December 5, 2022

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

Re: Medicare Program; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of final rulemaking regarding changes to the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP), and other federal programs for Calendar Year (CY) 2023 and beyond. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 160,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We have summarized a subset of recommendations at the onset of this letter that reflect our top priority areas. Detailed explanations for each of these recommendations are included in the main text of the letter. Additional information can also be found in our comments on the CY23 PFS proposed rule. The College is confident that these recommended changes would improve the strength of these policies and help to promote access to affordable care for Medicare patients, support efforts to improve health equity, support physicians' ability to deliver innovative care, and protect the integrity of the Medicare trust funds. The College understands that CMS is not statutorily required to provide a public comment period for a notice of final rulemaking, and we appreciate CMS taking the time to consider our feedback for CY23 and beyond. We look forward to continuing to work with CMS to implement policies that support and improve the practice of internal medicine.

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Summary of Top Priority Recommendations

Regulatory Impact Analysis

- **Conversion Factor:** ACP is deeply disappointed that CMS finalized the cuts to the CY23 conversion factor. ACP understands that CMS cannot unilaterally address the bulk of these cuts, but we urge the Agency to work with congressional leaders to address the greater challenge of improving structural deficiencies in Medicare that continually lead to these situations.
- **Clinical Labor Pricing Update:** The College is pleased that CMS has continued with its four-year transition to update clinical labor pricing.
- **Rebasing and Revising the Medicare Economic Index (MEI); Updates to Practice Expense (PE) Data Collection and Methodology:** We continue to urge CMS to postpone any updates in values via the MEI until there has been an opportunity to examine all possible avenues, including efforts by the AMA.

Potentially Misvalued Services under the Physician Fee Schedule, and Valuation of Specific Codes

- **Immunization Administration (CPT Codes 90460, 90461, 90471, 90472, 90473, and 90474):** The College is supportive of the increased work RVUs, as finalized, for all six codes in the immunization administration code family.
- **Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS Codes G0442 and G0444):** The College believes this revision will appropriately allow physicians and other practitioners to efficiently furnish the service, thereby supporting access to these screenings and facilitating billing.
- **Chronic Pain Management and Treatment Bundles (as proposed, HCPCS GYYY1 and GYYY2):** ACP would recommend CMS consider defining chronic pain as persistent or recurrent pain lasting longer than one month, rather than three.
- **Behavioral Health Services:** We strongly believe that CMS' finalized policies will improve access to and the quality of mental health care services.

Evaluation and Management (E/M) Visits, including Valuation and Split (or Shared) Visits

- **E/M Visits, including Hospital Inpatient and Observation Care (CPT Codes 99221-99236); Hospital and Observation Discharge Day Management (CPT Codes 99217, 99238, and 99239); Valuation of Prolonged Inpatient or Observation E/M Services (G0316, G0317, and G0318):** ACP is extremely pleased that CMS adopted the revised CPT guidelines and codes, as well as the RUC-recommended relative values for "Other" E/M code families, including hospital inpatient and observation visits (CPT codes 99221-99236). We disagree with CMS' decision to create G0316 that describes prolonged inpatient or observation services (to be reported in conjunction with CPT code 99223, 99233, and 99236). ACP strongly encourages CMS to be an active participant in the CPT/RUC processes to better provide for uniformity across the E/M codes.
- **Cognitive Assessment and Care Planning (CPT Code 99483):** The College is very pleased that CMS finalized the increase in work RVUs from 3.80 to 3.84. ACP is also pleased that CMS did not finalize its proposal that prolonged services would not be reportable in conjunction with HCPCS code G2212 (prolonged office/outpatient (O/O) E/M services).
- **Split (or Shared) Visits:** ACP is pleased that CMS finalized its year-long delay (until January 1, 2024) of the split (or shared) visits policy established for 2022. The College recommends that

when the physician participates and meaningfully contributes to the MDM—even if the physician does not perform the MDM in its entirety—or when the physician meets the time threshold, then the physician should be considered to have performed the substantive portion of the visit. ACP looks forward to working with CMS and the CPT/RUC E/M Workgroup to address clarifications and definitional requirements that would further substantiate MDM in this context.

Strategies for Improving Global Surgical Package Valuation: ACP appreciates CMS continuing the discussion on the global surgical packages under the PFS. We agree that the matter of global valuation is complex, but this does not negate the fact that numerous studies have reported that the majority of visits in the global period are not being furnished but are paid for, nonetheless.

Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order: ACP is pleased that CMS has finalized its policy to permit audiologists to furnish certain diagnostic tests. ACP believes this will also mitigate ongoing concerns of physician burnout.

Medicare Parts A and B Payment for Dental Services: ACP is pleased that CMS finalized its policy to clarify and codify aspects of the Medicare Fee-for-Service (FFS) payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition. ACP cautions against adding any such services that would impact budget neutrality and existing Part B payment rates.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers: ACP is pleased that CMS expanded their Medicare coverage policies for colorectal cancer screening.

Telehealth

- **Telephone E/M Services, and Requests to Add Services to the Medicare Telehealth Services List:** ACP is extremely concerned about the Agency's decision to remove from coverage the telephone (or audio-only) E/M codes (CPT codes 99441, 99442, and 99443).
- **Emotional/behavior Assessment, Psychological, or Neuropsychological Testing and Evaluation Services:** The College is pleased that CMS finalized its proposal to include CPT codes 97151-97158 on the list on a Category 3 basis.
- **Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19:** ACP continues to encourage CMS to collaborate with the CPT/RUC Telemedicine Office Visits Workgroup to ensure appropriate coding of visits performed via telehealth.
- **Expiration of PHE Flexibilities for Direct Supervision Requirements:** The College is pleased that CMS will continue to permit direct supervision through virtual presence through at least the end of CY23 under its previously finalized policy. ACP continues to urge the Agency to make the direct supervision flexibility permanent.
- **Originating Site/Implementation of 2021 and 2022 CAAs:** While the College is pleased that the CAA, 2022, extended certain telehealth services for 151 days after the end of the PHE, ACP continues to question why these extensions would be limited to 151 days and would not be made permanent, considering the expansive evidence base for their benefits and necessity. We continue to urge CMS to work with Congress and stakeholders to cover these services permanently.

