September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop: C4-26-05
7500 Security Boulevard,
Baltimore, MD 21244-1850

*Electronically submitted at https://www.regulations.gov/document/CMS-2022-0113-1871*

**RE: Medicare and Medicaid Programs: Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc.**

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 2023 Medicare Physician Fee Schedule (PFS) proposed rule as published in the *Federal Register* on July 29, 2022.

The Medicare physician payment system is on an unstable path that threatens beneficiary access to care. When adjusted for inflation in practice costs, Medicare physician payment has fallen 20 percent from 2001 to 2021, and without an inflation-based update, the gap between stagnant physician payment rates and rising inflation in medical practice costs will widen.

As recognized by the Medicare's trustees in their June 2022 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 being expressed by 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-

[1] 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; June 2, 2022. https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf

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 new 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 physicians became employees of larger health organizations or other corporate entities over the three-year period between Jan. 1, 2019 and Jan. 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.

The ACOI offers comment on specific proposals contained within this rule with the aim of minimizing further financial and administrative disruption to physician practices, and advancing policies that support beneficiary access to high-quality care.

**SPLIT (OR SHARED) SERVICES**

In the CY 2022 PFS final rule, CMS finalized a policy for evaluation and management (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, or 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.

**ACOI supports CMS' proposal to delay implementation of its definition of the substantive portion as more than half of the total time until Jan. 1, 2024 and further recommends that CMS discontinue its split/shared visits policy. At a minimum, CMS should define substantive portion as medical decision-making or time.**

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. ACOI shares the position of many other medical societies that CMS should abandon its split/shared services policy and instead introduce policies that recognize the importance of collaborative practice whereby excellent patient care relies on the expertise of

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

[3] Ibid.

several care practitioners who coalesce to provide care, leading to reduced levels of burden and more effective patient care.

ACOI asks the agency to fully consider the potential downstream consequences of its policy and to work with medical societies to advance policies that incentivize, rather than discourage, collaborative care.

## REBASING AND REVISING THE MEDICARE ECONOMIC INDEX (MEI)

ACOI agrees with CMS that the MEI cost weights need to be updated to reflect more current market conditions faced by physicians in furnishing physicians' services. We acknowledge the current 2006-based MEI relies on data collected from the American Medical Association (AMA) for self-employed physicians from the Physician Practice Information Survey (PPIS) and that the AMA has not fielded another survey since that 2006 data collection effort. **ACOI firmly believes rebasing and revising the MEI cost weights for physician fee schedule rate setting and the geographic practice cost index should not occur using the proposed sources of cost data until the AMA effort to collect practice cost data from physician practices is complete and the results of which have been considered.**

Use of 2017 data from the United States Census Bureau's Service Annual Survey (SAS) as proposed would result in significant fee schedule redistribution. Because the proposed updated MEI cost weights would shift payment weights from physician work to practice expense, internal medicine would experience a decrease of 2 percent while they continue to face uncertainty about the Medicare conversion factor.

ACOI wishes to underscore comments to CMS from the AMA Relative Update Committee (RUC) concerning the exclusion in CMS' analysis of roughly 36 percent of physicians employed in other health care settings, such as hospitals. Hospital-based physicians have a higher proportion of physician earnings and medical liability (PLI) cost relative to other practice costs, because many of the other costs are the responsibility of the hospital or other facility. Consequently, the CMS proposal greatly under-represents the cost share of physician work and PLI relative to practice expense due to this exclusion.

ACOI appreciates CMS will not implement its proposed updated MEI cost weights for 2023 and is soliciting comment on its proposal. We urge CMS to not finalize its proposal.

## PAYMENT FOR MEDICARE TELEHEALTH SERVICES

ACOI is disappointed CMS did not propose to keep the telephone E/M service codes 99441-99443 on the Medicare Telehealth Services List on a Category 3 basis beyond the 151 days following the end of the COVID-19 public health emergency.

According to data released by the Department of Health and Human Services (HHS) in February 2022,[4] the majority of adults 65 or older with a recent telehealth visit used audio-only.

[4] 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

According to the report, these findings were consistent with a recent 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 2023 to allow for further evaluation of data that may support their permanent addition to the Medicare telehealth services list on a Category 1 or Category 2 basis.**

**CHRONIC PAIN MANAGEMENT (CPM)**

ACOI agrees with stakeholders that have previously commented that beneficiaries with complex chronic pain conditions may require a lot of time for correct dosing of medications and counseling, and that such time is not captured effectively using exiting E/M codes. As such, **ACOI supports CMS' proposal to create separate coding and payment for CPM services beginning next year.** The establishment of a new monthly bundled payment for management of patients with chronic pain will better ensure the resources involved in furnishing CPM services to beneficiaries with chronic pain are appropriately recognized. ACOI further recommends broadening the types of pain care for which the new monthly codes may be used so they do not exclusively apply to pain that has persisted for at least three months. **GYYY1 and GYYY2 should also be used for treatment of acute pain and palliative care services.**

For 2023, CMS proposes new monthly bundled payments for management of patients with chronic pain, identified as codes GYYY1 and GYYY2. The first of these codes is defined as:

> *Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community-based care), as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes*

*personally provided by physician or other qualified health care professional, per calendar month.*

The second code would apply to up to three units of an additional 15 minutes of chronic pain management per month. CMS proposes to define chronic pain as pain lasting more than three months.

