American College of Osteopathic Internists • Stay True to Why You Pursued Medicine

September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

The American College of Osteopathic Internists (ACOI), representing the nation's osteopathic internists, medical subspecialists, fellows, residents, and students, welcomes the opportunity to provide comment on several policies included in the CY 2024 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1784-P) as published in the *Federal Register* on August 7, 2023.

The Medicare physician payment system is on an unstable path that threatens beneficiary access to care. As recognized by Medicare's trustees in their June 2023 report, the physician payment system put in place by the M*edicare Access and CHIP Reauthorization Act* "avoided the significant short-range physician payment issues" resulting from the sustainable growth rate (SGR),[1] yet raises long-range concerns that will "almost certainly" need to be addressed by future legislation. Most significant among concerns of ACOI members is the continuation of the statutorily set update of zero through 2025, and, starting in 2026, updates of just 0.75 for qualified physicians in advanced alternative payment models, and 0.25 for all other physicians. These updates are inadequate, and, as noted by Medicare's trustees, "do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases." Inadequate payment updates have been felt most acutely by physician practices as they contend with a tight labor market that is driving up wages for non-physician practitioners who are increasingly being relied upon to fill gaps to meet patient care demands, as well as medical technologists, and administrative staff.

In environments of uncertainty, physicians seek shelter, including by becoming employees of hospitals or corporate entities. According to the data from Avalere gathered in a study sponsored by the Physicians Advocacy Institute, almost three-quarters of U.S. physicians now work for hospitals, health systems, or corporate entities, up from 69 percent a year ago.[2] Avalere found that 108,700

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[1] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; March 31, 2023. https://www.cms.gov/oact/tr/2023

[2] COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021; Physicians Advocacy Institute, April 2022. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-

physicians became employees of larger health organizations or other corporate entities over the three years between January 1, 2019 and January 1, 2022, and, of that total, 83,000, or 76 percent, made the switch after the COVID-19 pandemic began.[3]

With Medicare reimbursement that has not kept pace with inflation, payment cuts on the horizon and regulatory and administrative burdens, the trends in practice consolidation and acquisition are not shocking and come at a cost to the Medicare system and to patients.

A fundamental restructuring of the Medicare physician payment system is needed, but it will take time. ACOI is urging Congress to pass legislation this year providing physicians with an annual inflation-based update tied to the full Medicare Economic Index (MEI). Additionally, we ask the Agency to use every policy lever available to reduce the proposed budget neutrality reduction for physician services in 2024 and to close the gap between the Medicare physician payment update and the rising cost of practicing medicine.

The ACOI offers comment on the following proposals contained within this rule to minimize further financial and administrative disruption to physician practices and to advance policies that support beneficiary access to high-quality care.

- Rebasing and Revising the MEI & Indirect Practice Expense Methodology
- Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Implementation
- Request for Comment About Evaluating E/M Services More Regularly and Comprehensively
- Split/Shared Services
- Telehealth Services
- Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging
- Vaccine Administration
- Diabetes Services
- Merit-based Incentive Payment System

REBASING AND REVISING THE MEI & INDIRECT PRACTICE EXPENSE METHODOLOGY

The MEI weights, that are the basis for current CMS rate setting, are based on data obtained from the American Medical Association's (AMA) Physician Practice Information (PPI), which was last conducted in 2007/2008 and collected 2006 data. ACOI acknowledges the MEI cost weights need to be updated to reflect more current market conditions faced by physicians in furnishing health care services.

The AMA and Mathematica formally launched a PPI survey on July 31, 2023. The survey, which will conclude in April 2024, will provide more than 10,000 physician practices with the opportunity

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Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d

[3] Ibid.

to share their practice cost data and number of direct patient care hours provided by both physicians and qualified health care professionals.