Electronic Prescribing of Controlled Substances (EPCS)

- **Cases where Prescribers Issue Only a Small Number of Part D Prescriptions:** The College remains supportive of the Small Prescriber Exception, having long been concerned that many small and independent physician practices are not able to cover the costs and acquire the necessary resources for technical or system upgrades required to incorporate EPCS into their existing EHRs. ACP appreciates CMS' reasons for modifying this exception to be based on Prescription Drug Event (PDE) data from the current evaluated year instead of the preceding year to determine whether a prescriber qualifies for an exception based on the number of Part D controlled substances claims.

Request for Information re: Potential Future EPCS Penalties

- **Timing for Issuing Non-compliance Notices:** ACP is very pleased that CMS finalized their proposal to extend the existing compliance action of sending notices to non-compliant prescribers from the CY23 EPCS program implementation year (January 1, 2023 through December 31, 2023) to the CY24 year (January 1, 2024, through December 31, 2024). ACP continues to recommend CMS study the true costs and implications of this mandate on clinicians. In the meantime, the College welcomes this extension for issuing non-compliance letters. We remain concerned, however, on the effect of the EPCS requirement for small, independent, and/or rural practices. ACP continues to recommend that a backup system, such as paper or telephone, should be established to accommodate systems going down or other technological barriers.

Updates and Modifications to the Quality Payment Program

Traditional MIPS

Quality Performance Category

- **High Priority Measures:** ACP is pleased with the finalization of expanding the definition of a high priority measure to include health equity-related measures.
- **CAPHS for MIPS Survey:** The College is encouraged by the change to the CAHPS for MIPS Survey measure which finalized replacing the "Asian language survey completion" case-mix factor with an adjustment to the proposed "language other than English spoken at home."
- **Quality Category Data Completeness:** ACP is displeased that CMS finalized the increase in data completeness criteria of 75%. The College continues to emphasize that a higher data completeness threshold would add more reporting burden to clinicians and divert attention from patient care.
- **Quality Performance Category Scoring:** The College is encouraged by the finalized changes to the quality performance scoring methodology including the removal of the three-point floor for measures reliably scored without a benchmark as well as measures without an available benchmark.
- **Changes to the Internal Medicine Specialty Quality Measure Set:** There are several new measures relevant to internal medicine clinicians finalized for adoption in the CY23 performance period. For detailed feedback on the below measures, please see ACP's comments to the CY23 PFS proposed rule.

    - *Screening for Social Drivers of Health*
    - *Kidney Health Evaluation*
    - *Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy*
    - *Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System*
    - *Adult Immunization Status*
- **Cost Performance Category:** ACP is supportive of the finalized policy of setting the maximum cost improvement score of one percentage point out of 100 for the cost performance category. We continue to urge CMS whenever possible to make technical improvements to measures as opposed to removing them unless doing so eliminates duplication.
- **Improvement Activities (IAs):** ACP is encouraged by CMS' continued commitment and action on the streamlining and elimination of duplicative IAs.
- **Promoting Interoperability:** ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance. The College is pleased that MIPS eligible clinicians, groups and virtual groups that are either Ambulatory Surgical Center (ASC) or hospital-based special statuses will continue to receive automatic reweighting. The College is also pleased that CMS finalized allowing APM Entities to report Promoting Interoperability (PI) data at the APM Entity level.
- **Promoting Interoperability/Query of Prescription Drug Monitoring Program (PDMP) Measure:** ACP is disappointed that CMS did not provide an opportunity for the public to comment on this change alongside the others in the CY23 proposed rule. The College is pleased that CMS finalized the proposal to increase reporting flexibilities for those participating in MIPS at the APM entity level. ACP is concerned that the Agency chose to discontinue automatic reweighting for select health care professionals for the duration of the PHE – a policy that has been in place to avoid creating undue administrative burden. ACP is additionally disappointed that CMS elected to make the PDMP measure mandatory, although the College appreciates the expanded scope of the measure to include Schedules III and IV drugs. The College continues to be concerned by the administrative burdens that will be exacerbated by this requirement.
- **Health Information Exchange Objective: Addition of an Alternative Measure for Enabling Exchange under TEFCA:** The College remains supportive of the Trusted Exchange Framework and Common Agreement's (TEFCA) underlying principles; however, we are disappointed that the Agency chose to finalize this policy as proposed. The College is disappointed that this new alternative measure requires "all-or-nothing" performance and fails to account for the significant expense to clinicians who wish to report.

Public Health Reporting and Information Blocking: The College remains supportive of efforts to improve interoperability of and patient access to electronic health information, and we agree these efforts are integral to improving patient-centered, value-based health care. We remain concerned that understanding how these complex information blocking provisions and exceptions interact with and potentially impact public health reporting requirements will be challenging for our physician members. Additionally, the College remains very concerned that the penalties for information blocking have not been made clear.

MIPS Value Pathways (MVPs)

- **MVP Development:** ACP is overall encouraged by the finalized changes to MVP development including finalization of a 30-day period where CMS will post draft versions of MVP candidates on the QPP website to solicit feedback for a 30-day period. ACP strongly supports that new MVPs will be prioritized, which align with items outlined in the CMS National Quality Strategy and will seek to advance health equity in accordance with the CMS Framework for Health Equity 2022-2023.
- **Revisions to Previously Finalized MVPs and Finalized New MVPs:** ACP applauds CMS' finalization of the Promoting Wellness MVP (as proposed) among the five new MVPs finalized in this rule.
- **Quality Measures:** ACP is generally supportive of the finalized inclusion of fourteen MIPS quality measures within the quality component of the Promoting Wellness MVP.
- **Improvement Activities:** Although ACP has not yet reviewed the measures finalized above, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.
- **Cost Measures:** ACP is disappointed that CMS finalized the inclusion of the Total Per Capita Cost (TPCC) measure, as it frequently places responsibility on physicians for costs outside of their control, penalizes physicians for performing recommended preventative health measures, and often fails to properly account for long-term savings.
- **Promoting Interoperability Measures:** Although ACP has not yet reviewed all the measures finalized, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.
- **Population Health Measures:** Although ACP has not yet reviewed all the measures finalized, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.
- **MVP Reporting Requirements:** The College is pleased that CMS does not intend to establish different reporting requirements for Promoting Interoperability measures in MVPs from what is established under traditional MIPS.

Medicare Shared Savings Program (MSSP): The College is extremely encouraged by the finalized changes to the MSSP, which provides greater incentives for entry, makes significant steps forward with the integration of health equity elements into the program, and removes unnecessary reporting burden.

