be remotely monitored from home without having an in-person visit, reducing the risk of exposure to COVID-19. Allowing new patients to be remotely monitored may also cut down on unnecessary hospital stays, ultimately reducing costs. In the event of an emergency, patients can be promptly notified to seek additional care.

CMS Should Allow Less Than 16 Days of Monitoring Within a 30-day Period for RPM and RTM Services

One of the barriers to the use of RPM and RTM services is the requirement that to bill for the initial set-up and continued monitoring, monitoring must occur during at least 16 days of a 30-day period. Expenses associated with configuring systems to capture necessary documentation and the actual clinician time spent documenting time spent per calendar month greatly outweigh Medicare reimbursement for these services. The 16-day requirement prevents providers from using these codes when clinical indications are that the patient would require less than 16 days of monitoring. For example, patients with pneumonia or COPD exacerbation can be sent home on oxygen therapy, requiring oxygen saturation (O₂sat) monitoring. Often, pneumonia or COPD exacerbation improves within less than 16 days. Similarly, a patient wearing a heart monitor to track palpitation symptoms might only need data collection during symptomatic periods, which could be fewer than 16 days. And if a healthcare practitioner intends to change heart medications for heart rhythm, the patient would require monitoring for less than 16 days. Additionally, the 16-day minimum threshold for transmitted physiologic data per 30 days undermines the value of time spent coordinating care and delivering needed services to patients who require monitoring less than 16 days in a 30-day period. Allowing fewer than 16 days of data transmission by a patient in a given month would greatly increase access to care and promote high value use.

CMS Should Not Restrict RPM and RTM Services to a 30-day Billing Cycle by a Single Provider and Should Allow Distinct Specialties to Simultaneously Provide RPM and RTM Services

CMS clarified that RPM and RTM may not be billed together, so that no time is counted twice by billing for concurrent RPM and RTM services. And that services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period.

The AAMC recommends that CMS remove this requirement to expand access to RPM and RTM services and reduce provider burden. Providers in various specialties might need to bill for RPM and RTM services to address distinct medical conditions. These requirements place an undue burden on providers to determine if they are unable to bill for services because another provider has already done so that month. In instances where billing is not possible for the month, providers will need to consistently check each month to determine if they are able to bill for the services. This could result in a delay in medically necessary care and ultimately negative clinical outcomes. If a provider unintentionally bills for services that another provider has already billed for that month, and they are subsequently asked to return the payment, providers may be concerned with billing these services in the future. This could result in a chilling effect for RPM and RTM services which could negatively impact patient care.

CMS Should Allow Patients to Manually Self-Report Data

The AAMC also supports allowing patients to manually enter their physiologic readings by a device into a platform for remote transmission. This would allow physicians to collect additional information that requires self-reporting data, such as pain, appetite, and other subjective metrics which could be beneficial when managing the patient's care. Allowing self-reported information is particularly important as it can help patients overcome key digital equity barriers.

CMS Should Allow 3rd Party Contracting Agreements for Set-up, Data Collection and Patient Monitoring for Both RTM and RPM Services

RPM and RTM services can collect a significant volume of patient data. Providers do not have the capacity to review all this patient data on their own. This volume will necessitate the involvement of third-party contractors to review and streamline the data for provider assessment. This includes setting up the remote devices, collecting the data and monitoring the data to alert the providers when vitals are outside of the appropriate ranges that were identified by the provider.

CMS Should Finalize Policy to Allow Physical Therapists (PTs) and Occupational Therapists (OTs) to Bill for RTM services Furnished by Physical Therapist Assistants (PTAs) and Occupational Therapist Assistants (OTAs) Under General Supervision.

CMS previously finalized policy that would allow Medicare payment for RTM services, including allowing any RTM service to be furnished under general supervision requirements. However, current regulations²⁵ specify that all occupational and physical therapy services are performed by, or under the direct supervision of, the occupational or physical therapist,

²⁵ 42 CFR § 410.59(a)(3)(ii) and 410.60(a)(3)(ii)

respectively, in private practice. These regulations make it difficult for physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) to bill for the RTM services performed by the PTAs and OTAs they are supervising, since the PTPP or OTTP must remain immediately available when providing direct supervision of PTAs and OTAs. CMS is proposing to establish an RTM-specific general supervision policy to allow OTTPs and PTPPs to provide general supervision only for RTM services furnished by their OTAs and PTAs, respectively. **We strongly support allowing OTAs and PTAs to provide RTM services under general, rather than direct supervision, to improve access to therapy services.**

ADVANCING ACCESS TO BEHAVIORAL HEALTH SERVICES

Payment for General Behavioral Health Integration Services

CMS Should Increase Payment for General Behavioral Health Integration Care Services

CMS proposes to increase the work RVU for CPT[®] code 99484 General Behavioral Health Integration Care services from 0.61 to 0.93 for a payment amount of \$54.03 in 2024 up from \$43.04 in 2023 for non-facility-based services. CMS also proposes to increase payment for HCPCS code G0323 Care Management Services for Behavioral Health Conditions for at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month from \$43.04 to \$54.03 for non-facility-based services to mirror changes made to CPT[®] code 99484.

We strongly support CMS's proposal to adopt the recommendations from the specialty societies regarding the values for CPT[®] code 99484 based on a crosswalk to CPT[®] code 99202, and to propose the same value for HCPCS code G0323. We appreciate CMS's recognition of the critical importance of behavioral health integration services and the need to ensure that these services are appropriately valued under the PFS.

Marriage and Family Therapists and Mental Health Counselors

Medicare Should Allow Coverage and Payment for Services Furnished by Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)

CMS proposes to implement the provision in the CAA, 2023 to allow for Medicare coverage and payment for services by MFTs and MHCs. Under this proposal, CMS would allow MFTs and MHCs to independently bill Medicare as a new provider enrollment type.

The AAMC strongly supports this proposal. The COVID-19 pandemic exacerbated and exposed the critical shortage of behavioral and mental health providers. According to data from the HRSA, as of September 10, 2023, approximately 164 million people currently reside in Mental Health HPSAs, and there is a shortage of 8,289 practitioners. Around 32% of mental health HPSAs are located in non-rural areas, and 7.5% are in partially non-rural areas. Currently, around 100 million people reside in Primary Care Shortage Areas, with a need for 17,303 more primary care practitioners.²⁶ Additionally, a June 2021 report from the AAMC predicts a shortage of up to 124,000 physicians by 2034.²⁷

²⁶ *Supra*, note 13

²⁷ *Supra*, note 14

Both MHCs and MFTs are qualified to evaluate, diagnose, and create treatment plans for their patients. MFTs and MHCs are also critical components of collaborative care teams and integrated behavioral health care teams. Allowing these providers to independently bill for Medicare services will improve access to behavioral health services for Medicare patients.

We commend CMS for recognizing the importance of expanding access to behavioral healthcare services and acknowledging the value that MFTs and MHCs bring to supporting this effort. However, we are concerned about the reductions in physician payments that could occur due to budget neutrality when adding approximately 400,000 providers that can independently bill the Medicare program. We believe that new provider services should not be subject to budget neutrality. We urge CMS to exercise the full scope of its administrative authority to mitigate any physician payment cuts that would be brought about because of budget neutrality due to the addition of MFTs and MHCs.

Psychotherapy Codes

CMS Should Increase Payment Adjustments for Psychotherapy Codes work Relative Value Units (wRVU) for One-on-One Timed Psychotherapy Codes.

The AAMC applauds CMS for attempting to address the historical undervaluation of these psychotherapy codes by enhancing their compensation. The proposal includes an anticipated increase of approximately 19.1 percent in wRVUs over a span of four years. This transition period is designed to gradually align compensation with the value and effort required for these services.

Although we believe that increasing payment for these undervalued services will improve access to mental and behavioral healthcare, we are concerned about the budget neutrality requirements. If the psychotherapy codes are increased, budget neutrality requirements will lead to arbitrary reductions in reimbursement for other services in the Medicare program. This is because in a budget-neutral system, when payment is increased for these services, payment must be decreased elsewhere in the program to ensure a zero-sum gain. Medicare provider payments have been constrained for many years by the budget neutrality system. We believe that ongoing structural problems with the Medicare PFS need to be addressed by Congress. As discussed above, we urge CMS to collaborate with Congress and other stakeholders to revamp the Medicare system and address the long-term structural challenges associated with a budget-neutral system.

CMS Should Finalize the Creation of Two New Codes for Psychotherapy for Crisis Services

CMS proposes to implement provisions of the CAA, 2023 to create two new HCPCS codes, GPFC1 and GPFC2, that are psychotherapy for crisis services furnished in any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting. The first code is psychotherapy for crisis in an applicable site of service during the initial 60 minutes and the 2nd code represents each additional 30 minutes. The codes are valued at 150 percent of the current PFS non-facility (RVUs) for the established Psychotherapy for crisis codes, CPT codes 90839 and 90840. **The AAMC strongly supports this proposal. We thank CMS for including an exemption from budget neutrality requirements for these services in**

order to expand access to care in psychotherapy for crisis services without lowering payments and jeopardizing care for other services.

Health Behavioral Assessment and Intervention (HBAI) Services

The AAMC supports CMS's proposal to implement policy in the CAA 2023 to allow the HBAI services CPT[®] codes (96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes) to be billed by CSWs, MFTs, and MHCs, in addition to CPs. CSWs, MFTs, and MHCs are critical components of team-based care and allowing these providers to offer this assessment will help patients access treatment for mental health conditions associated with other medical conditions.

Behavioral Health Request for Information

CMS expresses an interest in hearing feedback regarding ways to expand access to behavioral health service, such as ways to increase access to behavioral health integration (BHI) services and whether to consider new coding to allow interprofessional consultation to be billed by practitioners who are authorized by statute for the diagnosis and treatment of mental illness. and how to increase psychiatrist participation in Medicare.

The AAMC supports CMS's efforts to promote access to behavioral health services and is committed to advancing policies that enable teaching hospitals and health systems, medical school's faculty physicians, and other health care providers to deliver high-quality behavioral health care to their patients. The United States is experiencing a mental health and substance use disorder crisis that has worsened during the COVID-19 pandemic. Ensuring meaningful access to mental health and substance use disorder care is essential to addressing this crisis. Below are some specific recommendations on ways to expand access to behavioral health services.

Increasing Psychiatrist Participation in Medicare

The United States currently reports an acute lack of qualified behavioral health care providers, which limits patients' access to mental health and substance use disorder services. According to data from the HRSA, as of September 10, 2023, 164 million people reside in a Mental Health HPSAs.²⁸ Given the shortage of behavioral health providers, the AAMC supports policies that invest in education and training for behavioral health disciplines, such as psychiatry, addiction medicine, and others. We encourage CMS to support legislation introduced in Congress that invests in the physician workforce, including behavioral health disciplines, by increasing the number of residency slots or providing grants for training.

To address shortages and increase participation in Medicare, CMS should also examine ways to improve reimbursement for psychiatrists by improving the accuracy of valuation for the services they provide. CMS acknowledges in this proposed rule that services provided by psychiatrists and other mental health professionals may be undervalued and that any potential undervaluation of services can serve as an economic deterrent to furnishing services and be a contributing factor to the workforce shortage.