In the CY 2023 Medicare PFS final rule, CMS finalized but did not incorporate for 2023 new cost weights using a new methodology based primarily on a subset of data from the 2017 U.S. Census Bureau's Service Annual Survey (SAS). Use of the proposed MEI cost weights would have have resulted in significant redistribution within physician payments due in large part to an error in CMS' analysis which omitted nearly 200,000 facility-based physicians. We appreciate CMS' recognition of AMA's ongoing data collection efforts and the importance of balancing payment stability and predictability with incorporating new data through more routine updates.
Therefore, **ACOI urges CMS to finalize its proposal to not incorporate the 2017-based MEI in PFS rate setting again for 2024 and not until CMS has the benefit of the new PPI survey data.**

OFFICE/OUTPATIENT (O/O) E/M VISIT COMPLEXITY ADD-ON IMPLEMENTATION

With the statutory moratorium of Medicare PFS payment for HCPCS code G2211ending on December 31, 2023, CMS proposes to change the status of HCPCS code G2211 to make it separately payable by assigning the "active" status indicator, effective January 1, 2024. CMS is also proposing policy refinements with respect to use of G2211 which will lessen the impact of the code's use on the Medicare conversion factor.

The full descriptor for the O/O E/M visit complexity add-on code, as refined in the CY 2021 PFS final rule, is HCPCS code G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established))*. **ACOI believes this descriptor remains vague, despite examples in the rule of when the code would *not* be payable, and will contribute to confusion on when it can be appropriately reported, particularly among physician specialists.**

CMS is proposing G2211 will not be payable when it is reported with payment modifier -25. This modification helps to lower CMS' utilization assumption from 90 percent to 38 percent initially. CMS also revised its assumption by excluding: (1) claims from practitioners participating in CMS capitated models; and (2) claims for established patient visits performed by certain specialties that are unlikely to have a longitudinal care relationship with a beneficiary. CMS states it expects utilization to increase to 54 percent when fully adopted. While these revised assumptions will help to lessen the effect of budget neutrality on the conversion factor, its assumptions do not reflect the uptake of similar codes implemented in recent years. A study published in 2021 in the *Annals of Internal Medicine* looked at the utilization of the chronic care management and transition care management codes.[4] The study found:

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[4] Agarwal SD, Basu S, Landon BE. The Underuse of Medicare's Prevention and Coordination Codes in Primary Care : A Cross-Sectional and Modeling Study. Ann Intern Med. 2022 Aug;175(8):1100-1108. doi: 10.7326/M21-4770. Epub 2022 Jun 28. PMID: 35759760; PMCID: PMC9933078.

- About 22.5 percent of Medicare beneficiaries had a hospitalization eligible for transitional care management services. Among these beneficiaries, 43.3 percent were seen in primary care after discharge, and only 9.3 percent had a claim for transitional care management.

- Two-thirds of Medicare beneficiaries were eligible for chronic care management services; yet, only 2.3 percent of eligible patients had a claim for any of these services.

ACOI recommends that CMS consider that its estimates for initial use of G2211 may be over-inflated given the history of the uptake of these two care coordination codes. ACOI therefore encourages CMS to further reevaluate its assumptions and make its methodology transparent.

REQUEST FOR COMMENT ABOUT EVALUATING E/M SERVICES MORE REGULARLY AND COMPREHENSIVELY

CMS requests feedback about whether the current AMA/Specialty Society Relative Value Scale Update Committee (RUC) is the entity "best positioned" to provide recommendations to CMS on resource inputs for work and practice expense valuations, as well as to establish values for E/M and other physicians 'services, or if another entity would "better serve" CMS and interested parties in providing these recommendations.

The RUC is comprised of a volunteer group of 32 physicians and more than 300 medical advisors, other health care professionals and national specialty society experts that represent each sector of medicine, including primary care physicians and specialists. The RUC relies on the expertise of more than 100 specialty societies and health care professional organizations to evaluate thousands of individual services across the medical spectrum. The Committee's relative value recommendations to CMS reflect the continued importance of services that *all* physicians, including primary care physicians, perform.

To make the RUC process accessible and transparent to stakeholders and to the public, the RUC publishes meeting dates, meeting minutes, and vote totals for each service evaluated. The RUC submits recommendations to CMS which the Agency can choose to ignore or adopt in whole or in part. Final payment amounts are determined through rulemaking — a process that is open to public comment.