Advanced Alternative Payment Models (APMs)

- **APM Entity Reporting:** The College is supportive of the increased flexibility provided by the finalized policy.
- **QP Threshold:** ACP is disappointed that the QP Performance Threshold will increase to 75% for payment amount and 50% for patient count. Additionally, the College is displeased that CMS did not finalize the proposal to change the all-or-nothing approach to determining an ACO's eligibility for shared savings based on quality performance to allow for scaling of shared savings rates for ACOs that fall below the 30^{th}/40^{th} percentile quality standard threshold required to share in savings at the maximum sharing rate, but who meet minimum quality reporting and performance requirements.

- **Reporting Requirements:** ACP is encouraged that the Agency finalized the elimination of certain reporting requirements, such as the submission of marketing materials before disbursement to ACOs and modification of beneficiary notification requirements.
- **5% APM Incentive/Bonus:** While ACP understands that there is no further statutory authority to continue the 5% lump sum APM Incentive Payment, the College remains disappointed there is no extension of this incentive payment.

PFS Detailed Recommendations

Regulatory Impact Analysis

Conversion Factor (CF)

ACP is deeply disappointed that CMS finalized the cuts to the CY23 conversion factor. We understand, however, that the nearly 4.5% decrease is largely due to expiration of the three percent increase provided via legislation. Nonetheless, from 2001 to 2022, Medicare physician payment declined 22% when adjusted for inflation in practice costs. This is due, in part, to fundamental distortions in the Medicare payment structure itself. The College has continued to call on Congress to provide relief from these decades-long cuts that have ultimately undermined physician work and continue to jeopardize patient access to care. In order to ensure that medical practices are able to remain open and physicians continue to be able to work with Medicare beneficiaries, the payment cuts that are scheduled for next year must be prevented with immediacy.

ACP understands that CMS cannot unilaterally address the bulk of these cuts, but we urge the Agency to work with congressional leaders to address the greater challenge of improving structural deficiencies in Medicare that continually lead to these situations. In our recent response to Representatives Bera and Bucshon's Request for Information (RFI) on MACRA reform, we emphasized the immediate need to:

- Ensure Medicare provides annual physician payment updates consistent with MEI; and
- Stop the CY23 budget neutrality cuts.

We additionally recommended long-term improvements to Medicare and health care delivery that include:

- Supporting sufficient and sustained increases in Medicare payments for primary care services that are not limited by current budget neutrality constraints;
- Ensuring savings are calculated across all aspects of Medicare;
- Improving the effectiveness of MACRA; and
- Reforming MACRA to achieve greater equity and value.

As CMS works towards solutions to address immediate and forthcoming payments cuts, ACP looks forward to working with the Agency to ensure the financial viability of the Medicare physician payment system.

Clinical Labor Pricing Update

The College is pleased that CMS has continued with its four-year transition to update clinical labor pricing. As the Agency advances its work, ACP encourages CMS to work with physician organizations to determine how to update the cost data more frequently and fairly compensate physicians for rising costs, including the impact of inflation and increased staffing needs due to demand.

Rebasing and Revising the Medicare Economic Index (MEI); Updates to Practice Expense Data Collection and Methodology

Recognizing that the data currently utilized for the MEI are profoundly outdated, the College was supportive of CMS' call for comment on updates to practice expense (PE) data collection and methodology. The absence of any updates has led to inaccurate data, thereby negatively impacting physician practice. However, **we continue to urge CMS to postpone any updates in values via the MEI until there has been an opportunity to examine all possible avenues, including efforts by the AMA.** While the College strongly believes that PE data inputs must be updated to account for growing costs and should dually account for inflation, **we urge CMS (and the AMA) to strongly consider how these updates lead to the devaluation of physician work.** Under CMS' policy, the allocation to physician work is scheduled to drop from 50.9% to 47.5% in order to account for the PE increase from 44.8% to 51.2%. As we stressed in our comments on the CY23 PFS proposed rule, ACP is concerned that if these shifts continue, there will be very little left of physician work in the MEI.

As this work moves forward, the College looks forward to partnering with CMS, congressional leaders, and the AMA to address these challenges. We also look forward to future rulemaking cycles where CMS and stakeholders will have an opportunity to compare the results of the AMA PE data collection efforts to the data used in the new MEI calculation.

Potentially Misvalued Services under the Physician Fee Schedule, and Valuation of Specific Codes

Immunization Administration (CPT Codes 90460, 90461, 90471, 90472, 90473, and 90474)

The value for CPT code 96372, upon which the immunization administration services are a direct crosswalk, has declined more than 30% since 2015. ACP agrees with CMS that global policy objectives for ensuring maximum access to immunization services requires adequately ensuring maximum access to these services. The College is supportive of the increased work RVUs, as finalized, for all six codes in the immunization administration code family.

Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS Codes G0442 and G0444)

According to the National Institute on Alcohol Abuse and Alcoholism and the National Coverage Determination, 25.8% of people ages 18 and older reported that they engaged in binge drinking in the past month, and approximately 17% of persons older than 65 suffer from depression. Yet for 2020, codes G0442 and G0444 have been utilized 759,928 and 1,939,323 times, respectively. In light of the substantial growth in the need, the College is very pleased to see that the Agency finalized its revisions to the code descriptor for HCPCS G codes G0442 (*Annual alcohol misuse screening, 15 minutes*) and G0444 (*Annual depression screening, 15 minutes*) to state "up to 15 minutes" instead of the current "15 minutes." The College believes this revision will appropriately allow physicians and other practitioners to efficiently furnish the service, thereby supporting access to these screenings and facilitating billing. In future rulemaking cycles, ACP recommends that CMS look into whether G0442 and G0444 should be re-evaluated to ensure sufficient reimbursement that supports utilization and the increased need.

Chronic Pain Management and Treatment Bundles (as proposed, HCPCS GYYY1 and GYYY2)

While the College is supportive of CMS allowing separate payment for chronic pain management and treatment services, we urge the Agency to reconsider the definition of chronic pain. ACP understands that this definition is similar to the CDC's definition in its 2016 opioid prescribing guideline, but we believe this definition is far too narrow and leaves out a large population of people in need of care.

Instead, ACP would recommend CMS consider defining chronic pain as persistent or recurrent pain lasting longer than one month, rather than three.