²⁸ *Supra*, note 13

Use of Telehealth for Behavioral Health Services

The AAMC also urges CMS to implement policies that enable providers to effectively leverage technology, including telehealth, to reach more patients in need of behavioral health care. During the PHE, the removal of Medicare’s geographic and site of service limitations for services furnished via telehealth significantly increased access to care, particularly for behavioral telehealth services. In April 2020, at the height of the PHE, telehealth visits for psychiatry and psychology surpassed 50% of the total services. According to data from faculty practices included in the CPSC,²⁹ the use of telehealth for mental health services has remained consistent. In addition, there has also been a reduction in missed appointments for behavioral health services because telehealth expansion has made it easier for patients to access care. In prior rulemaking, CMS implemented provisions in the Consolidated Appropriations Act, 2021 (CAA, 2021) that removed geographic restrictions and permitted the home to be an originating site for telehealth services for the treatment of mental health disorders, as long as the practitioner furnishes an initial in-person visit 6 months prior to the first telehealth visit and a subsequent in-person visit at an interval to be determined by the Secretary. Subsequently, Congress passed the CAA, 2023 that delayed implementation of the in-person visit requirements until December 31, 2024. We believe that an in-person requirement acts as a significant barrier to care for mental health services. This barrier disproportionately affects those who, because of their job, lack of others to help care for their dependents, transportation issues and other limitations, are not able to attend an in-person visit. Continuation of care is crucial for mental health services, and this in-person visit requirement may result in a lapse of care and ultimately negative clinical outcomes for patients. **We encourage CMS to work with Congress to permanently eliminate this in person requirement for mental health services in the future to improve access to care.**

Promote the Use of Interprofessional Consults for Behavioral Health and Eliminate Barriers

The AAMC and its member health systems have found the use of provider-to-provider telehealth modalities and peer-mentored care as important ways to improve access to care, particularly for behavioral health where there are significant access and workforce challenges. However, services like interprofessional consults have been underutilized due to obstacles related to payment policies, particularly related to CPT® codes 99451 and 99452.

By way of background, the AAMC has partnered with over 50 adult and pediatric health systems through Project CORE (Coordinating Optimal Referral Experiences) to implement interprofessional consults (“eConsults”) and continues to engage new health systems and other health care organizations, including payers, interested in implementing and scaling this high value service. In the CORE model, eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP.

²⁹ AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

When eConsults can take the place of a referral, patients benefit from more timely access to the specialist's guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs.

In a 2022 survey of health systems participating in Project CORE, 90% reported having integrated behavioral health in their primary care clinics and over 50% offered eConsults in Psychiatry. Some of the common conditions or problems that have made good use cases for eConsults in Psychiatry include ADHD, anxiety, and depression. By managing a subset of consultations via eConsults, patients can receive input through their PCP on next steps to advance their care or treatment plan, avoid waiting for an in-person visit, and access is enabled in the Psychiatry clinic for patients who need an in-person visit. CORE health systems have found eConsults to be a part of the continuum of services for successful integrated behavioral health models. The AAMC believes that investing in these technologies will extend the capacity of the existing behavioral health workforce and promote access to care in historically underserved communities. The AAMC continues to develop resources for health systems to aid in the adoption and evaluation of both synchronous and asynchronous telehealth modalities.

However, there are several barriers to the use of Interprofessional Consults described below.

Barriers to Uptake & Sustainability of Interprofessional Consults

By way of background, in 2019 CMS began covering two new CPT[®] codes (99451 and 99452) created by the CPT[®] Editorial Panel that describe consultative services (e.g., e-consults) between providers. These codes are:

- CPT[®] code 99452 Interprofessional telephone/ Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes
- CPT[®] code 99451 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or qualified health care professional including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time

The following describes three of the major policy barriers to uptake and sustainability of interprofessional consults.

"Two Coinsurances" Issue

CMS requires that providers collect coinsurance from their patients when billing for CPT[®] codes 99451 and 99452. While the AAMC understands that CMS may not have the authority to waive coinsurance for CPT[®] codes 99451 and 99452 under the Medicare fee-for-service program, we remain concerned that the coinsurance requirement is a barrier to providing these important services for several reasons. First, given the structure of two distinct codes, patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider (99452), and one for the consulting provider (99451). While we believe that it is appropriate to reimburse both providers for their work in conducting the internet

interprofessional consultation, two coinsurance charges to the patient for what they perceive is a single service predictably induces confusion. Interprofessional consults are often used for patients with new problems who are not established within the consulting specialty's practice and therefore do not have an existing relationship with the consultant. A coinsurance bill for a service delivered from a provider that is unknown to the beneficiary could cause the patient to believe a billing error has occurred. This would place an undue burden on the practice's billing staff to address questions about billing. Additionally, if presented with the option of an interprofessional consult coinsurance payment versus a visit coinsurance payment, patients may elect to see the specialist in-person, which would be unnecessary and negatively impact the potential savings of these interprofessional consults.

The AAMC recognizes there are typically limited scenarios where the fraud and abuse laws allow the waiver of coinsurance in the Medicare program. However, we continue to believe that the "two coinsurances" issue will stifle use of these value-promoting, physician-to-physician services that analyses of the CMMI-funded CORE model show to be cost-saving to CMS. Therefore, the Agency should explore a pathway to waiving the patient coinsurance for 99451 and 99452. CMS should explore whether there may be avenues available to waive the specialist coinsurance (99451) to minimize overall administrative complexity and confusion for beneficiaries who have no established relationship with the specialist consulting provider. At a minimum, the coinsurance should be waived in circumstances where there is a straightforward mechanism to do so, such as CMMI's waiver authority for specific services in alternative payment models (APMs), including the new Making Care Primary model.

Barriers to Billing the 99452 Code

Guidance for CPT[®] code 99452 clarifies that it should be reported by the treating physician/QHP for 16-30 minutes in a service day preparing the referral and/or communicating with the consultant. We believe that the time for these codes should include all the activities associated with the interprofessional exchange between the treating provider and consulting physician, including follow through on the consultant's recommendations. For an interprofessional consult to have its intended value for the patient, the treating physician must receive a response from the specialist, review it in the context of the patient's needs, and make a clinical decision about how best to incorporate the specialist's guidance. Therefore, we recommend that these follow-up activities be considered part of the minimum 16 minutes of time for the treating provider to bill this code. This clarification would help to expand the use of these valuable services in the future and ensure from a program integrity standpoint that patients and payers are realizing the intended value of this service. Interprofessional consults are only valuable to providers, patients, and payers when the treating provider poses a question, the specialist consultant provides recommendations and a contingency plan, and the plan is implemented and communicated back to the patient by the treating provider.

Since the establishment of these codes in 2019, there is now precedent for codes that cross dates of service. For example, the e-Visit codes (CPT[®] Codes 99421-99423) are reported for online digital evaluation and management service, for an established patient, for up to 7 days and includes cumulative time during the 7 days, 5-10 minutes.

The AAMC commends CMS for addressing this barrier to use of the 99452 CPT[®] code in the new Making Care Primary model. This new eConsult code for MCP participants is described in the recently released request for applications:

“In Track 2, participants will be able to bill the MEC for their MCP-attributed beneficiaries, to incentivize and encourage primary care clinicians to increase use of e-consults. The MEC will be valued at the same level as the existing requesting physician interprofessional consultation (IPC) code (99452), including geographic adjustments and facility non-facility adjustments. Currently, the code for primary care (requesting) physicians is valued at 0.70 wRVUs (in the CY 2023 Medicare Physician Fee Schedule). However, to address current barriers to utilizing the current IPC codes, CMS intends to include post-service time in the time requirements and propose payment for the MEC code at \$40 per service (subject to geographic adjustments). The MEC will be able to be billed by an MCP primary care clinician for a consultation with any specialist, regardless of whether the consulting specialist is one with whom the primary care clinician has a collaborative care arrangement (CCA). Specialty Care Partners will not be able to bill the MEC.”³⁰

EHR Interoperability: The AAMC has previously commented to the Office of the National Coordinator for Health IT (ONC) on interoperability hurdles for clinical practice, including challenges when working across health systems or EHR systems.³¹ While ONC has worked to improve common data standards for EHRs as part of its health IT certification efforts, this has not solved interoperability issues due to semantic differences when implementing such standards. Our experience working with member academic health systems through Project CORE has highlighted significant interoperability issues across systems, even in cases where they are operating within the same platform or using the same EHR tools developed by the same EHR vendor. For example, a call at one institution for the value of a white blood count lab may return the value but using the same vendor platform (or a FHIR API) to call at another institution might not result in a returned value due to semantic inconsistency. Currently, there are no feedback loops to address such inconsistencies in the implementation of normative standards across the nation. We urge CMS to coordinate with ONC to support broader semantic standardization through the development of national and regional user groups that provide feedback loops on semantic differences, helping to serve as a mechanism for truly normalizing national data standards into clinical practice. Additionally, CMS should work with the ONC to support for broader adoption and implementation of standard ontologies with quality assurance processes (i.e., LOINC, RxNorm, SNOMED, etc.) which may help improve semantic differences between health systems.

Increasing Access to Integrated Behavioral Health Care Services

In the 2024 PFS proposed rule, CMS asks about ways to increase access to integrated behavioral health care services. Integrated behavioral health care involves a multi-disciplinary team of medical and behavioral health providers working together with patients and their families to address the medical, behavioral, and social factors that affect health and well-being. Integrated

³⁰ CMMI, [Making Care Primary \(MCP\) Model Request for Applications \(RFA\)](#)

³¹ AAMC, [Comments to ONC on HTI-1](#) (June 2023)

behavioral health models seek to reduce the stigma around mental health services and expand access to care by facilitating behavioral health services within the primary or specialty care clinical setting. Academic medical centers have been at the forefront of developing and implementing a wide array of coordinated care models to meet their patients' needs and promote access to behavioral health care. To promote access, the AAMC recommends that CMS take the following steps:

- ***Reform CoCM CPT Codes to Allow for Appropriate Payment:*** Although there are CPT[®] codes that may be billed to receive reimbursement for the integrated behavioral health services under the Collaborative Care Model (CoCM), there are barriers that limit the uptake of these services. First, the current CoCM CPT[®] codes only allow for 70 minutes of integrated care in a patient's first month, followed by 60 minutes in subsequent months. It is administratively burdensome for providers to keep track of the time spent caring for individuals over one month. In addition, reimbursement rates for these services are low and there are significant start-up costs to establish these programs, including recruiting staff, hiring care managers, and registry development. Therefore, we recommend that these codes be amended to appropriately describe the services, reduce administrative burden, and sufficiently reimburse behavioral health providers for their time spent delivering integrated care. Increasing the payment for these services to better reflect the work associated with providing them would enable more providers to participate in CoCM, which would expand access to care.
- ***Extend Medicare Reimbursement to All IBH Team Members:*** Although the IBH multidisciplinary care team may include a diverse array of medical and mental health professionals, not all of these team members may bill Medicare for their services. For this reason, the AAMC supports policies to enable Medicare reimbursement for integrated behavioral health services to other licensed mental health providers such as licensed clinical social workers, mental health therapists and others. In addition, consideration should be given to funding mechanisms for certified peer support specialists and community health workers.
- ***Establish an Advisory Committee:*** We recommend CMS establish a multi-stakeholder advisory committee to re-examine the Collaborative Care Model and Behavioral Health Integration Billing codes to determine their utilization, barriers to uptake, and identify changes that could be made to increase use of these important services and improve patient access.