Furthermore, the RUC's methodology standards are designed to ensure it is collecting the most reliable and robust data. We fear that critics of the AMA RUC process seek to sow division within the House of Medicine. As such, **ACOI believes maintaining the Medicare relative value scale is a clinical and scientific activity that must remain in the hands of the medical profession. As such, the AMA RUC should remain the principal vehicle for refining the work and practice expense components of the resource-based relative value scale.**

SPLIT/SHARED SERVICES

In the CY 2022 PFS final rule, CMS finalized a policy for E/M visits furnished in a facility setting, to allow payment to a physician for a split (or shared) visit (including prolonged visits), where a physician and non-physician practitioner provide the service together (not necessarily concurrently) and the billing physician personally performs a substantive portion of the visit.

For CY 2022, CMS defined substantive portion as one of the following: history, exam, or medical decision-making, or more than half of total time. CMS subsequently finalized that for CY 2023, the definition of substantive portion would be more than half of total time.

Consistent with past comments, ACOI is concerned with the detrimental effect this policy will have on care delivery models and on patient experience. CMS' split/shared policy is contrary to effective patient co-management and clinical alignment. The AMA CPT Editorial Panel has finalized revisions, which are final as of September 1, 2023, to aspects of split or shared visits. The new CPT guidance states:

> *Physician(s) and other qualified health care professional(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service. If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service. For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP.*

CMS' payment policies must recognize the importance of collaborative care whereby excellent patient care relies on the expertise of several care practitioners who coalesce to provide care, leading to reduced levels of burden and more effective patient care. Adoption of this CPT guidance would allow physicians or QHPs to report split or shared visits based on time or medical decision-making, and it supports team-based care. **ACOI asks CMS to adopt the new CPT guidance for split/shared visits and to delay its application until January 1, 2025.**

TELEHEALTH SERVICES

CMS proposes to implement the telehealth flexibilities included in the *Consolidated Appropriations Act of 2023* including waiving the geographic and originating site requirements for Medicare telehealth services and extending payment for the CPT codes for audio-only visits (99441-99443 and 98966-98968) through December 31, 2024. CMS further proposes to continue payment for all other services that were on the 2022 Medicare Telehealth Services List in any category through 2024 when they are provided via telehealth and to delay in-person visit requirements for telehealth services for patients with mental health conditions. **ACOI strongly supports these telehealth policy proposals and asks that they be finalized.**

According to data released by the Department of Health and Human Services (HHS) in February 2022,[5] the majority of adults 65 or older with a recent telehealth visit used audio-only. According to the report, these findings were consistent with a study that found that 26 percent of Medicare beneficiaries lack access to a desktop, laptop, or smartphone at home. The report noted that some seniors may also encounter barriers related to technological literacy, cognitive decline, and physical disability. The report analyzed data regarding telehealth use from the Census Bureau's Household Pulse Survey from April to October 2021. Discontinuing payment for audio-only services would exacerbate inequities in health care, particularly for those who lack access to audio-video capable devices, such as seniors and minority communities. The HHS data analysis of telehealth use also found that Black, Latino and Asian adults are more likely than their white counterparts to use audio telehealth services rather than video. We appreciate, as the report notes, that audio-video telehealth visits may allow the provider to check on a patient's home environment. The priority, however, should be ensuring that beneficiaries can access timely health care services. **ACOI, therefore, strongly urges CMS to maintain separate payment for the CPT codes for audio-only E/M visits at least through 2024 and that this payment policy be permanently extended.**

Supervision of Residents in Teaching Settings

ACOI supports CMS' proposal to allow through December 31, 2024 a teaching physician to have a virtual presence in all teaching settings, but limited to clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with all parties in separate locations). As noted by CMS, this would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for all residency training locations. As CMS considers how telehealth services can be furnished in all residency training

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[5] Karimi M, Lee F, Couture S. National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. Feb. 1, 2022. https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf

locations beyond December 31, 2024, **ACOI suggests that other clinical treatment situations in which it would be appropriate to permit virtual presence of the teaching physician could include ambulatory care, critical care, and care for patients in isolation or any environment in which limited direct person-to-person exposure is necessary for the health and safety of the patient.**

MEDICARE APPROPRIATE USE CRITERIA (AUC) PROGRAM FOR ADVANCED DIAGNOSTIC IMAGING

ACOI strongly supports CMS' proposals to pause implementation of the AUC Program for reevaluation and to rescind the current AUC program regulations, effectively ending the educational and operations testing period.