Behavioral Health Services

ACP is greatly supportive of efforts to improve access to behavioral health services. We strongly believe that CMS' finalized policies will improve access to and the quality of mental health care services. The College also believes these regulatory revisions will help to reduce existing barriers and make greater use of and recognition for the services of licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs), clinical psychologists (CPs), and clinical social workers (CSWs). Basing HCPCS code G0323 on a direct crosswalk to the work values and direct PE inputs for CPT code 99484 is also appropriate.

Evaluation and Management (E/M) Visits, including Valuation and Split (or Shared) Visits

E/M Visits, including Hospital Inpatient and Observation Care (CPT Codes 99221-99236); Hospital and Observation Discharge Day Management (CPT Codes 99217, 99238, and 99239); Valuation of Prolonged Inpatient or Observation E/M Services (G0316, G0317, and G0318).

ACP is extremely pleased that CMS adopted the revised CPT guidelines and codes, as well as the RUC-recommended relative values for "Other" E/M code families, including hospital inpatient and observation visits (CPT codes 99221-99236). The consolidation of a number of these codes into a single code set will be a welcomed change that aligns nicely with the overall effort to update coding and payment for E/M to be less administratively complex and more accurately paid under the PFS.

However, the College is concerned with CMS' decision to create Medicare-specific coding for payment of "Other" E/M prolonged services. Requiring these services to be reported with three separate Medicare-specific G codes will reinstate the complexity that has been untangled over the past few years. As an active participant in the CPT and RUC process, the College is disappointed to see CMS reject the CPT/RUC recommendation to adopt CPT code 99418. **We disagree with CMS' decision to create G0316 that describes prolonged inpatient or observation services (*to be reported in conjunction with CPT code 99223, 99233, and 99236*).**

We further have concerns with CMS' belief that a prolonged code should only be applicable after the total time for the primary service is exceeded (the total time used or assumed in valuation of the primary service, plus the full 15-minutes described the prolonged code). While ACP understands that CMS disagreed with CPT and the RUC regarding the point in time at which the prolonged code should apply, we believe the best resolve is to work through the CPT/RUC process to find an approach that is consistent with the established objectives of the CPT/RUC E/M Workgroup: to decrease administrative burden of documentation and coding and align CPT and CMS whenever possible. This approach additionally permits for the interested specialty societies to provide input. **ACP strongly encourages CMS to be an active participant in the CPT/RUC processes to better provide for uniformity across the E/M codes.**

Cognitive Assessment and Care Planning (CPT Code 99483)

The College is very pleased that CMS finalized the increase in work RVUs from 3.80 to 3.84. This increase will better account for the increase in physician time and more appropriately supports access to this

important service. ACP is also pleased that CMS did not finalize its proposal that prolonged services would not be reportable in conjunction with HCPCS code G2212 (prolonged office/outpatient (O/O) E/M services). We agree that the presence of a typical time in the descriptor for CPT code 99483 should not prevent reporting of prolonged services.

Split (or Shared) Visits

ACP is pleased that CMS finalized its year-long delay (until January 1, 2024) of the split (or shared) visits policy established for 2022. This policy defines "substantive portion" as more than half of the total time. For CY23, then, the definition of substantive portion continues to be any of the following elements: history; performing a physical exam; MDM; spending time (more than half of the total time).

As ACP indicated in our comments to the CY23 PFS proposed rule, we continue to recommend that CMS transition to using either MDM or time to determine the substantive portion of the visit. We also appreciate that CMS expressed its intent to review any revisions made by CPT to standardized language, including any definition of "substantive portion." We strongly encourage CMS' future policymaking to recognize physician contributions and provide appropriate compensation for the time it takes to supervise and furnish these services. For these reasons, **the College recommends that when the physician participates and meaningfully contributes to the MDM—even if the physician does not perform the MDM in its entirety—or when the physician meets the time threshold, then the physician should be considered to have performed the substantive portion of the visit. ACP looks forward to working with CMS and the CPT/RUC E/M Workgroup to address clarifications and definitional requirements that would further substantiate MDM in this context.**

Strategies for Improving Global Surgical Package Valuation

ACP appreciates CMS continuing the discussion on the global surgical packages under the PFS. We agree that the matter of global valuation is complex, but this does not negate the fact that numerous studies have reported that the majority of visits in the global period are not being furnished, but are paid for, nonetheless. The College is greatly encouraged by the Agency taking action to improve the valuation of the services currently valued and paid under the PFS as global surgical packages. As CMS continues to consider specific strategies, concerns regarding impact on the relative value scale, and the resources required to revalue these codes, ACP recommends the Agency partner with the College and other stakeholders to inform these discussions.

Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order

ACP is pleased that CMS has finalized its policy to permit audiologists to furnish certain diagnostic tests. In our comments on the CY23 PFS proposed rule, we highlighted our Patients Before Paperwork: Reducing Administrative Burdens initiative designed to reduce administrative complexities and eliminate unessential tasks that detract from patient care and contribute to physician burnout. This finalized policy will allow beneficiaries direct access to an audiologist without an order from a physician or non-physician practitioner (NPP) for non-acute hearing conditions and will permit audiologists to bill for this direct access without a physician or practitioner order. ACP believes this will also mitigate ongoing concerns of physician burnout.

Medicare Parts A and B Payment for Dental Services

ACP is pleased that CMS finalized its policy to clarify and codify aspects of the Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition. However, while we understand that Medicare payment for dental services has long lagged the extensive needs of adults, ACP cautions against adding any such services that would impact budget neutrality and existing Part B payment rates.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

ACP is pleased that CMS expanded their Medicare coverage policies for colorectal cancer screening. By reducing the minimum age payment and coverage limitation from 50 to 45 years and expanding the regulatory definition of colorectal cancer screening tests, these revisions will expand access to quality care and improve health outcomes through prevention, early detection, more effective treatment, and reduced mortality. These expanded policies will also advance health equity goals and promote access for cancer prevention and early detection in rural communities and communities of color.

Telehealth

Telephone E/M Services, and Requests to Add Services to the Medicare Telehealth Services List

ACP is extremely concerned about the Agency's decision to remove from coverage the telephone (or audio-only) E/M codes (CPT codes 99441, 99442, and 99443). Patients with significant impairments and limited resources often have little to no access to transportation nor audiovisual platforms, and the physician's ability to provide services via audio-only modalities allows greater opportunities for care and maximizes use of physician and patient time. Removing audio-only E/M codes from coverage would leave millions of patients without any care. Countless studies and reports have underscored the importance of preserving access to receiving services via these modalities, and the College has continued to re-emphasize the importance of improving health equity across CMS programs. As we have stated, there exists no 'good' version of a global health crisis, but the COVID-19 pandemic has brought to the forefront the power in and unique benefits of receiving health care services via telephone. The emergence of telehealth at-large has enabled physicians to provide access to care for patients in rural, underserved, and urban areas, often for the first time.