Digital Therapies - Including Cognitive Based Therapies

In the 2024 PFS proposed rule CMS seeks feedback on digital therapy including Cognitive-Based therapies. Digital therapeutics encompass evidence-based software products, used either alone or in combination, designed for managing, preventing, or treating diseases³². Typically, the FDA regulates these products as "Medical Devices" or "Software as a Medical Device"

³² American National Standards Institute/Consumer Technology Association, [Standard Definitions and Characteristics of Digital Therapeutics](#) (ANSI/CTA-2098). (Oct. 2021)

(SaMD). Within this category, digital cognitive behavioral therapy (dCBT) devices, a subset, deliver evidence-based psychological treatment. These digital therapies have the potential to significantly enhance access to effective treatment, particularly for underserved communities.

However, despite their potential benefits, the establishment of comprehensive codes and guidelines for these digital therapies is challenging. CMS should consider creating new codes to cover the training of patients in device usage, the implementation of devices into clinical care, and the review and analysis of data generated. CMS should also consider payment to incorporating a “digital navigator” to assist patients in setting up and operating these devices and communicating with patients between visits. This role would be similar to a peer support specialist and should not require any additional licensure. Furthermore, CMS should explore the utilization of digital therapies through mobile applications. Smartphones offer a cost-effective means of gathering critical patient information that can be utilized to treat medical conditions

TREATMENT OF OPIOID USE DISORDER

CMS Should Allow Periodic Assessments via Audio-only Technology in Opioid Treatment Programs (OTPs)

During the COVID-19 PHE, OTPs have also been permitted to provide periodic assessments furnished by audio-video communication technology, and through audio-only technology if the patient does not have access to audio-video technology. In previous rulemaking, CMS extended the ability for OTPs to furnish periodic assessments via audio-only communication technology through 2023. To align the OTP policies with the telehealth provisions of the CAA, 2023, CMS proposes to extend this policy on audio-only periodic assessments through December 31, 2024.

Audio-only services improve access to virtual care for patients who do not have access to the devices or broadband for audiovisual calls, are not comfortable with digital technology, or do not have a caregiver available to assist them. During the PHE, coverage and payment for audio-only technology has been critical to ensure access to care for patients who are participating in OTPs. Eliminating coverage for audio-only periodic assessments will result in inequities in access to services for specific populations. Reports suggest that lack of video services or discomfort regarding the use of video may particularly affect certain populations, including the elderly, those with low socioeconomic status, and certain races and ethnicities. Data from the CPSC, which contains claims data from 90 physician faculty practices, shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient, with 17% of visits delivered via audio-only interaction for patients 41-60 years of age, 30% for patients 61-80 years of age, and 47% of visits for patients over 81.³³ CMS also released data showing that nearly one third of Medicare beneficiaries received telehealth by audio only telephone technology.³⁴ Audio only continues to be an important mode of service delivery for certain populations. This demonstrates the importance of continuing to allow equitable coverage

³³ AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

³⁴ *Supra*, note 9

and payment for telephone services to Medicare beneficiaries. In addition, patients in rural areas and those with lower socio-economic status are more likely to have limited broadband access, making it more difficult to receive telehealth services by audio and video interactions. For these patients, their only option to receive services remotely is through a phone. Many services, including periodic assessments, can be clinically appropriate when provided via an audio-only interaction, and that option should exist for patients.

MEDICARE AND MEDICAID PROVIDER AND SUPPLIER ENROLLMENT

To clarify or strengthen certain components of the enrollment process, CMS proposed several changes to existing Medicare provider enrollment regulations.

Revocations

Under current regulations, CMS may not revoke a provider's or suppliers' enrollment due to a misdemeanor. CMS provides examples of several problematic misdemeanors which it believes justify revocation. Therefore, CMS proposes that it may revoke a providers' or supplier's enrollment if they, or any owner, managing employee or organization, officer, or director thereof, have been convicted of a misdemeanor under federal or state law within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries, including:

- Fraud or other criminal misconduct involving the provider's or supplier's participation in a federal or state health care program or the delivery of services or items.
- Assault, battery, neglect, or abuse of a patient (including sexual offenses).
- Any other misdemeanor that places the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

CMS requests comments on this proposal. The AAMC has concerns that this authority could be used to revoke the enrollment of a provider or supplier when the misdemeanor conviction took place many years before they were employed by the provider and supplier and were for misdemeanors that were unrelated to the Medicare program or its beneficiaries, such as reckless driving. Additionally, we have concerns about the potential impact of this proposal on the provision of reproductive health care services following the 2022 Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*.³⁵ After the Dobbs decision some states have begun to enforce abortion bans and restrictions on care and are proposing to enact new restrictions. As a result, providers are fearful of being prosecuted for providing medically necessary reproductive health care services. Similarly, we are concerned about the movement to criminalize gender affirming care. We urge CMS to reconsider this proposal in light of the current state policy landscape related to reproductive care and gender affirming care.

³⁵ 142 S. Ct. 2228 (2022).

Timeframes for Reversing a Revocation

Current regulations provide that if an enrollment revocation was due to adverse activity by a provider or supplier's, owners, managing employee, authorized or delegated officials, or supervising physician, the revocation can be reversed if the provider or supplier terminates, and submits proof that it has terminated its business relationship with that party within 30 days of the revocation notification. CMS proposes to reduce this 30-day period to 15 days and seeks comments on whether 15 days is an appropriate timeframe. The AAMC urges CMS to continue to allow a 30-day period, as we believe that 15 days is too short for a provider to investigate, carry out a termination of the business relationship, and submit that information to CMS.

APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING

CMS Should Pause Implementation and Rescind AUC Regulations

CMS proposes to pause implementation of the AUC Program for reevaluation and to rescind current AUC regulations found at 42 CFR § 414.94, due to the agency's exhaustion of all reasonable options for operationalizing the AUC Program consistent with statutory intent. CMS does not propose a time frame for recommencing implementation. **The AAMC appreciates CMS's approach in response to stakeholder concerns regarding the AUC Program and we support this proposal to both pause implementation and rescind current rules.** We have previously supported policies to delay the AUC Program in recognition of competing priorities due to the COVID-19 PHE as well as the need to address the inclusion of advanced diagnostic imaging services performed as part of a clinical trial.³⁶ Back in 2017, we commented that there must be sufficient time to engage providers on the guidelines, uses of clinical-decision support mechanisms (CDSM) software, modify workflow patterns, update EHRs, and pilot test systems – little to know of which has been done due to operational challenges CMS notes in this proposal.³⁷ **Given all these challenges, the AAMC supports the pause to implementation and rescission of current AUC regulations. We urge CMS to work collaboratively with Congress to address the challenges posed by the AUC Program.**

REQUIREMENT FOR ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES (EPCS) FOR A COVERED PART D DRUG

In the 2022 Medicare payment final rule, CMS established several EPCS policies. Specifically, CMS stated that physicians were required to electronically prescribe Medicare Part D controlled substances in 2022 with compliance enforcement starting in 2023 with several exceptions.

CMS finalized a policy that it would only issue noncompliance letters in 2023 for prescribers who violate EPCS requirements. The letters notify prescribers that they are violating an EPCS requirement; provide information on how to come into compliance with the requirement; describe the benefits of EPCS; include an information solicitation as to why they are not conducting EPCS; and provide a link to the CMS portal to request a waiver. CMS proposes to extend its policy of only sending noncompliance letters to noncompliant prescribers for the EPCS program for subsequent measurement years. **The AAMC supports this proposal to**

³⁶ AAMC, [Comments on the CY2022 Physician Fee Schedule Proposed Rule](#) (Sep. 2021)

³⁷ AAMC, [Comments on the CY2018 Physician Fee Schedule Proposed Rule](#) (Sep. 2017)

extend the enforcement policy of sending a letter to physicians who are not in compliance with the requirement. We agree with CMS that this approach would support increased EPCS adherence, increase EPCS adoption rates, and minimize burden on providers. The AAMC commends CMS for engaging stakeholders in the conversation surrounding electronic prescribing, and we believe that it is important to provide further education and assistance for providers.

MEDICARE SHARED SAVINGS PROGRAM (SSP)

Quality Reporting

CMS Should Permanently Adopt the New Medicare CQMs Reporting Option to Allow SSP ACOs to Meaningfully Report Quality Performance

CMS proposes to adopt a new Medicare CQM quality reporting option for ACOs beginning with CY2024 performance. This new option is intended to support prior finalized policies to sunset the CMS Web Interface and transition alternative payment model (APM) quality reporting to the APM Performance Pathway (APP) measure set. Currently, the APP only allows reporting eCQMs and MIPS CQMs across all patients and all payers. The new Medicare CQM reporting option would mirror the MIPS CQM reporting option, save for the measurement population. Under the Medicare CQM option, ACOs would be required to report the three APP CQMs for a Medicare fee-for-service (FFS) beneficiary population that receives care from ACO professionals used in beneficiary assignment or who designate an ACO professional as coordinating their care. CMS believes this will allow ACOs to focus their investments and understanding of CQM reporting on a measurement population that it can better match and aggregate data for, as opposed to a broader all-patient measurement population. As proposed, the Medicare CQM reporting option would be eligible for the health equity adjustment when calculating quality performance scores. CMS notes in the proposed rule that it intends for the Medicare CQM reporting option to be a temporary reporting option to transition ACOs to be able to successfully report all patient/all payer eCQMs and MIPS CQMs.

The AAMC supports this proposed new Medicare CQM reporting option for SSP ACOs.

We have previously commented to CMS that all-patient/all-payer measures require significant investment and expertise to successfully report on, and that ACOs need additional time to be able to do so. All-patient/all-payer measures represent a significant challenge for ACOs that include a greater number of specialist participants, as specialists may treat a higher number of patients without meaningful, broad care relationships with the ACO. The ACO does not have the same flexibilities to design care interventions for all patients treated by the ACO's participant clinicians nor the ability to readily access patient data for the patients not attributed to the ACO but treated by ACO participants. Therefore, the requirement to report all-patient/all payer measures might frustrate ACO efforts to fully collect data to meet data completion thresholds or to influence quality performance. Reporting CQMs for the Medicare FFS patients with a treatment relationship to ACO professionals with a primary care or related specialty ensures that CMS receives meaningful quality information on the ACO's influence on the Medicare FFS population. If forced to transition to all patient/all payer reporting options, ACOs might be incentivized to make significant changes to their ACO professional participants to reduce or even

completely remove non-primary care specialists from participation to ensure they are not disadvantaged by data collection or performance outside of the ACO's control. While primary care is critical to the success of accountable care, so too is coordination and engagement with specialty care. **We encourage CMS to retain the Medicare CQM reporting option permanently to ensure that any policy to push ACOs to all patient/all payer quality measure reporting does not have an unintended consequence of discouraging specialist participation in ACOs.**

CMS Should Ensure That Quality Reporting and Performance Policy Does Not Reduce Incentives for Specialists to Continue Participation in ACOs

CMS seeks feedback from stakeholders on potential future policies to provide quality bonus opportunities for specialists who participate in ACOs and report MIPS Value Pathways (MVPs). CMS is considering a future policy to award bonus points for ACOs with specialists who report quality MVPs (with the bonus applied after MIPS scoring is complete) as it believes this could lead to increased specialty engagement in the SSP. The AAMC believes that this approach alone will not result in increased engagement.