In the rule, CMS cites the real-time, claims-based reporting requirement prescribed by the *Protecting Access to Medicare Act* as an "insurmountable barrier" for CMS to fully operationalize the AUC program. CMS presents a strong rationale for using its regulatory authority to pause the program, including increased administrative burden on providers and the potential for the Program to expose beneficiaries to financial risk or delay timely access to imaging services. The burden of the AUC Program requirements would have been particularly profound for many ACOI members given the range of conditions and symptoms that general osteopathic internists commonly manage.

While ACOI supports CMS' proposed pause of the AUC Program, there is questionable necessity of an AUC Program that is siloed from other CMS quality and value-based initiatives. We draw CMS' attention to commentary published on August 31, 2023, in *Health Affairs*[6] which states:

> "Since PAMA was enacted in 2014, CMS has operationalized the Quality Payment Program, including the Merit-based Incentive Payment System and Advanced Alternative Payment Models, as well as several accountable care and value-based initiatives that are intended to encourage health care providers to take responsibility and risk for both the quality of care and the cost of care for their patients. These programs align the incentives of entire teams of providers around "value"—e.g., (quality + outcomes)/cost—as they care for patients; measures that promote adherence to evidence-based care guidelines become attractive to providers and can be incorporated into workflows for the right reasons (as defined by the local care teams and their patients). As a result of these advances, the risks and expenses inherent in the AUC program are no longer justified. They would likely prove counterproductive, as the low-value AUCs may work counter to newer, better-quality initiatives and value-based care programs."

ACOI believes the entire AUC Program mandate should be repealed by Congress and that the objectives of value-based programs and initiatives be recognized as sufficient for encouraging

[6] "Medicare Imaging AUC Program: Sometimes Less Is More", Health Affairs Forefront, August 31, 2023. DOI: 10.1377/forefront.20230830.836161

appropriate resource use for the delivery of high-quality care, including advanced diagnostic imaging as well as other health care services.

VACCINE ADMINISTRATION

Medicare beneficiaries have a higher disease burden than the general population. As highlighted by the Medicare Payment Advisory Commission in its June 2021 report,[7] recommended vaccines may be more likely to improve quality of life and prevent hospitalizations and medical costs for Medicare beneficiaries.

We appreciate that CMS is using its analysis of the use of HCPCS billing code M0201, which indicates that a COVID-19 vaccine was furnished in the home to a Medicare fee-for-service beneficiary, to inform its proposal to maintain the in-home additional payment for COVID-19 vaccine administration under the Part B preventive vaccine benefit and to also extend it to the other three preventive vaccines included in the Part B preventive vaccine benefit – the pneumococcal, influenza, and hepatitis B vaccines. CMS' analysis shows the in-home additional payment for the COVID-19 vaccine administration is being billed significantly more frequently for beneficiaries who are harder to reach and who may be less likely to otherwise receive these preventive benefits, thereby positively impacting health equity and health care access. Given the positive results of the analysis, **ACOI asks CMS to finalize its proposal to extend the at-home vaccine administration payment to all Part B preventive vaccines, as well as its proposal to increase the in-home additional payment annually based on the increase to the MEI.**

ACOI also concurs with the AMA that CMS should consider an additional payment for an extended visit with the patient or an extended commute to the patient, and to clarify that billing for additional unexpected services at the same visit is permitted.

Finally, we believe that all vaccines, including, but not limited to, the shingles and Respiratory Syncytial Virus (RSV) vaccines, should be accessible in all settings of care.