ACP fully supports the continued coverage of audio-only E/M codes for the sake of retaining and improving patient access, supporting health equity, and ensuring appropriate compensation. The College continues to encourage CMS to empower physicians as the key decision-maker in determining which services could and should be performed via audio-only versus audio-visual formats. This discretion should rest with the physician, and CMS should trust the clinical decision-making of physicians rather than remove coverage altogether.

The College is considerate of CMS' belief that it does not have the statutory authority to waive the audio-visual standard that informs the permissible use of telehealth. Through our endorsement for H.R. 4040, the Advancing Telehealth Beyond COVID-19 Act of 2021, the College has supported the continued coverage of telephone E/M services beyond the declared PHE and through 2024. ACP strongly encourages CMS to work with Congress to inform and pass H.R. 4040, which would extend several other currently-law telehealth flexibilities, as noted below.

- Remove geographic requirements and expand originating sites for telehealth services.
- Extend telehealth services for FQHCs and RHCs.

- Delay the in-person requirements under Medicare for mental health services furnished through telehealth and telecommunications technology.
- Allow for the furnishing of audio-only telehealth services for E/M services.

Ahead of future rulemaking cycles, ACP encourages CMS to heed the September 2022 report from the Office of the Inspector General (OIG). Though we understand the Agency's concerns regarding fraud, waste, and abuse, the College strongly believes these incidents of misconduct are not representative of the group, and CMS would be in err to remove access to and reimbursement for appropriately furnished telehealth services, including telephone visits. ACP believes the findings from OIG's report, namely that 99.8% of physicians and other "providers" showed no evidence of worrisome billing practices, adequately and appropriately substantiate this belief and support CMS continuing to provide coverage for and separate reimbursement of telephone E/M services.

As CMS continues to consider its approach, ACP encourages the Agency to collaborate with the College on its ongoing data collection effort. This effort spans across our 160,000 internal medicine physician members and collects data regarding the benefit, importance, and appropriate utilization of telephone visits. ACP also encourages CMS to collaborate with the CPT/RUC Telemedicine Office Visits Workgroup to assess available data and determine accurate coding and valuation for E/M office visits performed via audio-visual and audio-only modalities.

Emotional/behavior Assessment, Psychological, or Neuropsychological Testing and Evaluation Services

The College is pleased that CMS finalized its proposal to include CPT codes 97151-97158 on the list on a Category 3 basis. ACP agrees that this approach will allow for the collection and evaluation of data that could potentially support permanent inclusion. However, we re-emphasize that there is a concern that some patients may not be able to be fully assessed via interactive audio-visual modalities. While we believe this should not outweigh inclusion of the services, ACP recommends CMS partner with clinicians that offer these services to ensure access to high-quality emotional/behavior health services is adequately and appropriately provided.

Use of Modifiers for Medicare Telehealth Services Following the End of the Public Health Emergency (PHE) for COVID-19

As stated in our comments on the CY23 PFS proposed rule, ACP continues to encourage CMS to collaborate with the CPT/RUC Telemedicine Office Visits Workgroup to ensure appropriate coding of visits performed via telehealth. While ACP believes the use of a modifier and the appropriate POS code could inform the Agency's tracking and future decision-making, we caution the Agency against increasing administrative burden.

Expiration of PHE Flexibilities for Direct Supervision Requirements

The College is pleased that CMS will continue to permit direct supervision through virtual presence through at least the end of CY23 under its previously finalized policy (i.e., continuation through the end of the calendar year in which the PHE ends). **Additionally, ACP continues to urge the Agency to make the direct supervision flexibility permanent.** Doing so would support the expansion of telehealth services and protect frontline health care workers. The College believes that clinicians should feel empowered to supervise clinical staff virtually, at their discretion, regardless of whether there is a PHE.

Originating Site/Implementation of 2021 and 2022 CAAs

ACP appreciates CMS' clarification that if a beneficiary started receiving mental health telehealth services during the PHE or during the 151-day period after the end of the PHE, then they would not be required to have an in-person visit within six months and would instead be required to have at least one in-person visit every 12 months. However, the College is disappointed that CMS implemented provisions of the 2021 and 2022 CAAs that establish a six month in-person requirement for new mental health telehealth services. The College believes that there are many positive aspects of both phone and video visits that benefit patients (i.e., access to other family members, transportation issues, the ability to check medications, etc.) and sees no solid rationale or clinical indication for requiring a physician to see a patient in person for a mental health exam. This requirement is not based on medical necessity, and the College continues to oppose the imposition of regulations that do not improve patient safety or outcomes.

While the College is pleased that the CAA, 2022, extended certain telehealth services for 151 days after the end of the PHE, ACP continues to question why these extensions would be limited to 151 days and would not be made permanent, considering the expansive evidence base for their benefits and necessity. If these services can be delivered effectively via telehealth for 151 days after the end of the PHE, there appears to be no reason why they cannot be effectively delivered via telehealth thereafter, for the long term. Therefore, we question the arbitrary 151-day limit to coverage of these services and **continue to urge CMS to work with Congress and stakeholders to cover these services permanently**.

Electronic Prescribing of Controlled Substances (EPCS)

Cases where Prescribers Issue Only a Small Number of Part D Prescriptions

Where the practice is less burdensome for both patients and clinicians, ACP supports the use of electronic prescribing for controlled substances, though we caution it is not always true that e-prescribing of controlled substances is actually less burdensome. Thus, the College remains supportive of the Small Prescriber Exception, having long been concerned that many small and independent physician practices are not able to cover the costs and acquire the necessary resources for technical or system upgrades required to incorporate EPCS into their existing EHRs. ACP appreciates CMS' reasons for modifying this exception to be based on Prescription Drug Event (PDE) data from the current evaluated year instead of the preceding year to determine whether a prescriber qualifies for an exception based on the number of Part D controlled substances claims. This will provide consistency for practices by allowing the Small Prescriber Exception to align with all other exceptions described in the CY22 PFS final rule, which are evaluated based on data from the same year to which the exception is applied.