We believe that better payment incentives are needed to drive overall physician engagement in the SSP, regardless of specialty. The sunset of the payment bonus for qualifying participants (QPs) in Advanced APMs (AAPMs), the increase in the thresholds to be classified as QPs, and the increase in reporting burden for participants in ACOs, discourage physicians from engagement in the SSP. Beginning in CY 2026, clinicians in AAPMs have the opportunity for a 0.75% update to the CF while those not in AAPMs would receive a .25% update. While there will be a higher update to the conversion factor beginning in the 2026 payment year for QPs in an AAPM as compared to non-QPs, we do not believe that this higher update would be sufficient to incentivize participation. In last year's physician fee schedule rule, CMS projected that it might not be until after the CY 2038 payment year when the QP conversion factor will equate to the anticipated maximum positive payment adjustment under MIPS.³⁸ Projected impact of the Quality Payment Program (QPP) participation tracks on physician payment will likely be the single greatest driving factor in ACO and APM participation, with clinicians who believe they can maximize positive payment adjustments under MIPS likely to choose MIPS participation. So, while bonus points to quality scoring for ACOs whose specialists report MVPs might encourage some participation of specialists, we do not believe it will have significant impact. **CMS should consider quality reporting incentives for continued SSP participation that focus on meaningful measures, appropriate performance standards and comparisons, and reducing burden relative to participation in MIPS.** We also encourage CMS to support the Value in Health Care Act of 2023³⁹ to extend the QP bonus of participation in AAPMs and to allow CMS to set lower thresholds for QP determinations. These policies, if passed by Congress,

³⁸ 87 FR 45860, at 46333, CMS notes "While only some MIPS eligible clinicians could earn the maximum positive payment adjustment, there is nonetheless a significant range of potential positive payment adjustments under MIPS that would exceed the differentially higher QP conversion factor beginning in payment year 2026 and for many years to come. As illustrated in Figure 5, the QP conversion factor, with the compounded differentially higher 0.75 percent update in each year, is not expected to equate to the anticipated maximum available positive payment adjustment under MIPS until after CY 2038."

³⁹ [H.R. 5013](#), introduced in the 118th Congress 1st session (July 2023)

would have a greater impact on broad physician engagement with the SSP and strengthen value-based care delivery in the Medicare program.

CMS Should Modify the Health Equity Adjustment to Ensure ACOs Are Not Unfairly Impacted by Insufficient Beneficiary-Level Data or Biased Measures of Social Vulnerability

Last year, CMS finalized the adoption of Health Equity Adjustment (HEA) as a bonus opportunity for quality performance scoring to reward high quality care delivered to underserved Medicare beneficiaries. The HEA involves a basic calculation: scaled quality performance multiplied by an ACO's proportion of underserved patients. The "underserved multiplier" is the proportion of the ACO's assigned Medicare FFS patients who are either dually eligible for Medicare and Medicaid and or receive the Part D Plan Low Income Subsidy (LIS), or who reside in a census block that is in the 85th percentile or greater national ranking under the Area Deprivation Index (ADI). Patients who do not have dual eligible status or LIS and who do not have sufficient information available regarding a numeric national ADI percentile rank value would be included in the denominator but unable to contribute to the numerator. In this proposal, CMS seeks to modify the calculation of the underserved multiplier with immediate effect, in recognition that it might unfairly penalize ACOs with a greater share of Medicare patients who do not have sufficient information to assess under the ADI national rankings. Instead, such beneficiaries would simply not contribute to the calculation of an ACO's underserved multiplier. **The AAMC supports this immediate modification to ensure that ACOs are not unfairly penalized for caring for patients with insufficient information regarding national ADI percentile rank.**

We also urge CMS to reconsider use of the ADI national ranking to assess an individual's social vulnerability and to expand the underserved multiplier to recognize high quality care delivered to *all* underserved patients where an ACO reports all patient eQMs or MIPS CQMs. CMS must fully evaluate the inclusion of geographic-based indicators, like the Area-Deprivation Index (ADI), to determine whether there are unintended pitfalls to their use. It is unclear whether area-based indices can appropriately measure deprivation in urban and rural contexts.⁴⁰ Research points to a potential bias against urban deprivation under the ADI due to its lack of standardization for variables linked to cost of living, finding that overall ADI scores reflected median home values in New York State.⁴¹ This does not appear to be unique to New York. Using the Neighborhood Atlas online mapping tool suggests that no single area within the

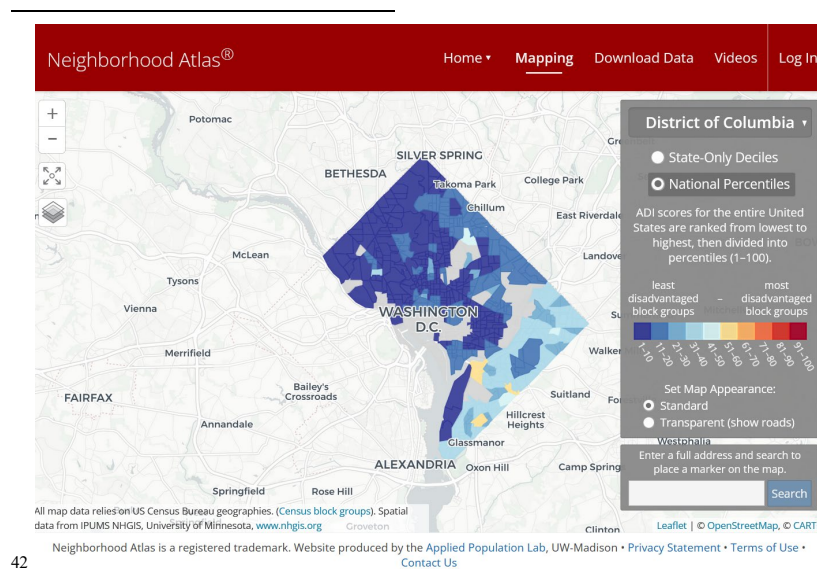
⁴⁰ M Bertin, et al, [Can a deprivation index be used legitimately over both urban and rural areas?](#) International Journal of Health Geographics (June 2014)

⁴¹ EL Hannan, et. al., [The Neighborhood Atlas Area Deprivation Index For Measuring Socioeconomic Status: An Overemphasis On Home Value](#), Health Affairs (May 2023), concluding that Neighborhood Atlas-computer ADI scores for New York block groups are mainly representative of median home value, and its use in quality assessment and funding may result in under resourcing for disadvantaged neighborhoods with high housing prices.

District of Columbia scores greater than or equal to the 61st percentile nationally.⁴² This raises face validity concerns with the ADI, considering known inequities in resource allocation and health outcomes in Washington, DC.⁴³ The AAMC concurs with researchers who recommend requiring a “ground-truth perspective” from the public when applying community comparisons to policy.⁴⁴ Regarding the broader use of the HEA with all patient eCQMs and MIPS CQMs, the AAMC believes that if the HEA calculation is scaling performance across all patients (as it does when evaluating ACO performance on eCQMs and MIPS CQMs) it should also consider the broader context of all patients for the “underserved multiplier,” such that an ACO is appropriately rewarded for providing high quality care for any underserved patient, and not solely those enrolled in FFS Medicare. As currently devised, it is only under the new Medicare CQM reporting option that the HEA measure population is congruent between both the performance scaler and the underserved multiplier.

CMS Should Not Finalize a Policy to Sunset Certified EHR Technology (CEHRT) Thresholds and Require ACOs to Report MIPS Promoting Interoperability Measures

In the proposed rule, CMS proposes to remove current CEHRT use threshold requirements for ACOs at the end of PY 2023 and instead require ACOs, or their eligible clinicians, to report the MIPS Promoting Interoperability (PI) performance category starting with PY 2024. Currently, the SSP does not require ACOs to report MIPS PI category measures, though eligible clinicians not participating in AAPM risk tracks of the SSP must report PI measures for MIPS scoring. QPs in AAPMs must only meet the SSP requirement for ACOs to certify that at least 75 percent of their eligible clinicians participating in the ACO use CEHRT. CMS believes this policy change will “reduce administrative burden” for ACOs by no longer having to manage compliance with



42 Screenshot taken Sep 8, 2023 from <https://www.neighborhoodatlas.medicine.wisc.edu/mapping>

43 C Busette and S Elizondo, [Economic disparities in the Washington, D.C. metro region provide opportunities for policy action](#), The Brookings Institution (April 2022)

44 DH Repkopf and RL Phillips Jr., [The Neighborhood Atlas Area Deprivation Index and Recommendations For Area-Based Deprivation Measures](#), Health Affairs (May 2023)

two CEHRT program requirements.⁴⁵ However, this *creates* burden for ACOs in AAPM risk tracks by creating a more burdensome reporting of their CEHRT use, counter to the statutory objective of the legislation. Congress, when creating the Quality Payment Program, intended to incentivize clinicians to participate in AAPMs in part by being exempt from MIPS reporting requirements.⁴⁶ **We believe that participation in APMs is sufficient incentive to drive interoperable use of CEHRT to [REDACTED] adding burdensome measure reporting only serves yet another potential disincentive for ACO participation in the SSP, especially in higher risk tracks.**

Beneficiary Assignment

CMS Should Ensure That Expanded Definitions and Steps for Attribution Reflect Meaningful Care Relationships with ACO Professionals

In the proposed rule, CMS proposes to revise the definition of assignable beneficiary to incorporate Medicare FFS beneficiaries who receive their primary care services from non-physician ACO professionals, such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists, referred to broadly in these comments as non-physician practitioner ACO professionals (or NPPs), when determining whether an ACO is responsible for a beneficiary's care. Currently, a beneficiary is not eligible for ACO assignment if they do not have at least one primary care service furnished by a physician participating in the ACO during the 12-month assignment window. As noted by CMS, this is in part due to a statutory requirement that attribution be based on primary care services furnished by physicians. CMS proposes to remedy this by incorporating a third step to assignment that would use an expanded window for assignment for determining whether a beneficiary is assignable, by examining claims in the 12-month assignment window for at least one primary care service from an ACO participating NPP. If satisfied, then CMS would look back an additional 12 month (creating a 24-month assignment window) to see if the beneficiary received a primary care service from an ACO participating physician who is either a primary care physician or has a specialty designation used in ACO assignment. If yes, this beneficiary would be assignable, and CMS would evaluate whether the beneficiary received a greater proportion of primary care services furnished by ACO professionals than any other ACO. If so, the beneficiary would be assigned to the ACO under this new Step 3 to assignment. Medicare beneficiaries who are assignable under the current assignment policies would not be affected and would continue to be considered for assignment to ACOs based on Steps 1 and 2 to claims-based assignment. CMS believes that this proposed policy would allow more beneficiaries who receive primary care from NPPs to become assignment eligible to ACOs, while also ensuring that statutory requirements for physician services remain in place. Additionally, CMS believes the expanded 24-month assignment window appropriately prioritizes primary care services that were provided reasonably recently. CMS proposes to adopt this policy change effective with PY 2025.

⁴⁵ 88 FR. at 52435.

⁴⁶ Section 1848(q)(1)(C)(ii) of the Social Security Act, as amended by Medicare Access to CHIP Reauthorization Act of 2015, states "Exclusions. – For the purposes of clause (i), the term 'MIPS eligible professional' does not include, respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who- (I) is a qualifying APM participant (as defined in section 1833(z)(2))[".]"