DIABETES SERVICES

Diabetes Screening

Consistent with a recently revised recommendation by the U.S. Preventive Services Task Force (USPSTF), **ACOI supports CMS' proposal to add the Hemoglobin A1C (HbA1c) test to the types of diabetes screening tests covered by Medicare. We ask CMS to finalize its proposal, as well as its proposal to expand frequency limitations for diabetes screening to twice within a rolling 12-month period.** Diabetes affects more than 37 million Americans and disproportionately affects Black Americans and other minoritized groups.[8] As the UPSTF stated in its August 2021 USPSTF revised final recommendation, "Because HbA1c measurements do not require fasting, they are more convenient than using a fasting plasma glucose level or an oral glucose tolerance test."

[7] Medicare Vaccine Coverage and Payment. June 2021 https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch7_medpac_report_to_congress_sec.pdf

[8] American Diabetes Association. https://www.diabetes.org/about-us/statistics/about-diabetes

Coverage of HbA1c tests will ideally increase screening uptake and, therefore, improve earlier diagnosis and interventions among Medicare beneficiaries to avoid or delay diabetes-associated complications including, but not limited to, retinopathy, coronary artery disease, stroke, heart failure, and renal failure. Diabetes is also the leading risk factor of atherosclerosis, the most common cause of peripheral artery disease which puts patients at a dramatically higher risk of lower extremity amputation.

DIABETES SELF-MANAGEMENT TRAINING (DSMT) SERVICES FURNISHED BY REGISTERED DIETITIANS (RDS) AND NUTRITION PROFESSIONALS

Consistent with our support of policies that remove barriers that improve the uptake of medical management that delay or avoid medical complications associated with diabetes, **ACOI supports the proposal to increase access to DSMT telehealth services by: 1) allowing distant site DSMT practitioners to report DSMT services that are furnished via telehealth (including when performed by others within the DSMT entity); and 2) allowing the one hour of in-person initial and/or follow-up training of insulin injection training, when required for insulin-dependent beneficiaries, to be provided via telehealth.**

Merit-based Incentive Payment System (MIPS)

Physicians value meaningful quality improvement activities; however, a zero payment update and another cut to the conversion factor make it increasingly difficult for practices, especially solo and small practices, to dedicate resources to successful participation in MIPS. According to a study published in the *Journal of the American Medical Association* on the costs for physician practices to participate in MIPS, physicians, clinical staff, and administrative staff together spend 201.7 hours annually on MIPS-related activities at a per-physician, per-year cost of $12,811.[9] Furthermore, according to a survey conducted by the Medical Group Management Association, 90 percent of physician practice respondents said positive payment adjustments do not cover the costs of time and resources spent preparing for and reporting under MIPS.

ACOI is very concerned with CMS estimates, based on its proposed MIPS policies for 2024, that eligible clinicians in groups smaller than 100 clinicians are more than 60 percent likely to face a MIPS penalty in 2026. The threat of additional payment reductions (that get redistributed to larger group practices — some of which are owned by hospitals and large health systems) for unsuccessful participation in a program that is administratively burdensome and costly for small practices is fundamentally unfair.

On this basis, the ACOI recommends the following to CMS:

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[9] Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. JAMA Health Forum. 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527

- Maintain or reduce the performance threshold — currently set at 75 — rather than increase it to 82 points for the CY 2024 performance period to limit the number of physicians who receive payment penalties.

- Finalize the proposal to define the "prior period" by which CMS will establish the performance threshold as three performance periods vs. a single performance period).

- Adopt data completeness requirements for the quality category that are based on a sample of eligible patients or case minimums per measure. Maintain the data completeness criteria at 70 percent for the 2024 and 2025 performance periods.

- Finalize the proposal to score cost improvement at the category level, instead of the cost measure level.

- Allow MIPS-eligible clinicians to attest (yes/no) to the use of certified electronic health record technology.

- Continue to encourage participation in MIPS Value Pathways, including subgroup participation, voluntarily.

CONCLUSION

ACOI appreciates the opportunity to comment on the CY 2024 PFS proposed rule and issues of importance to osteopathic internists. Any questions or requests for additional information should be directed to Tim McNichol, ACOI Deputy Executive Director, at tmcnichol@acoi.org or (301) 231-8877.

Sincerely,

Joanne Kaiser-Smith, DO, FACOI
President, American College of Osteopathic Internists