Request for Information re: Potential Future EPCS Penalties

Timing for Issuing Non-compliance Notices

ACP is very pleased that CMS finalized their proposal to extend the existing compliance action of sending notices to non-compliant prescribers from the CY23 EPCS program implementation year (January 1, 2023 through December 31, 2023) to the CY24 year (January 1, 2024, through December 31, 2024). Many clinician practices have not had time to implement the necessary technology and/or are struggling with the costs or other challenges associated with this technology. For example, criticism has been

leveled against the costs of two-factor authentication that some third-party vendors are passing onto the practices. Also, since e-prescribing adds an unfunded mandate whereby participating clinicians must pay an annual fee to use—and there are broadband issues for some clinicians—e-prescribing is often an additional burden. For these reasons, ACP continues to recommend CMS study the true costs and implications of this mandate on clinicians. In the meantime, the College welcomes this extension for issuing non-compliance letters.

We remain concerned, however, on the effect of the EPCS requirement for small, independent, and/or rural practices. These under-resourced practices face distinct challenges. For example, in addition to the financial burden of implementing EPCS technology, in some rural parts of states, the EPCS system does not operate consistently due to limited broadband availability or reliability, and there is no manual backup system in place. Therefore, ACP continues to recommend that a backup system, such as paper or telephone, should be established to accommodate systems going down or other technological barriers. In looking forward to January 1, 2025, we advise CMS to pay close attention to the real, true conditions in practice and the downstream implications of its policies—especially to small, independent practices and those in rural areas—and be willing to extend the date of compliance actions in further rulemaking if it is determined that a significant percentage of small, rural, or independent practices are still facing implementation barriers.

Updates and Modifications to the Quality Payment Program

Traditional MIPS

Quality Performance Category

High Priority Measures

While **ACP is pleased with the finalization of expanding the definition of a high priority measure to include health equity-related measures**, the College would appreciate greater specification on the guardrails.

CAPHS for MIPS Survey

The College is encouraged by the change to the CAHPS for MIPS Survey measure which finalized replacing the "Asian language survey completion" case-mix factor with an adjustment to the proposed "language other than English spoken at home." Instead, the finalized variables include "Spanish language spoken at home," Asian language spoken at home," and "other language spoken at home." This expansion of variables may allow for greater accuracy in capturing language preference.

Quality Category Data Completeness

ACP is displeased that CMS finalized the increase in data completeness criteria of 75%. While ACP understands that the intent of a higher data completeness threshold is to provide a more comprehensive view of performance, clinicians are still adjusting from the ongoing COVID-19 PHE. The College continues to emphasize that a higher data completeness threshold would add more reporting burden to clinicians and divert attention from patient care.

Quality Performance Category Scoring

The College is encouraged by the finalized changes to the quality performance scoring methodology including the removal of the three-point floor for measures reliably scored without a benchmark as well as measures without an available benchmark.

Changes to the Internal Medicine Specialty Quality Measure Set

CMS finalized a total of 198 quality measures for the 2023 performance period. There are several new measures relevant to internal medicine clinicians finalized for adoption in the CY23 performance period:

- *Screening for Social Drivers of Health*: This measure evaluates the number of patients older than 18 that are screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
- *Kidney Health Evaluation*: This measure evaluates the percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) and Urine Albumin-Creatinine Ratio (uACR).
- *Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy:* This measure evaluates the percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (Stages 1-5, not receiving Renal Replacement Therapy (RRT)) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period.
- *Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System*: The annual risk-standardized rate of acute, unplanned cardiovascular-related admissions among Medicare FFS patients aged 65 years and older with heart failure (HF) or cardiomyopathy.
- *Adult Immunization Status*: This measure evaluates the percentage of patients 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal.

For detailed feedback on the above measures, please see ACP's comments to the CY23 PFS proposed rule.

Cost Performance Category

ACP is supportive of the finalized policy of setting the maximum cost improvement score of one percentage point out of 100 for the cost performance category.

As stated in comments on the 2022 PFS final rule, ACP continues to have specific concerns, including attributing costs at the group practice level or higher, not attributing the same costs to multiple clinicians/groups, and risk adjusting for social determinants of health. We continue to urge CMS whenever possible to make technical improvements to measures as opposed to removing them unless doing so eliminates duplication.

Improvement Activities (IA)

ACP is encouraged by CMS' continued commitment and action on the streamlining and elimination of duplicative IAs.

Promoting Interoperability

Although ACP has not yet reviewed the measures finalized for addition, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.

The College is pleased that MIPS eligible clinicians, groups, and virtual groups that are either Ambulatory Surgical Center (ASC) or hospital-based special statuses will continue to receive automatic reweighting. The College is also pleased that CMS finalized allowing APM Entities to report Promoting Interoperability (PI) data at the APM Entity level.

Promoting Interoperability/Query of Prescription Drug Monitoring Program (PDMP) Measure

CMS finalized the six proposals outlined in the CY23 proposed rule to alter the Promoting Interoperability performance category, as well as a seventh policy that was not included in the proposed rule for public review and comment, "to limit a clinician's time at the first level of active engagement to one performance period but delaying the applicability date until performance periods in 2024." ACP is disappointed that CMS did not provide an opportunity for the public to comment on this change alongside the others in the CY23 proposed rule.

The College is pleased that CMS finalized the proposal to increase reporting flexibilities for those participating in MIPS at the APM entity level. This will allow APM entities to choose between reporting PI data at the individual, group, and APM entity level. However, ACP is concerned that the Agency chose to discontinue automatic reweighting for select health care professionals for the duration of the PHE – a policy that has been in place to avoid creating undue administrative burden. ACP is additionally disappointed that CMS elected to make the PDMP measure mandatory, although the College appreciates the expanded scope of the measure to include Schedules III and IV drugs. The College continues to be concerned by the administrative burdens that will be exacerbated by this requirement.

Health Information Exchange Objective: Addition of an Alternative Measure for Enabling Exchange under TEFCA

The College remains supportive of the Trusted Exchange Framework and Common Agreement's (TEFCA) underlying principles; however, we are disappointed that the Agency chose to finalize this policy as proposed. While ACP appreciated CMS' responses to our comments on the proposed rule, the College remains concerned about implementation burden on small or independent practices, limiting rural MIPS eligible clinicians and small practices from participating; the measure failing to account for the clinical relevance of the information used at the point of care and the lack of value in continually querying for data; and MIPS eligible clinicians often being unaware of their health system's engagement with TEFCA, which places additional burden on the MIPS eligible clinician by them having to defer to others who have this information.