The AAMC commends CMS for considering policies that expand access to accountable care relationships for Medicare patients. We agree that the current methodology fails to recognize the valuable role that NPPs play in our health care system and primary care delivery. However, we are concerned that this proposed policy could assign beneficiaries who received specialized, point-in-time care from ACO professionals during the assignment period, but otherwise do not have long standing primary care relationships with the ACO. This is in part due to CMS's inability to differentiate NPPs practicing primary care compared to those practicing specialty care as NPPs. When they enroll in Medicare, NPPs cannot report a specialty designation. Thus, beneficiaries that received care from NPPs who are practicing as specialists may be assigned to an ACO, even if that beneficiary no longer has a primary care relationship with ACO professionals by the applicable performance period. **We urge CMS to consider methods to better distinguish NPPs in primary care settings to ensure that assignment based on care delivered by NPP ACO professionals meaningfully reflects primary care relationships with the ACO.**

CMS Should Finalize the Addition of New Services to the Definition of "Primary Care Services" to Recognize Care Furnished Under Newly Adopted Codes for the Fee Schedule

CMS proposes to add several proposed and existing services, as identified by specific billing codes, to the definition of primary care services it uses to identify primary care delivered on behalf of ACO professionals for beneficiary assignment. These additional services reflect services that are provided in conjunction with office/outpatient E/M services or other preventive services and care management services currently included in the definition. The AAMC agrees and supports these proposed additions to the definition of primary care services effective with PY 2024 ACO assignment.

Financial Benchmarking

CMS Should Adopt the New Regional Service Area Risk Score Growth Adjustment Factor to Address Impacts of Uncapped Risk Score Growth in the Regional Service Area on ACO Benchmarks

In the rule, CMS proposes to modify the calculation of the regional update factor used to update ACO historical benchmarks from the benchmark year 3 to the performance year by capping prospective risk score growth in an ACO's regional service area through the application of an adjustment factor. This proposed adjustment factor would be based upon the number of Medicare FFS beneficiaries the ACO serves in its region to mitigate ACO influence on coding intensity and application of the cap. In effect, ACOs with greater aggregate market share will see smaller increases in the regional component of the update factor to their benchmarks in regions with risk score growth above the cap. CMS believes this policy will improve accuracy of regional update factors for ACOs in regions with high-risk score growth, particularly in the later performance years during the 5-year agreement period (that is, as performance years are farther from the third benchmark year). The AAMC supports this approach to better account for regional risk score growth when applying the regional update factor to ACO benchmarks.

CMS Should Adopt the Alternative Risk Adjustment Proposal to Use the Same CMS HCC Risk Score Model for Performance Year and Benchmark Year Risk Scores for All ACOs

In CY 2024, the Medicare Advantage (MA) program will transition to a new prospective CMS-HCC Risk Score Model, Version 28, and CMS believes it is an opportunity to modify risk adjustment policy for the SSP. Currently, when calculating ACO financial benchmarks and performing risk adjustment to account for changes in risk scores between the benchmark years and the performance year, CMS applies the CMS-HCC model that was in use in that calendar year. CMS proposes an alternative approach, where it would use the CMS-HCC model applicable to the calendar year corresponding to the performance year to calculate risk scores for the performance year and for each benchmark year of the ACO's agreement period (that is, use a consistent model to determine risk score growth). Modeling of the current approach under the new V28 model suggests that ACOs who have participated in the program the longest and ACOs participating in two-sided risk tracks are more likely to be adversely impacted by the transition to V28 when compared to the V24 model in use for the third benchmark year. CMS believes that adopting the alternative approach, effective for ACO agreements that begin on or after January 1, 2024, will prevent the adverse impacts of the transition to the V28 CMS-HCC model and more consistently apply the model in the SSP as compared to MA. **The AAMC supports this policy change in response to the CMS-HCC model update but urges CMS to consider applying the change for all ACOs effective January 1, 2024, and not solely those entering new agreements on or after 2024.** It is unclear whether ACOs with existing agreements that began prior to January 1, 2024, if stuck with the current approach until their current agreement ends (potentially as late as PY 2027), would continue to participate in the program. CMS should apply this policy change to all ACOs to ensure optimal engagement and continued participation for ACOs in existing agreements as well as those entering agreements effective January 1, 2024.

CMS Should Eliminate Negative Regional Adjustments to ACO Benchmarks

Following last year's policies to mitigate the effects of negative regional adjustments to ACO financial benchmarks, CMS proposes to go one step further and eliminate the application of a regional adjustment to the benchmark for ACOs where such adjustment would be negative. ACOs with an overall positive regional adjustment would continue to receive such adjustment and not be impacted by this proposal, ensuring that no ACO would be negatively impacted by this proposal. CMS believes doing so will encourage greater participation in the SSP by ACOs caring for medically complex, high-cost beneficiaries. The AAMC agrees and supports this proposal.

Requests for Information (RFIs)

Designing a Higher Risk and Reward Track for the Program

CMS seeks feedback on the future incorporation of a higher risk track than the current ENHANCED track, which is based on the Pioneer ACO Model that ended in 2016. CMS notes that it could use the experiences of the Next Generation ACO Model, which ended in 2021, and the ongoing ACO Realizing Equity, Access, and Community Health (ACO REACH) model to inform the design of such a track for the SSP.

The AAMC encourages CMS to use the experience of those two higher risk models to inform design of a new, permanent participation track in the SSP. We believe there are two primary features that would improve a higher risk/reward track in the SSP: payment-based participation incentives and meaningful policies to promote health equity. Payment-based incentives are necessary to support care transformation. These could include creating a 100% financial risk option, offering primary care capitation payments above current levels of primary care spending and payment incentives for team-based care (such as the benefit enhancements offered in NGACO for skilled nursing care, home visits, and telehealth not subject to standard FFS payment policies or the PHE, in the case of telehealth payment). Additionally, financial benchmarking should encourage long-term participation for long-term savings due to evidence-based care transformation. Risk adjustment policies should influence both payment-based incentives and the promotion of health equity, by ensuring through design that it allows for the allocation of more resources to underserved and socially disadvantaged beneficiaries, rather than from simply coding intensity. Currently, SSP risk adjustment policies are based on prior service utilization and coding intended to predict future spending. This creates disincentives for establishing new care relationships with underserved beneficiaries, as appropriate care might create short-term increases in service utilization with little room for risk adjustment to appropriately increase benchmarks from historical low utilization of services.

Financial Benchmarking Methodology Changes to Address Overall Ratchet Effects

CMS seeks feedback on two potential financial benchmarking changes to address the ratchet effects as the SSP continues to largely base benchmarks off of historical expenditures influenced by long-term ACO participation. Those two pieces of the benchmarking methodology are the prior savings adjustment and the use of a prospectively projected administrative growth factor, called the Accountable Care Prospective Trend (ACPT), adopted in last year's rule. The AAMC was supportive of both policies for their potential to address overall market-wide ratchet effects – both from an ACO's ongoing success in reducing spending while maintain or improving quality of care and from the effects of selective ACO participation on spending growth trends.

We believe the prior savings adjustment is an appropriate method for rewarding successful ACOs and incentivizing their continued participation in the SSP. We support increasing the adjustment to up to 75 percent of shared savings achieved for ACOs under a prior arrangement that assumed downside financial risk, not necessarily limited to participation in the ENHANCED track. This would ensure that ACOs are not penalized by rebasing to historical expenditures they directly influenced through successful care transformation. We would support additional changes to the positive regional adjustment to reduce the influence of longstanding regional differences on achieving shared savings. CMS, as a national payer, should support value-based care transformation that remediates geographic variation in service utilization and spending not supported by meaningful clinical differences in populations served.

Similarly, we supported the additional of the prospective external growth factor under the ACPT. While there is more to understand regarding the calculation of the growth rate and its interaction with current benchmarking policies, we believe it sets an important policy goal of ensuring a stable, predictable component to the update factor. Rather than replace the national component of the blends for the update factor, we wonder if instead there is more value in using the ACPT to

inform design of a transition to full administrative benchmark that truly moves ACO benchmarks away from historical expenditures. We believe this could be a more sustainable long-term path, assuming such an approach meaningfully rethinks risk adjustment that appropriately considers the clinical and social risk factors that influence health care utilization and costs and sets payment according to broad health care delivery goals.

ACO Collaboration with Community-Based Organizations (CBOs)

CMS seeks feedback on future policy proposals to promote ACO collaboration with CBOs. The AAMC agrees with CMS's assessment that ACOs may already wish to address the social needs of their patients and "want to make investments in good or social services" to enable ACO providers to collaborate with CBOs with expertise in providing appropriate services.⁴⁷ We strongly believe that health care providers should, partner with community experts to address health-related social needs (HRSNs) of their patients.

The AAMC has two primary policy suggestions for improving ACO collaboration with CBOs to address social needs of ACO patients. The first relates to recent changes in the fraud and abuse regulations to better support such efforts by providers when participating in value-based arrangements.⁴⁸ Since the finalization of these changes, little has been shared about CMS and HHS Office of Inspector General (HHS OIG) efforts to understand how providers in value-based arrangements have (or have not) used the new rules to improve population health and care delivery. The AAMC encourages CMS to work in concert with HHS OIG to evaluate gaps in provider understanding of this new approach, and whether there are challenges to implementing collaboration with CBOs due to either misunderstandings of the rules or limitations to the new frameworks for ensuring appropriate protections from fraud and abuse liability for ACOs wishing to form such collaborations.

The second relates to opportunities in concert with the proposed new payment codes for services addressing HRSNs: screening assessments, community health integration services, and principal illness navigation services. As proposed, these new payment codes would require providers to collect the 20% coinsurance from Medicare patients (unless provided as part of the annual wellness visit). Such cost sharing would be a barrier to patients receiving these important services. We recommend that CMS use waiver authority to create a new benefit enhancement that would allow ACO professionals to waive cost sharing when providing SDOH risk assessments, community health integration services and principal illness navigation services for ACO assigned beneficiaries. Participation in such benefit enhancement could be contingent upon an ACO having an approved collaboration plan with a CBO partner and require documentation of the ACO's efforts under such a plan. There is new evidence that providers participating in value-based care, particularly ACOs and bundled payments, are most likely to screen for HRSNs and collaborate with external partners to address HRSNs.⁴⁹ CMS policies should strengthen

⁴⁷ 88 FR at 52496.

⁴⁸ See both 85 FR 77494 (Dec. 2, 2020) and 85 FR 77684 (Dec. 2, 2020)

⁴⁹ J. Ashe, PhD, ThM, MDiv, et al., [Screening for Health-Related Social Needs and Collaboration With External Partners Among US Hospitals](#), JAMA Netw Open (Aug 2023), finding participation in value-based care, including accountable care contracts and bundled payments, was associated with more screening efforts, strategies to address needs and social determinants of health, and external partnership types to support interventions.

existing efforts and maximize the impact of the new proposed payment codes. In doing so, CMS can be confident that that the financial incentives under the SSP to deliver value-based, equitable care and achieve shared savings balance any potential for overuse of such services without beneficiary cost-sharing.

QUALITY PAYMENT PROGRAM

The AAMC appreciates CMS's efforts to continue to develop Quality Payment Program (QPP) policies that more effectively reward high-quality care of patients and increase opportunities for Advanced APM participation. While we support the goals of the program to improve quality care and reduce costs, we believe that significant refinements to the program are needed to achieve these goals. **We encourage CMS to work with key stakeholders to identify longer term policy solutions in the future that would improve quality, attain health equity for all beneficiaries, improve patient outcomes, and reduce burden.** Our comments on the proposals in the rule related to the QPP follow.