**In response to CMS' request for feedback on the inclusion of "administration of a validated pain assessment rating scale or tool," ACOI recommends the use of such a tool be at the discretion of the physician, rather than required.** Physicians, especially those trained in osteopathic medicine, are focused on listening to their patients, not working through a checklist.

ACOI appreciates that CMS is interested in hearing from stakeholders on how the initial patient should be conducted, including whether visits could be conducted in-person or via telehealth. **ACOI suggests that, at a minimum, telehealth should be permitted for follow-up visits.**

F**inally, ACOI supports CMS proposal to permit billing by another practitioner after HCPCS code GYYY1 has already been billed in the same calendar month by a different practitioner.** We agree with CMS there could be instances where care of an individual with chronic pain is transferred to a pain specialist or other specialist during the same month they received the CPM services from a primary care practitioner, for ongoing care.

## IMMUNIZATION ADMINISTRATION AND PART B PAYMENT FOR PREVENTIVE VACCINE ADMINISTRATION SERVICES

**ACOI supports CMS' proposal to adopt the AMA RUC's recommended work RVUs and direct practice expense inputs for vaccine administration services (CPT codes 90460, 90461, 90471, 90472, 90473, and 90474).**

Medicare beneficiaries have a higher disease burden than the general population. As highlighted by the Medicare Payment Advisory Commission in its June 2021 report,[5] recommended vaccines may be more likely to improve quality of life and prevent hospitalizations and medical costs for Medicare beneficiaries than for other individuals. Ensuring that costs of administering these preventive vaccines are adequately reimbursed is a straightforward step toward improving the take-up rates of preventive vaccines by Medicare beneficiaries and closing the gap in preventive vaccination among racial and ethnic minorities. Vaccine hesitancy and medical mistrust are among the barriers to improving preventive vaccination rates among Black adults and other racial and ethnic minorities. Overcoming these barriers oftentimes requires added consultation by the physician, which should be adequately reimbursed.

**Specific to influenza, pneumococcal, and hepatitis B vaccines, ACOI supports geographically adjusting preventive vaccine administration services annually, as well as updating the payment amount (set at $30) based upon the annual increase to the MEI.** We

[5] 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

agree with CMS these changes will better account for the costs of administering preventive vaccines and reflect cost differences for each geographic locality. We also agree with aligning administration of the COVID-19 vaccines with the payment rate for the administration of other Part B preventive vaccines after the COVID-19 public health emergency ends.

**MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)**

Physicians value meaningful quality improvement activities; however, a tight labor market — coupled with higher costs due to inflation, a zero payment update and a cut to the conversion factor — make it increasingly impractical for practices, especially solo and small practices, to dedicate resources to participation in MIPS. The economics simply do not work in the favor of physician practices.

Even CMS' own estimates describe the limited return on investment for practices that successfully participate in MIPS, and the struggle for MIPS-eligible clinicians in solo and small practices to understand and meet program requirements.

According to CMS and based on its proposed policies, the average positive payment adjustment among engaged clinicians is estimated to be 2.49 percent and the average negative payment adjustment among engaged clinicians to be -1.64 percent. CMS notes that a large proportion of those eligible clinicians who are non-engaged, or not submitting data to MIPS, are clinicians in small practices. Among those who CMS estimates would not engage with MIPS, 79.8 percent are in small practices (16,614 out of 20,810 clinicians).

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

- Apply the automatic Extreme and Uncontrollable Circumstances Hardship Exception for the 2022 MIPS performance period.

- Work with Congress to extend the $500 million exceptional performance bonus, the last year for which it is available is the 2024 payment year.

- Reduce the performance threshold — currently set at 75 — to reduce the number of physicians who receive payment penalties.

- Adopt data completeness requirements for the quality category that are based on a sample of eligible patients or case minimums per measure. At a minimum, ACOI supports CMS' proposal to continue the data completeness criteria at 70 percent for the 2023 performance period and opposes increasing the data completeness threshold to 75 percent beginning with the 2024 MIPS performance period.

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

- Continue to encourage participation in MIPS Value Pathways (MVPs), including subgroup participation, on a *voluntary* basis.

## CONCLUSION

ACOI appreciates the opportunity to comment on the CY 2023 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,

Robert L. DiGiovanni, DO, FACOI
President, American College of Osteopathic Internists