The College is disappointed that this new alternative measure requires "all-or-nothing" performance and fails to account for the significant expense to clinicians who wish to report. Additionally, the attestations finalized in this rule assume clinicians know if their hospital or healthcare system is a signatory to a Framework Agreement, and whether the entity is in good standing. Most physicians are not aware of their health system's implementation of TEFCA, and this would put the clinician in a position of having to defer to others with this knowledge – an unnecessary and onerous task that increases burden.

Generally, ACP supports CMS' focus on interoperability and patient access to data, as well as its intention to give clinicians greater flexibility while reducing their burdens and exchanging information safely. However, participating in TEFCA comes at substantial cost to practices, which limits access to this measure and disadvantages rural clinicians and small practices during a period of great challenges due to severe nationwide staffing shortages and the ongoing COVID-19 pandemic. The College continues to recommend CMS explore ways to increase interoperability that do not also increase burden on physicians.

Public Health Reporting and Information Blocking

The College remains supportive of the Department of Health and Human Services' (HHS) efforts, through coordination across the various agencies, including the Office of the National Coordinator for Health IT (ONC) and CMS, to improve interoperability of and patient access to electronic health information, and we agree these efforts are integral to improving patient-centered, value-based health care. The College is appreciative of CMS reiterating its views on compliance in public health reporting and information blocking. However, we remain concerned that understanding how these complex information blocking provisions and exceptions interact with and potentially impact public health reporting requirements will be challenging for our physician members. Additionally, the College remains very concerned that the penalties for information blocking have not been made clear. In the absence of further details regarding penalties, it is difficult for physicians to understand the ramifications of information blocking violations. The College continues to request CMS and HHS clarify penalties and other important parameters of information blocking regulations through additional rulemaking.

MIPS Value Pathways (MVPs)

MVP Development

ACP is overall encouraged by the finalized changes to MVP development including finalization of a 30-day period where CMS will post draft versions of MVP candidates on the QPP website to solicit feedback for 30 days. CMS will then review the feedback and determine if any recommended changes should be incorporated into a candidate MVP in the event it's proposed in rulemaking. However, CMS also finalized that if the Agency determines changes should be made, CMS will not notify the group or organization that originally submitted the MVP candidate in advance of rulemaking. Communication between relevant stakeholders, including developers and participants, throughout the MVP development process is essential. Stripping communication from these groups at a critical time is counter to the goal of increased transparency and collaboration. ACP strongly supports that new MVPs will be prioritized, which align with items outlined in the CMS National Quality Strategy and will seek to advance health equity in accordance with the CMS Framework for Health Equity 2022-2023.

Revisions to Previously Finalized MVPs and Finalized New MVPs

ACP applauds CMS' finalization of the Promoting Wellness MVP (as proposed) among the five new MVPs finalized in this rule. This MVP provides another option that is strongly tied to the daily practice of general internal medicine physicians and has been adapted from one of the MVPs submitted by ACP in February 2020.

Overall, we are pleased to see many of the changes that have been finalized by CMS with regards to measure additions and measure removals. Of the 14 quality measures finalized, ACP's prior review

indicates support for eight of them, does not support four of them with uncertain validity, has found one of them to be invalid, and one has not been formally reviewed. For a detailed review of these measures, see our comments on the PFS 2023 proposed rule.

Quality Measures

ACP is generally supportive of the finalized inclusion of 14 MIPS quality measures within the quality component of the Promoting Wellness MVP. CMS also finalized inclusion of six broadly applicable MIPS quality measures (see below).

MIPS quality measures within the quality component of the Promoting Wellness MVP:

- Q039: Screening for Osteoporosis for Women Aged 65-85 Years of Age: This MIPS quality measure assesses women, 65-85 years of age, who have ever received a dual-energy x-ray absorptiometry (DXA) test to evaluate for the disease osteoporosis.
- Q112: Breast Cancer Screening: This MIPS quality measure ensures women have a mammogram to screen and for breast cancer.
- Q113: Colorectal Cancer Screening: This MIPS quality measure ensures patients have received appropriate screening for colorectal cancer.
- Q309: Cervical Cancer Screening: This MIPS quality measure assesses women to determine if they were screened for cervical cancer.
- Q310: Chlamydia Screening for Women: This MIPS quality measure identifies women that are sexually active to ensure that they have had at least one test for chlamydia.
- Q400: One-Time Screening for Hepatitis C Virus (HCV) for all Patients: This MIPS quality measure requires that patients have received a one-time screening for hepatitis C virus (HCV) infection.
- Q475: HIV Screening: This MIPS quality measure ensures patients receive a one-time test for HIV.
- Q493: Adult Immunization Status: This MIPS quality measure ensures patients are assessed for and/or receive the influenza, Tdap/Td, herpes zoster, and pneumococcal vaccines, as recommended.

Broadly applicable MIPS quality measures that are relevant to promoting wellness:

- Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: This MIPS quality measure assesses patients, aged 18 years and older, with a BMI documented and who had a follow-up plan documented if their most recent documented BMI was outside of normal parameters.
- Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan: This MIPS quality measure ensures all patients are screened for depression with a follow-up plan discussed for those patients who screen positive.
- Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: This MIPS quality measure screens patients for tobacco use and if the patient is screened positive for tobacco use then they should receive tobacco cessation intervention.
- Q321: CAHPS for MIPS Clinician/Group Survey: This survey would provide direct input from patients and their experience regarding timely care, effective communication, shared decision

making, care coordination, promotion of health and education, completion of health status/functionality, and courtesy of office staff.

- Q431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: This MIPS quality measure screens patients, aged 18 years and older, for unhealthy alcohol use using a systematic screening method at least once within the last 12 months. If the patient is screened positive for unhealthy alcohol use, then they should receive brief counseling.
- Q483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM): This MIPS quality measure evaluates the high value aspects of primary care based on a patient's relationship with the clinician or practice and allows patients the ability to communicate their perspective of the quality of care received to their clinicians and/or care team.