TRADITIONAL MIPS

MIPS Performance Thresholds

CMS establishes a performance threshold (score) that eligible clinicians must meet to avoid a MIPS penalty. The threshold is computed as the mean or median (as elected by CMS) of the final scores for all MIPS eligible clinicians with respect to the prior period specified by CMS. For MIPS performance years 2024, 2025, and 2026, CMS has selected the mean as the threshold methodology. For performance periods 2022 and 2023, CMS selected a single respective performance period as the prior period. CMS proposes, beginning with 2024 performance year, that the prior period used to identify the threshold would be a span of 3 performance years (2017-2019), which would result in the mean of 82 points applied as the performance threshold, an increase from the current 75-point threshold.

While we understand that the statute requires CMS to set the performance threshold at the mean or the median, the AAMC is concerned that approximately 46 percent of MIPS eligible clinicians would receive a negative payment adjustment for the 2024 performance year (2026 payment year) if the proposed policies for the QPP, including this proposed threshold are finalized. **As physician practices continue to face challenges in the aftermath of the COVID-19 pandemic, staffing shortages, inflation, and looming payment cuts, we urge CMS to consider lowering the performance threshold. Additionally, we urge CMS to support any efforts in Congress that would allow CMS to have more flexibility to set MIPS performance thresholds based on current circumstances rather than a preset formula.**

MIPS Performance Category: Quality

For the 2024 performance year CMS proposes to maintain the same quality performance relative weights as set for the previous year. As in the past, eligible clinicians must report a minimum of six measures, unless fewer applicable measures are available, and one of those six measures must be an outcomes measure or a high priority measure.

Further, CMS is maintaining the previously finalized quality measure data completeness thresholds for the 2024 and 2025 performance periods at 75 percent and proposing to increase the quality measure data completeness threshold to 80 percent starting in 2027 performance period. Finally, CMS is proposing the inclusion of 14 new quality measures, the elimination of 12 quality measures, and significant modifications to 59 existing quality measures.

CMS Should Maintain a Data Completeness Threshold at 75 Percent

The AAMC urges CMS to maintain the data completeness threshold at 75 percent instead of increasing it to 80 percent in 2027. The 75 percent threshold is already very high, and CMS should not add to this burden in light of the additional reporting requirements that CMS is asking clinicians to implement, such as reporting MVPs and digital quality measures. Some physicians under the same TIN provide services at multiple sites and not all sites have the same electronic health record (EHR) platform or use the same option for reporting under MIPS. In these instances, the data needs to be seamlessly integrated across settings to facilitate reporting, which can be difficult. It is important to maintain the threshold at 75 percent until systems are better able to integrate data for reporting. Increasing the reporting requirement is counter to CMS's goals of reducing administrative burden within the MIPS program.

AAMC Urges CMS to Convene Stakeholders to Discuss Challenges with Removal of MIPS Quality Measures and Identify Solutions

Annual program changes increase administrative burden, add to complexity, decrease effectiveness of ongoing quality efforts, and increase the cost of the program for stakeholders, while running counter to the Agency's Patients Over Paperwork Initiative. The imposed burden of measure churn is substantial. Faculty practices invest time and resources to implement their chosen quality measures and update their systems accordingly. Removing or changing measures forces a practice to pick new measures to satisfy reporting requirements, requiring additional system changes, workflow adjustments, and clinician education. Measure inventory changes, therefore, require careful consideration from the stakeholder perspective as well as the agency's viewpoint.

We also note that measure removal ends the ability to follow performance trends for that measure. This may be appropriate for most topped-out measures, but some practices will wish to retain measures that are especially meaningful to their clinicians even if topped out. CMS has acknowledged this by allowing retention of certain topped-out measures in the inventory for use in the Shared Savings Program, and we believe this flexibility should be applicable to other clinician subsets. We further note that quality improvement results often take several years and significant work to properly assess; removal of existing MIPS measures can unintentionally thwart these efforts.

We recognize that the measure inventory cannot remain static over the long-term. Clearly, changes that remove measures that potentially cause patient harm or reflect substantively updated clinical guidelines must move forward in a timely manner. However, a period of measure inventory stability would be particularly appropriate at this time for all other measures, while practices continue to restore normal quality improvement operations after COVID-19 PHE disruptions and CMS returns to pre-pandemic quality program policies. Further, if clinicians

must transition to MVP reporting, they will need access to a full range of measures to develop enough MVPs to meet the reporting needs of all clinicians.

AAMC requests that CMS utilize the Measure Set Review (MSR) Committee of the Partnership for Quality Measurement or another similar consensus-based expert group for the purpose of discussing current challenges associated with measure removal and explore solutions.⁵⁰ Options to be explored might include expanding the Call for Measures process to assess measures being considered for removal before their removal is proposed through rulemaking. Another option might be to make measure removal a two-year process -- once proposed for removal, clinicians who report that measure could receive a notification that the measure is on track for removal in the subsequent year. The notification could include the option to reply using a template form about issues that would be created by removal. CMS could consider the input and consider whether to finalize in the subsequent rulemaking cycle. We are open to other options but recommend that discussion begin in the near future.

MIPS Performance Category: Cost

For the 2024 performance year, CMS proposes to weigh the cost category at 30 percent as required by statute. We recognize that the statute requires that the cost performance category be set at 30% in performance year 2024. However, the AAMC urges CMS to use its administrative authority under policies (such as the Extreme and Uncontrollable Circumstances policy) to reweight the Cost Performance Category as needed. The Cost Performance Category has been significantly impacted by the COVID-19 pandemic. In recognition of this impact, CMS reweighted the cost performance category to zero percent of MIPS final scores for the 2020 and 2021 performance periods. We greatly appreciated CMS's decision to reweight cost for those years as we were very concerned that clinicians would not be reliably and fairly scored under this measure. However, this means that clinicians have had two less years to familiarize themselves with the cost measures.

At a minimum, CMS should suppress certain cost measures as appropriate to avoid inappropriately penalizing providers. The COVID-19 PHE has demonstrated that the assessment of costs can be significantly affected by substantial changes to clinical practice and service utilization. Physicians and practices that have been on the frontlines treating COVID-19 patients can be unfairly penalized by cost measures. Physicians treating COVID-19 may have patients that are more likely to have complications, admissions, and readmissions due to the COVID-19 PHE which may cause these physicians to receive lower scores on cost measures. It also is possible that the PHE may cause disruptions to attribution, reliability, and validity.

Beginning with the 2024 performance year (2024 calendar year), CMS proposes to add 5 new episode-based measures. **The AAMC recommends that all cost measures used in the MIPS program be appropriately adjusted to account for clinical complexity and social risk factors.** The episode cost measures are risk-adjusted based on variables such as age and comorbidities by using Hierarchical Condition Categories (HCC) data and other clinical characteristics. While the Total Per Capita Cost (TPCC) measure and the Medicare Spending Per

⁵⁰ [Partnership for Quality Measurement](#)

Beneficiary (MSPB) measures are risk adjusted to recognize demographic factors, such as age, or certain clinical conditions, these measures are not adjusted for other social risk factors. In addition to differences in patient clinical complexity, social risk factors can drive differences in average episode costs. A recent report from the National Academies of Science, Engineering and Medicine⁵¹ clearly acknowledged that sociodemographic status variables (such as low income and education) may explain adverse outcomes and higher costs.

The COVID-19 pandemic has demonstrated the importance of accurate risk adjustment. The virus has a disproportionate impact on racial and ethnic minorities, the homeless, individuals in long-term care facilities, the elderly, and those with underlying conditions. Literature has shown that patients who are already at high-risk due to social factors are at increased risk of serious illness related to COVID-19.⁵²

Without accurately accounting for clinical complexity, and social risk factors, the cost measure scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be adequately reflected in their overall MIPS score. Cost measures must be appropriately specified to ensure all patients access and receive all necessary care. Physicians at academic medical centers care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere, and without adjustment are likely to have distorted cost outcomes. We request that these cost measures be adjusted to appropriately account for these risk factors to present an equitable picture of cost of care.

Additionally, attribution methodology should be clear and transparent and accurately determine patient/clinician relationship. It is critical that when measuring costs there is an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often receive care from multiple clinicians across several facilities and teams within a single practice or facility. The attribution method should be clear and transparent to clinicians. We suggest that better data sources and analytic techniques should be explored in the future to support more accurate attribution of these episodes.

We also urge CMS to provide more timely feedback to physicians on their performance on cost measures. Physicians do not know at the time that they provide services or throughout the performance year how they are performing on these measures, including which patients are attributed to them, and what costs or services provided by other health care professionals or facilities outside of their practice for which they will be held accountable. Without this information, it is difficult for physicians to identify ways to improve care delivery and avoid unnecessary costs.

⁵¹ National Academies of Sciences, Engineering, and Medicine. Accounting for social risk factors in Medicare payment: Criteria, factors, and methods. The National Academies Press. 2016. Doi: 10.17226/23513

⁵² Koma, W. et al. [Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus](#). Kaiser Family Foundation. May 7, 2020

MIPS Performance Category: Promoting Interoperability (PI)

Prescription Drug Monitoring Program (PDMP) Measure

Last year, CMS finalized a policy that, beginning with 2023 performance, the PDMP measure would be required and worth 10 points. CMS allowed for two exclusions: one for clinicians unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs, and another for clinicians who write fewer than 100 permissible prescriptions. CMS proposes to modify that second exclusion further to better clarify that clinicians who are unable to prescribe opioids or Schedule III and IV drugs under the first exclusion may also claim the second exclusion. The AAMC supports this modification for clarity.

Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

The SAFER Guides measure was adopted with 2022 performance and requires clinicians to attest “yes” or “no” to whether they have conducted an annual assessment using the High Priority Practices Safer Guide at any point during the performance year. Currently, the measure simply requires an attestation and there is no PI performance category scoring consequence if a clinician attests to not having conducted the assessment. CMS proposes that beginning with 2024 performance clinicians must attest “yes” for their response to count for completion of the measure, and a “no” response will result in a score of zero for the PI performance category. **The AAMC supports self-assessment under the High Priority Practices Safer Guide for promoting the safety and use of CEHRT. However, we urge CMS to delay the proposed scoring change for at least one year, to ensure that clinicians have sufficient time to understand self-assessments under the SAFER Guides measure and fully succeed under the PI performance category.** The AAMC does not see sufficient evidence provided in this proposed rule to suggest that levels of implementation for eligible clinicians have sufficiently changed to support a new scoring approach only two years after the measure’s adoption, especially considering other critical priorities during that period due to the COVID-19 PHE.

MIPS VALUE-BASED PATHWAYS (MVPs)

In the 2020 PFS final rule, CMS established a new MIPS participation framework, referred to as MIPS Value Pathways (MVPs). Beginning in 2023, CMS eligible clinicians can report under the MIPS Value Pathways. CMS has indicated its goal to move away from Traditional MIPS and to have MVPs become the only method available to participate in MIPS in future years; however, in this rule CMS does not make any proposals for a date to sunset Traditional MIPS. This rule includes proposals that address operational aspects of subgroup reporting, the MVP development and maintenance process, and scoring for MVPs. CMS proposes to add 5 new MVPs and revise all 12 existing MVPs so that there will be 16 MVPs available to report in performance year 2024.

As CMS considers how MVPs and subgroups would be operationalized, it is important to understand the unique challenges posed by the QPP for large multi-specialty practices such as those typically found in academic medical centers. Physicians at AAMC member institutions are organized into large multi-specialty groups known as faculty practice plans which often have a single TIN. Recent data shows that the practice plans range in size from a low of 115 individual NPIs to a high of 3,694 with a mean of 1,258 and a median of 1,088. On average these practices

have over 70 adult and pediatric specialties and numerous subspecialties, such as burn surgery, gastroenterology, and pediatric endocrinology, to name a few. In some cases, faculty practice plans are highly integrated and make decisions about quality and care coordination as a single entity. In other instances, such decision-making occurs at the departmental or specialty level. With the large number of distinct specialties reporting under one TIN, it will be very challenging to identify MVPs that will be meaningful for the myriad of specialties and subspecialties in the practice. Even if multiple MVPs are selected for reporting, it will still be challenging to identify MVPs that encompass the scope of conditions treated and the vast number of specialties included in academic medical centers. These faculty practice plans have physicians that join and leave the practice throughout the course of the year, which makes it more complicated to identify which physicians should be included in a particular subgroup.

Therefore, we support CMS’s proposal to continue to make MVP reporting voluntary. However, we have significant concerns with CMS’s plans to sunset the traditional MIPS program in future years, making MVPs or the APP performance pathway the only mechanism for participating in the Quality Payment Program. There are several conceptual challenges with the MVP program and sufficient time will be needed to address them before sunsetting traditional MIPS. First, there must be enough measures available to create MVPs that are meaningful to the over 1 million eligible clinicians that participate in the MIPS program. Given the numerous physician specialties and subspecialties, it will be difficult to create a sufficient number of MVPs, especially anytime in the near future. Development of MVPs will require significant input from physicians. **Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome for reporting in the MIPS program.**

Subgroup Reporting

To generate more clinically relevant information about clinician performance, particularly for clinicians in large multispecialty groups, CMS established a “subgroup” reporting mechanism for MVPs in prior rulemaking. Subgroups would consist of a subset of a group that is identified by a combination of the group Tax Identification Number (TIN), the subgroup identifier, and each eligible clinician’s National Provider Identifier (NPI). We appreciate CMS’s recognition of the importance of allowing a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup than to the larger group.

We urge CMS not to allow only one subgroup to be reported for each TIN-NPI combination as it will limit reporting on clinically relevant measures. We also encourage CMS not to impose any limits on the specialty number and types of clinicians in a subgroup. Practices should have the flexibility to identify which MVPs are meaningful for which physicians in the practice. Many specialties have multiple subspecialties. Within one specialty, the MVP that a subgroup chooses to report may be meaningful for one subspecialty but not for another subspecialty. In some instances, it may be appropriate for multiple specialties (such as internal medicine, family medicine, and endocrinology) to report the same MVP and be part of the same subgroup. We believe that the group practice is in the best position to determine which physicians in the practice should be part of the subgroup to which the MVP applies. The

practice should identify which specific physicians in the group practice would be participants in the subgroup and provide that list of participants' NPIs to CMS.

In prior rulemaking CMS required multispecialty groups to configure as subgroups to report MVPs beginning with performance year 2026. **While the AAMC supports a subgroup option in MIPS, the AAMC strongly urges CMS to maintain the subgroup as a voluntary participation pathway for multispecialty groups to participate in MVPs. Reporting as subgroups can enable specialists within multispecialty practices to report clinically relevant measures.** Still, CMS must consider the fact that it may be operationally difficult to move from participating in a group practice to participating as a subgroup. Large groups would need to manage multiple applications to form subgroups, invest in tracking different measures and data submission mechanisms for subsets of physicians, and figure out how to manage multiple Medicare physician fee schedule payment adjustments and compensation. Practices need time to plan and determine whether clinicians and practices will be able to successfully report MVPs as a subgroup.

Subgroup Reweighting and Scoring

CMS proposes to make several changes to its scoring policies for subgroups. Specifically, CMS proposes that it would not calculate a facility-based score at the subgroup level. Also, subgroups would receive their affiliated group's complex patient bonus, if applicable. Regarding reweighting, subgroups would only receive reweighting based on any reweighting applied to its affiliated group. CMS explains the challenges with making these determinations at the subgroup level.

We believe that CMS is raising valid concerns with the scoring challenges. **We recommend that CMS explore solutions to address these concerns to enable subgroup reporting and scoring that is meaningful in the future.** Information on the subgroup levels performance that is more granular would be more meaningful to clinicians and consumers. If CMS is able to do so in the future, we recommend determining the complex patient bonus and any reweighting at the subgroup level and the group level and give the highest score of the two options.

We also support CMS's proposal to allow MIPS eligible clinicians who participate in MVP reporting and are scored as a subgroup to request a targeted review.

ALTERNATIVE PAYMENT MODEL (APM) PERFORMANCE PATHWAY (APP)

MIPS Eligible Clinicians Participating in MIPS APMs and ACO Reporting

In 2021, CMS established the APM Performance Pathway for MIPS reporting and scoring for clinicians in MIPS APMs. Clinicians in MIPS APM Entities may report Traditional MIPS using any available MIPS reporting pathway, including the APM Performance Pathway (APP), Traditional MIPS, and MVPs. CMS required ACOs to report using the APM Performance pathway. APM entities that do not report through the APP will continue to have the cost performance category weighted at zero percent of their MIPS score, but will be required to report on quality, improvement activities and promoting interoperability. Eligible clinicians reporting through the APP Pathway are scored on a fixed set of quality measures, which includes 3 eCQMs/MIPS CQMs, the MIPS for CAHPs Survey, and two population-based measures.

Through the 2024 performance year, CMS has finalized a policy that ACOs are allowed to report the 10 CMS Web Interface measures or the 3 eCQMs/MIPS CQMs, in addition to the CAHPS for MIPS survey, and beginning with the 2025 performance year ACOs would no longer have the option to report the CMS Web Interface measures. CMS proposes, beginning with the 2024 performance year, the addition of the Medicare CQMs collection type in the APP measure set, which would be available to only ACOs participating in the Shared Savings Program (SSP). Under the Medicare CQM option, ACOs would be report on their Medicare FFS beneficiaries who meet the definition of a beneficiary eligible for Medicare CQMs instead of having to report on their all payer/all patient population under the eCQM/MIPS CQM option. This is intended as a temporary transition.

The AAMC supports this proposed new Medicare CQM reporting option for SSP ACOs.

All-patient/all-payer measures require significant investment and expertise to successfully report on, and ACOs need additional time to be able to do so. All-patient/all-payer measures represent a significant challenge for ACOs that include a greater number of specialist participants, as specialists may treat a higher number of patients without meaningful, broad care relationships with the ACO. The ACO does not have the same flexibilities to design care interventions for all patients treated by the ACO's participant clinicians nor the ability to readily access patient data for the patients not attributed to the ACO but treated by ACO participants. Therefore, a requirement to report all-patient/all payer measures might frustrate ACO efforts to fully collect data to meet data completion thresholds or to influence quality performance. Reporting CQMs for the Medicare FFS patients with a treatment relationship to ACO professionals with a primary care or related specialty ensures that CMS receives meaningful quality information on the ACO's influence on the Medicare FFS population. If forced to transition to all patient/all payer reporting options, ACOs might be incentivized to make significant changes to their ACO professional participants to reduce or even completely remove non-primary care specialists from participation to ensure they are not disadvantaged by data collection or performance outside of the ACO's control. While primary care is critical to the success of accountable care, so too is coordination and engagement with specialty care. **We encourage CMS to retain the Medicare CQM reporting option permanently to ensure that any policy to push ACOs to all patient/all payer quality measure reporting does not have an unintended consequence of discouraging specialist participation in ACOs.**

ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMS)

If an eligible clinician participates in an Advanced APM and is a qualifying APM participant (QP) or a partial qualifying APM participant (partial QP), the MIPS reporting requirements and payment adjustment do not apply to that clinician. For payment years 2019-2024 (performance years 2017-2022), QPs received a 5 percent APM incentive payment and for the 2025 payment year (2023 performance year), QPs receive a 3.5 percent APM incentive payment. Beginning with payment year 2026 (performance year 2024), there is no further statutory authority for an APM Incentive Payment. However, for payment year 2026 (performance year 2024) and beyond, clinicians in AAPMs have the opportunity for a .75% update to the CF while those not in AAPMs would receive a .25% update.

We are deeply concerned that the expiration of the APM incentive payment will have a chilling effect on participation in alternative payment models. We urge CMS to include in its legislative agenda support for the continuation of the AAPM 5 percent bonus (e.g., support for legislation, such as the Value in Health Care Act of 2023). If Congress does not act to extend the bonus, we urge CMS to take administrative actions within its authority that would mitigate the effects of the 3.5 percent bonus loss. This could include changes to benchmarking, increasing shared savings opportunities, reducing administrative burden, allowing more flexibility, and allowing longer transitions for APMs to downside risk.

Value-based care is improving patient care and successfully reducing costs in the healthcare system. For example, ACOs have generated \$17 billion from in gross savings with \$6.4 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients from 2013-2021. CMS recently announced that ACOs saved Medicare another \$1.8 billion in 2022 compared to spending targets for the year, marking the second highest annual savings accrued for Medicare since the program's inception.⁵³ APMs give providers tools to innovate and coordinate care, resulting in improved outcomes for beneficiaries.

Under Advanced APMs, participating clinicians bear financial risk for the cost and quality of care. The 5% bonus payments have been critical to clinicians in covering the investment costs of moving to new payment models and reinvesting the 5% bonus payment into practice redesign to better manage care. This includes investing in new EHRs, additional staff, care managers, telehealth platforms, and other areas that will enable them to better coordinate care when at risk. ACOs, for example, have used these incentives to fund advance care planning programs, pay for patient transportation and meals programs, and hire care coordinators. Although these services are not typically reimbursed under the Medicare program, they improve health outcomes.

The AAMC is concerned that the lack of the 5 percent (3.5% in in performance year 2023) financial incentive under the Quality Payment Program for APMs for the 2026 payment year will discourage participation in Advanced APMs in performance year 2024. For payment year 2026, clinicians in MIPS have the opportunity for a payment adjustment of +/-9% while those in AAPMs have the opportunity for a .75% update to the CF while those not in AAPMs would receive a .25% update. While there will be a higher update to the conversion factor beginning in 2026 payment year for QPs in an AAPM as compared to non-QPs we do not believe that this higher update will be sufficient to incentivize participation. As CMS showed in the 2023 physician fee schedule rule, the QP conversion factor is not expected to equate to the anticipated maximum positive payment adjustment under MIPS until after CY 2038.⁵⁴ We urge CMS to use its administrative authority to make changes to the program, such as improving benchmarks, increasing shared savings opportunities, and reducing administrative burden, that make it more attractive for providers to participate in Advanced APMs and improve health outcomes.

⁵³ CMS, [Press Release: Medicare Shared Savings Program Saves Medicare More Than \\$1.8 Billion in 2022 and Continues to Deliver High-quality Care](#) (Aug. 2023)

⁵⁴ 87 FR 46333 (July 29, 2022)

Qualifying Participants (QPs) in AAPMs

CMS Should Encourage Congress to Eliminate QP Thresholds Altogether or Grant Authority to Set Thresholds at a Level That Would Encourage Participation in APMs

To be classified as a qualifying participant (QP) or partial QP in an AAPM, providers need to meet or exceed thresholds based on patients seen or payment received for services provided through AAPMs. These thresholds, which were established by Congress in 2015, have been progressively increased per statute since the start of the program. Originally, the Medicare Access and CHIP Reauthorization Act of 2015 set higher thresholds for the payment years 2023 and beyond that required clinicians to have at least 75% of their revenue in the Medicare FFS program received through a Medicare APM, or 50% of their Medicare FFS patients would need to receive services through the APM, in order to be considered a QP. These thresholds are too high and would have made it much more difficult for an eligible clinician to be considered a QP and to receive the 5% bonus payment in 2023. Congress recognized this problem and addressed it in the Consolidated Appropriations Act, 2022 which froze the thresholds for payment years 2023 and 2024 at the 2021 and 2022 payment year levels. The Consolidated Appropriations Act, 2023⁵⁵ froze the thresholds for an additional year through payment year 2025.

We remain deeply concerned about the increase to the thresholds that will occur in the 2026 payment year (2024 performance year). The increasing thresholds that must be met to be considered QPs in advanced APMs will discourage participation, thereby limiting beneficiary access to high quality and better coordinated care. It is very difficult for APMs to increase the volume of payments received through the APM or amount of Medicare FFS patients who receive services through the APM. It is especially difficult for ACOs in rural areas and those that include specialists since primary care determines ACO assignment.

We urge CMS to encourage Congress to eliminate QP thresholds altogether, or, at a minimum, give CMS the authority to set thresholds in the future at a level that will incentivize participation in advanced alternative payment models. One alternative to QP thresholds could be a bonus payment system that is based solely on Medicare payments for care delivered to patients under the AAPM, thus incentivizing more patients are treated through AAPMs.

QP Determinations at Individual Level Instead of the APM Entity Level

As stated above, CMS has set forth thresholds that must be met for clinicians participating in Advanced APMs to become APM Qualifying Participants (QPs) to receive payment incentives. By design, CMS makes nearly all QP determinations for a performance year at the APM Entity level, such that QP status is awarded at that level based on the collective performance of clinicians found on the APM's Participant List on one or more of the three "snapshot" dates during the performance year. QP status is awarded either to all or none of the entity's clinicians.

CMS expresses concerns that making QP determinations at the APM Entity level could lead to some eligible clinicians becoming QPs when they would not have met the QP Threshold

⁵⁵ CAA, 2023; [P.L. 117-328](#), (Dec. 2022)

individually. On the other hand, some eligible clinicians may not become QPs when they might have qualified individually. CMS believes that the policy to make QP determinations at the APM entity level may have inadvertently discouraged some AAPM Entities (such as ACOs) from including certain types of eligible clinicians, particularly specialists. Therefore, CMS proposes, beginning with performance year 2024, to make all QP determinations at the individual level-for each unique NPI associated with an eligible clinician participating in an AAPM. Specifically, CMS would calculate a threshold score for each NPI based on all covered professional services furnished across all Tax Identification Numbers (TINs) to which the eligible clinician has reassigned their billing rights.

The AAMC is similarly concerned that the current approach incentivizes APM entities to exclude clinicians (primarily specialists) who furnish proportionally fewer services that lead to attribution of patients or payment amounts to the APM entity from their APM Participation Lists. Under the current design of the program, the participation of these specialists could negatively impact clinicians who furnish services to large number of patients through the APM by dragging down the entity's collective QP threshold scores. However, we believe that making QP determinations at the individual level could make it extremely difficult for specialists to meet the QP thresholds. This is especially true for specialists that are participants in an ACO, where they tend to provide much fewer services to ACO patients due to lack of influence on attribution. This could discourage Advanced APM participation by specialists, which is contrary to the agency's plan for transitioning Medicare to a value-based program and encouraging increased specialist participation in APMs.

To encourage Advanced APM participation by primary care providers and specialists, we recommend that CMS make two determinations of whether the QP thresholds are met by calculating thresholds at both the APM entity level and the individual level. If either QP determination exceeds the relevant threshold, the eligible clinician should be considered a QP. We recommend that in future years CMS explore an approach to QP determinations that would better identify and reward individual eligible clinicians with substantial engagement in Advanced APMs.

Payment Amount and Patient Count Methods- Modification to Definition of Attribution Eligible

When making QP determinations at the APM Entity or individual eligible clinician level, CMS begins by calculating threshold scores using the payment amount and patient count methods. These Threshold Scores are percentages based on the ratio of the payment amounts or patients counts for Attributed beneficiaries to the payment amounts or patient counts for Attribution-eligible beneficiaries during the performance period.

In the rule, CMS seeks comment on its proposal to modify the sixth criterion in the definition of "Attribution-eligible beneficiary" to include a beneficiary who has a minimum of one claim for any covered professional service furnished by an eligible clinician who is on the APM Participation List for at any determination date during the QP Performance Period. **We support this proposal as it better captures the care delivered by specialists through AAPMs by including those patients who receive only non-E/M covered services through the AAPM**

that may be more likely to have been provided by specialists. Therefore, it would more appropriately recognize Advanced APM participation of specialists (who are less likely to provide E/M services) for whom QP determinations are begin made at the individual level.

CEHRT Use Criteria for Advanced APMs

Under the statute to be an AAPM the payment model must require its participants to use certified EHR technology (CEHRT). Currently, CMS requires that 75% of eligible clinicians in each participating APM entity must use CEHRT to document and communicate clinical care to their patients or health care providers. Based on the definition of CEHRT, AAPMs have required their participant to use CEHRT that meets all requirements of a qualified EHR, even if they include some requirements not directly applicable to the APM Entities' practice. In this rule, CMS proposes to amend the definition of CEHRT required to be an AAPM to provide more flexibility for each APM to determine what CEHRT functionalities are relevant to the model and its participants. CMS also proposes to end the current 75% CEHRT use requirement and instead states that the AAPM must require *all* eligible clinicians in each participating APM entity to use CEHRT that meets the proposed modified, and more flexible definition of CEHRT.

We support the proposal to allow more flexibility for APMs to determine the relevant CEHRT functionalities to use. The current standards for CEHRT have been a barrier to advanced APMs because the standards have not allowed APMs to consider whether certain CEHRT modules are relevant for the specific clinical practice areas of the participants. This will foster innovation and model design and allow opportunities for a broader range of participants in the models. However, we do not support the requirement that all eligible clinicians (instead of 75%) must use CEHRT. Although we believe that AAPM participation will likely incent broad use of CEHRT, setting a requirement for all participants to use CEHRT is an absolute bar and could be a barrier to Advanced APM participation. For example, an ACO might seek to add rural practices as participants; however, these rural practices may not be able to immediately use an EHR platform that meets the CEHRT requirements.

PUBLIC REPORTING ON THE COMPARE WEB-BASED TOOLS HOSTED BY CMS

Telehealth Indicator

In the 2023 PFS rule, CMS finalized adding an indicator to the profile pages of clinicians furnishing telehealth services, based on specific codes used on the claims (e.g., POS 02, POS 10, modifier 95). To stay current, CMS proposes that instead of only using POS 02, 10, or modifier 95 to identify telehealth services, it would use the most recent codes at the time the data are refreshed to identify whether the clinician furnished a telehealth services. We support the addition of this information, as accurately identifying telehealth services and knowing whether a clinician offers telehealth services will be helpful to Medicare beneficiaries. This information could help to further access and health equity goals by providing meaningful information on care delivery options available.

Publicly Reporting Utilization Data on Profile Pages: Incorporating Medicare Advantage Into Public Reporting

To enable patients to identify specific types of clinicians and specific procedures they perform, the 2023 PFS rule established a policy to publicly report procedure information on patient facing clinician profile pages in an understandable format, no earlier than 2023. In the 2023 PFS rule, CMS stated that the information reported would reflect only traditional Medicare fee-for-service (FFS) claims data. CMS stated it is targeting the release of procedure data based on FFS claims on clinician profile pages later this year, beginning with 13 priority procedure categories. CMS proposes to publicly report aggregated counts of procedures performed by providers including Medicare Advantage data in addition to Medicare FFS data.

While the AAMC supports providing more information to patients, we commented last year that the utilization data would provide an incomplete picture of the services each physician performs and be misleading to patients since it would be limited only to Medicare FFS utilization data. We believe that the inclusion of Medicare Advantage data will help to alleviate some of this concern. However, we remain concerned that the dataset would still not include any utilization data for Medicaid, Veteran Affairs, or patients covered by private payers. **We believe that for this information to be meaningful to beneficiaries, it would need to include utilization data beyond Medicare FFS and Medicare Advantage claims.**

RFI- Publicly Reporting Cost Measures

CMS is evaluating ways to publicly report cost performance on clinician and group profile pages beginning with data from the 2024 performance period/2026 MIPS payment year. A total of 25 cost measures could be available for publicly reporting. CMS is seeking comment on several aspects of how to best establish publicly reporting cost measures.

While we support transparency, the AAMC is concerned that the cost measure performance information that would be reported on the *Care Compare* website may be unhelpful or misleading to consumers for several reasons. First and foremost, we are concerned that there is not a broader understanding of and use case for how patients and families will interpret and use clinician cost information. Patients and consumers want to know what their potential financial contribution will be for their care, which would be different than the information that would be shared on the Compare website. Also, patients and families managing multiple conditions might be frustrated when trying to determine which episode-based cost measures best apply to their own care needs. Added to this is whether patients believe cost is indicative of clinical expertise and quality. Ideally cost performance information should be displayed alongside clinically relevant quality measures for patients and their families to make informed decisions. Unfortunately, the current MIPS Program design does not support clinically meaningful and accurate reporting of clinician quality performance. The patient perspective must be well understood to inform the direction of publicly reporting and to mitigate unintended consequences.

Additionally, we believe that many of the existing cost measures do not accurately account for clinical complexity, and health-related social needs. As a result, the scores of physicians that treat the neediest patients are negatively and unfairly impacted, and their performance is not

adequately reflected in their score. Physicians at academic medical centers care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere. Until these measures are appropriately adjusted to account for these factors, the information publicly reported may not be meaningful to consumers.

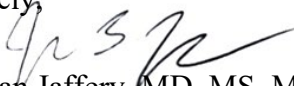
Further, challenges remain with attribution, which is a key component of cost measures. It is critical that when measuring costs there is an accurate determination of the relationship between a patient and a clinician to ensure that the appropriate clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often receive care from multiple clinicians across several facilities and teams within a single practice or facility. Current data methods are unable to account for such care delivery patterns. Meaningful information for patients and consumers requires better data sources and analytic techniques to support more accurate attribution across these care episodes.

Given all these challenges, **we urge CMS to proceed with caution when considering publicly reporting of cost performance information so that the information does not unintentionally lead to misinformed health care decisions.**

CONCLUSION

The AAMC appreciate your consideration of the above comments. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medicine community. Please contact my colleagues Gayle Lee (galee@aamc.org), Ki Stewart (kstewart@aamc.org), and Phoebe Ramsey (pramsey@aamc.org) with any questions about these comments.

Sincerely,



Jonathan Jaffery, MD, MS, MMM
Chief Health Care Officer
AAMC

Cc: David Skorton, MD, AAMC President and CEO