Improvement Activities

The following improvement activities are finalized for inclusion in this MVP:

- IA_AHE_3: Promote Use of Patient-Reported Outcome Tools
- IA_BE_4: Engagement of patients through implementation of improvements in patient portal
- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
- IA_BE_12: Use evidence-based decision aids to support shared decision-making
- IA_BMH_9: Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients
- IA_CC_2: Implementation of improvements that contribute to more timely communication of test results
- IA_CC_13: Practice improvements for bilateral exchange of patient information
- IA_CC_14: Practice improvements that engage community resources to support patient health goals
- IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
- IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation
- IA_PM_11: Regular review practices in place on targeted patient population needs
- IA_PM_13: Chronic Care and Preventative Care Management for Empaneled Patients
- IA_PM_16: Implementation of medication management practice improvements
- IA_PSPA_19: Implementation of formal quality improvement methods, practice changes, or other practice improvement processes

Although ACP has not yet reviewed the measures finalized above, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.

Cost Measures

ACP is disappointed that CMS finalized the inclusion of the Total Per Capita Cost (TPCC) measure, as it frequently places responsibility on physicians for costs outside of their control, penalizes physicians for performing recommended preventative health measures, and often fails to properly account for long-term savings.

Promoting Interoperability Measures

The following promoting interoperability measures are finalized for inclusion in this MVP:

- Security Risk Analysis
- Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)
- e-Prescribing
- Query of the Prescription Drug Monitoring Program (PDMP)
- Provide Patients Electronic Access to Their Health Information
- Support Electronic Referral Loops By Sending Health Information, AND
- Support Electronic Referral Loops By Receiving and Reconciling Health Information, OR
- Health Information Exchange (HIE) Bi-Directional Exchange, OR
- Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)
- Immunization Registry Reporting
- Syndromic Surveillance Reporting (Optional)
- Electronic Case Reporting
- Public Health Registry Reporting (Optional)
- Clinical Data Registry Reporting (Optional)
- Actions to Limit or Restrict Compatibility or Interoperability of CEHRT
- ONC Direct Review

Although ACP has not yet reviewed all of the measures finalized, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.

Population Health Measures

The following population health measures are finalized for inclusion in this MVP:

- Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups (Collection Type: Administrative Claims)
- Q484: Clinician and Clinician Group Risk standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Collection Type: Administrative Claims)

Although ACP has not yet reviewed the measures finalized, ACP continues to encourage the inclusion of measures that are methodologically sound, evidence-based, and addressing clinical areas of importance.

MVP Reporting Requirements

The College is pleased that CMS does not intend to establish different reporting requirements for Promoting Interoperability measures in MVPs from what is established under traditional MIPS.

Medicare Shared Savings Program (MSSP)

The College is extremely encouraged by the finalized changes to the MSSP, which provides greater incentives for entry, makes significant steps forward with the integration of health equity elements

into the program, and removes unnecessary reporting burden. CMS finalized several promising policies outlined in the PFS 2023 proposed rule with minimal changes, including:

- Establishing Advance Investment Payments (AIPs) for new, low revenue ACOs that are inexperienced with performance-based risk Medicare ACO initiatives;
- Allowing ACOs applying to the program that are inexperienced with performance-based risk to participate in up to 7 years under a one-sided shared savings model;
- Establishing a health equity adjustment that will upwardly adjust an ACO's quality performance score, to reward ACOs that report all-payer eCQMs/MIPS CQMs, that are high performing on quality, and serve a high proportion of underserved beneficiaries;
- Revision of the benchmarking methodology to reduce the effect of ACO performance on ACO historical benchmarks ("Ratchet Effect"), increase opportunities for ACOs caring for medically complex, high-cost beneficiaries, and strengthen incentives for ACOs to enter and remain in the Shared Savings Program, and meet the programmatic goals of improving quality of care and lowering growth in FFS expenditures;
- Revision to capitation of positive prospective HCC risk score growth aimed to better account for medically complex, high-cost populations while continuing to guard against coding initiatives;
- Removal of the requirement to submit marketing materials prior to use. ACOs will be required to submit marketing materials only upon request from CMS, but CMS retained the requirement that an ACO must discontinue use of any marketing materials or activities for which CMS has issued a notice of disapproval.

Advanced Alternative Payment Models (APMs)

APM Entity Reporting

The College is supportive of the increased flexibility provided by the finalized policy. The policy establishes a voluntary option for APM Entities to report the Promoting Interoperability performance category at the APM Entity level.

QP Threshold

ACP is disappointed that the QP Performance Threshold will increase to 75% for payment amount, and 50% for patient count.

Additionally, the College is displeased that CMS did not finalize the proposal to change the all-or-nothing approach to determining an ACO's eligibility for shared savings based on quality performance to allow for scaling of shared savings rates for ACOs that fall below the 30th/40th percentile quality standard threshold required to share in savings at the maximum sharing rate, but who meet minimum quality reporting and performance requirements.

Reporting Requirements

ACP is encouraged that the Agency finalized an elimination of certain reporting requirements, such as the submission of marketing materials before disbursement to ACOs and modification of beneficiary notification requirements.

5% APM Incentive/Bonus

While ACP understands that there is no further statutory authority to continue the 5% lump sum APM Incentive Payment, the College remains disappointed there is no extension of this incentive payment. As CMS acknowledged, without this incentive payment, entry into APMs decreases significantly in feasibility for practices – particularly small practices). However, the College was encouraged to see that CMS looked meticulously through statute to try to alleviate future consequences of this expiration. CMS finalized the utilization of a section of MACRA to apply two different conversion factors (CFs) depending on the clinician's QP status. The CF for services furnished by clinicians who achieve QP status for a year is 0.75, while the update to the PFS CF for services that are furnished by clinicians who do not achieve QP status for a year is 0.25. QP would update to 0.75 starting in payment year 2026. Additionally, MIPS eligible clinicians will receive positive, neutral, or negative MIPS payment adjustments to pay for their Part B covered professional services in a payment year based on performance during a prior performance period. The College is cautiously optimistic that this could provide some redeeming incentive to the program.

Conclusion

Thank you for the opportunity to provide feedback on CMS' finalized policy regarding changes to the CY23 PFS and QPP. ACP is confident these recommended changes would improve the strength of these policies and help promote access to affordable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We look forward to continuing to work with CMS to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Ph.D., Director, Regulatory Affairs for the American College of Physicians, at boutland@acponline.org or (202) 261-4544 with comments or questions about the content of this letter.

Sincerely,

William Fox, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians