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September 6, 2022

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

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

Dear Administrator Chiquita Brooks-LaSure:

The Association of American Medical Colleges (the AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) 2023 Physician Fee Schedule and Quality Payment Program (QPP) proposed rule published July 29, 2022 (87 Fed. Reg. 45860). The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

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

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

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

The COVID-19 pandemic has posed enormous challenges, and the ongoing pandemic has placed tremendous stress on our entire health care system. In response teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19. We thank CMS for reducing regulatory burden and providing flexibility during the public health emergency (PHE). These flexibilities have enabled providers to be more innovative in their care of patients. We believe that it will be important to continue many of these changes, such as the expansion of telehealth and use of other communication-based technologies, beyond the public health emergency to continue providing greater access and improved care to patients.

The AAMC commends CMS for its commitment to promoting health and health care equity and expanding patient access to comprehensive care. We share CMS's goal to reduce disparities in health care and support initiatives to close the equity gap. Our members have been working to implement new strategies aimed at promoting health and health care equity. The AAMC also applauds CMS for its proposals in this rule to expand access to vital medical services, such as behavioral health services and cancer screenings, and to encourage participation in Accountable Care Organizations. These efforts will improve the health of Medicare beneficiaries and reduce costs.

While we support the direction CMS has taken on a number of issues, we also are concerned about some of the proposed policies in the rule. Among those is the significant reduction to the Medicare conversion factor in 2023. These reductions in payment would have a devastating impact on physicians and other health care professionals and the patients they treat.

¹ Data derived from The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient.

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

The following summary reflects the AAMC's comments on CMS's proposals regarding physician payment updates, telehealth payment policy, Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs), the Quality Payment Program (QPP), and requests for information (RFIs) in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Proposed Rule:

PHYSICIAN FEE SCHEDULE

- ***Payment Updates:*** Given the unprecedented challenges faced by physicians and the critical importance of patient access to health care services, the AAMC encourages CMS to support stakeholders' efforts to have Congress pass legislation that provides a 4.5% conversion factor (CF) adjustment for 2023 and waives the 4% statutory PAYGO requirement.
- ***Rebasing and Revising Medicare Economic Index (MEI):*** Given the significant impact of rebasing and revising the MEI, the AAMC recommends that CMS collaborate on an effort to collect new data to ensure that the data used for physician payment is valid and reliable and postpone any updates to the MEI weights using other practice cost data until new survey data is available for consideration.
- ***Split (or Shared) Visits:*** The AAMC supports a delay in implementing the time-based definition of substantive portion for split (or shared) visits. We urge CMS to finalize an alternative policy that would allow billing of split (or shared) visits based on who performs more than 50% of the time or who performs the key medical decision-making component of the service.
- ***Critical Care:*** The AAMC urges CMS not to require 104 minutes before CPT code 99292 is billed. This policy directly conflicts with all prior definitions and guidance associated with billing for CPT codes 99291 and 99292.
- ***"Other" Evaluation and Management Visits:*** The AAMC supports CMS's proposal to adopt the coding changes and payment rates for "Other E/M services" recommended by the Relative Value Scale Update Committee (RUC) and finalizing the policy that would allow physicians to select a visit level and document based on either medical decision-making or time.
- ***Prolonged Services:*** The AAMC urges CMS to adopt the code created by the CPT Editorial Panel (CPT code 993X0) to describe prolonged services instead of establishing these G codes (GXXX1, GXXX2, and GXXX3).
- ***2022 Consolidated Appropriations Act (CAA) Extension:*** AAMC supports the 151-day extension of the COVID-19 flexibilities provided for in the CAA, 2022 including:
 - payment for telehealth services in any geographic location including the patient's home,
 - payment for audio-only technology,

- the expanded definition of eligible providers to include physical therapists, occupational therapists, speech-language pathologists, and audiologists of telehealth services,
- payment for telehealth services provided by FQHCs and RHCs, and
- the in-person requirement delays for mental health services.

We recommend that CMS permanently implement these policies.

- ***Extension of Other Telehealth Services:*** The AAMC supports CMS's proposal to extend Telehealth Services that are not included on a Category 1, 2, or 3 basis for a period of 151 days to match flexibilities in the CAA 2022. We recommend that CMS allow providers to permanently receive payment for these services when provided by telehealth.
- ***Payment Rate for Telehealth Services:*** The AAMC urges CMS to continue to pay providers at the non-facility rate instead of the facility rate for telehealth services post-PHE.
- ***Direct Supervision:*** The AAMC recommends that CMS allow direct supervision through virtual supervision on a permanent basis.
- ***Remote Therapeutic Monitoring (RTM):*** The AAMC commends CMS for establishing four new RTM Codes. We support allowing auxiliary staff to bill GRTM1 and GRTM2 under general rather than direct supervision and allowing qualified nonphysician health care professionals to bill GRTM3 and GRTM4. AAMC opposes the 16-day monitoring requirement to bill RTM services, and we recommend that CMS allow the provider to determine the appropriate duration for monitoring based on the clinical needs of the patient.
- ***Behavioral Health Services:*** The AAMC supports CMS's proposal to create a new G Code for general behavioral health integration services performed by clinical psychologists or clinical social workers to account for monthly care integration; we support CMS's proposal to allow psychiatric diagnostic evaluation (CPT 90791) to serve as the initiating visit for the new general IBH service; and we strongly support CMS's proposal to allow licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs) and other behavioral health practitioners to provide services under general (rather than direct) supervision.
- ***Vaccine Administration Services:*** The AAMC supports CMS's proposal to continue payment for COVID-19 Vaccinations.
- ***Chronic Pain Management (CPM):*** The AAMC supports CMS's proposal to create separate coding and payment for CPM. We recommend that CMS add both the initial visit and subsequent visit CPM codes to the telehealth list and permit the use of audio-only technology for CPM.
- ***Opioid Use Disorders:*** The AAMC supports extending the COVID-19 flexibilities for the Opioid Treatment Programs (OTP), including allowing periodic assessments to be furnished via audio-only technology for patients who are receiving treatment, such as buprenorphine. We also support payment for Opioid Treatment Programs (OTP) mobile units.

MEDICARE SHARED SAVINGS PROGRAM (MSSP) ACOS

- ***Adding Advance Investment Payments (AIP) for New ACOs:*** The AAMC urges CMS to allow all new, inexperienced ACOs to receive AIP payments.

- ***Slowing the Path to Risk:*** The AAMC recommends that CMS ensure all new ACOs have a reasonable progression to risk and encourage their participation in the program.
- ***Adding a Health Equity Adjustment for Quality Scoring:*** The AAMC supports the proposal for a new health equity adjustment but recommends that CMS apply the adjustment to quality performance scoring for all ACOs to better incent the expansion of accountable care to all Medicare fee-for-service beneficiaries.
- ***Incorporating an Alternative Quality Performance Standard:*** The AAMC supports CMS's proposal to evaluate ACO quality under an alternative standard to allow greater opportunity for ACOs to share in savings.
- ***CAHPS for Merit-Based Incentive Payment System (MIPS) RFI:*** The AAMC urges CMS to thoroughly evaluate patient and provider perspectives before incorporating new questions into the patient experience survey and allow specialist groups to administer a modified version of the survey.
- ***Scaling Savings in the BASIC Track:*** The AAMC urges CMS to remove the high-low revenue standard and allow all ACOs in the BASIC Track to share in scaled savings in the ACO's first agreement period for performance years where they generate savings but fail to meet the minimum savings rate to share in maximum shared savings.
- ***Adding a Prospective Trend Factor to Financial Benchmarks:*** The AAMC recommends CMS delay adoption of a new prospective trend until there is more information about its potential impact and more discussion with stakeholders.
- ***Adjusting Benchmarks for Prior Savings:*** The AAMC supports CMS's proposal to adjust benchmarks to avoid penalizing an ACO for prior success generating savings under the program.
- ***Modifying the 3% Cap on Risk Score Growth:*** The AAMC urges CMS to increase the cap on risk adjustment in addition to finalizing its proposal to account for demographic risk score changes prior to applying the cap.

QUALITY PAYMENT PROGRAM

- ***MIPS Value Pathways (MVPs):*** The AAMC supports CMS's proposal to make MVP reporting voluntary. However, we have significant concerns with CMS's plan to sunset the traditional MIPS program in future years, making MVPs or the APM Performance Pathway (APP) performance pathway the only mechanism for participating in the Quality Payment Program. There are a number of conceptual challenges with the MVP program and sufficient time will be needed to address them before sunsetting traditional MIPS.
- ***MVPs and Large Multi-Specialty Practices:*** With the large number of distinct specialties reporting under a single tax identification number (TIN) in academic medical centers, the AAMC believes it would be very challenging to identify MVPs that would be meaningful for all specialties in the practice. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome for reporting in the MIPS program.
- ***Subgroups:*** The AAMC supports the concept of subgroup identifiers that would allow reporting and performance measurement at the subgroup level. The physician practice should be allowed to identify and provide a list to CMS of the eligible clinicians within a subgroup.

- **Subgroup Scoring:** To obtain more meaningful performance information, the AAMC recommends that CMS explore solutions to enable subgroup reporting across all measures and performance categories in the future. CMS should work with physician organizations and MVP developers to test new and innovative cost measures that are clinically appropriate for the MVP.
- **Advanced Alternative Payment Model (AAPM) 5% bonus:** The AAMC urges CMS to include in its legislative agenda support for the continuation of the AAPM 5% bonus (e.g., support for legislation, such as the Value in Health Care Act (H.R. 4587)). If Congress does not act to extend the bonus, we urge CMS to take administrative actions within its authority that would mitigate the effects of the 5% bonus loss.
- **Advanced Alternative Payment Models (QP thresholds):** The AAMC recommends CMS support any Congressional efforts that would give the Agency the discretion to set the thresholds to be qualified participants in an advanced APM at an appropriate level to encourage AAPM participation.
- **MIPS Quality Performance Category:** The AAMC supports the adoption of the proposed health equity screening measure with modifications and recommends that CMS not increase the data completeness threshold and provide a gradual transition away from the use of the Web Interface reporting option to give practices sufficient time to implement a new reporting method.
- **MIPS Cost Performance Category:** Given the multiple concerns under the cost performance category, including the impact of COVID-19 on patterns of care, clinicians' lack of familiarity with cost measures, the need for risk adjustment, and the need for better attribution methodologies, the AAMC strongly urges CMS to weigh the cost category at 20% or less.
- **MIPS Improvement Activities Category:** The AAMC supports the proposed adoption of new optional activities that clinicians may choose to report for traditional MIPS scoring.
- **MIPS Promoting Interoperability Category:** The AAMC urges CMS to maintain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure and supports providing a 10-point bonus if reported, and the yes/no attestation instead of numerator/denominator for this measure. While the AAMC supports CMS's proposal for eligible clinicians to submit their level of active engagement under the Public Health and Clinical Data Exchange Objective, we urge CMS not to finalize its proposal to require that the eligible clinicians progress to option 2 (validated data production) after one year.
- **Risk Adjustment:** As appropriate, the AAMC recommends CMS risk-adjust outcome measures, population-based measures, and cost measures for clinical complexity and sociodemographic factors.
- **MIPS Quality Performance Category & APM Performance Pathway Health Equity RFIs:** The AAMC recommends CMS consider equity measures that can inform not only patients and clinicians, but also drive improvement towards addressing health-related social needs. If potential measures are not intended for comparison, CMS should consider making them pay-for-reporting rather than score them as pay-for-performance measures.

PHYSICIAN FEE SCHEDULE

PAYMENT UPDATES

Update to the Physician Fee Schedule Conversion Factor for 2023

CMS Should Work with Congress to Increase the Conversion Factor

In the proposed rule, CMS sets forth the dollar conversion factor that would be used to update the payment rates. For 2023, the conversion factor (CF) would be \$33.08, which is approximately a 4.5% reduction from the 2022 conversion factor. This reflects the expiration of the one-year 3% increase for services furnished in 2022 under provisions included in the Protecting Medicare and American Farmers from Sequester Cuts Act and budget neutrality adjustments.

On top of this 4.5% CF reduction, on January 1, 2023, physician practices are facing additional payment cuts from the imposition of a 4% PAYGO sequester reduction. Taken together, these cuts would result in approximately an 8.5% reduction in payment. These cuts are further compounded by the termination of the 2% sequestration moratorium in July 2022. Physicians also face a statutory freeze in annual Medicare PFS updates until 2026, when updates will resume at a rate of only 0.25%, which is well below the rate of inflation.

We are deeply concerned about the impact of these significant cuts. Payment reductions of this magnitude would pose a major problem at any time, but to impose these large cuts at a time when teaching physicians and other health care professionals are continuing to respond to multiple public health emergencies and the associated longer-term challenges, such as historic workforce shortages, will be extremely harmful. The COVID-19 pandemic has caused significant disruption to physician practices. Physician practices are still recovering from the financial impact of the ongoing COVID-19 pandemic. Continued implementation of infection control protocols has also increased the cost of providing care. Practices have had to purchase additional personal protective equipment (PPE), update cleaning protocols, maintain adequate social distancing, create physical barriers, and undertake other costly measures with increased costs due to inflation.

Even prior to the pandemic there were major concerns about physician well-being, and the pandemic only increased those concerns. Physician well-being is low due to many factors, including concerns regarding their health and safety and that of their staff and family, increased hours of care, workforce shortages, and challenges with providing care during a pandemic that requires additional procedures and protocols. Payment for services should be commensurate with services provided. An 8.5% cut in physician payment will add to the stress and is likely to trigger further retirement or reduction in physician services during a time when physicians are needed the most in their communities.

We are concerned that the additional reductions in revenue from the budget neutrality adjustments and sequester could result in significant access problems for patients. **Given these unprecedented challenges and the critical importance of patient access to health care**

services, we encourage CMS to support stakeholders' efforts urging Congress to pass legislation that provides a 4.5% CF adjustment for 2023 and waives the 4% statutory PAYGO requirement. We also urge CMS to support legislation that would provide a one-year inflationary update based on the Medicare Economic Index (MEI). This would help to ensure that physicians and other health care providers can continue to provide high quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Looking ahead, we believe that there are ongoing structural problems with the Medicare Physician Fee Schedule that need to be addressed by Congress. Medicare provider payments have been constrained for many years by the budget neutrality system. The updates to the conversion factor have not kept up with inflation, while the cost of running a medical practice has increased significantly. The budget neutrality requirement has led to arbitrary reductions in reimbursement. **We would welcome an opportunity to work collaboratively with CMS, Congress, and other stakeholders to address these long-term challenges in the future.**

Rebasing and Revising the Medicare Economic Index

CMS proposes to rebase and revise the Medicare Economic Index weights for the different cost components of the MEI to reflect more current market conditions but delay its implementation for use in PFS rate setting and the proposed 2023 geographic practice cost indices (GPCIs). The current MEI weights are based primarily on results from the AMA's Physician Practice Information (PPI) survey, which is based on 2006 data. CMS proposes to use data from the Census Bureau's 2017 Service Annual Survey (SAS) as the primary source for the new weights and to supplement the SAS data with other sources when SAS does not provide the necessary detail.

The MEI is used to proportion the components of the resource- based relative value scale (RBRVS) between work, practice expense, and professional liability insurance and to update the GPCIs. CMS states the current and proposed proportions of payment would be as follows based on the updated MEI: physician work (current =50.9%; proposed =47.3%); Practice Expense (current =44.8%; proposed =51.3%); and malpractice (current =4.3%; proposed=1.4%). CMS details the specialty-specific impact of implementing the proposed and revised MEI in physician fee schedule rate setting through a 4- year transition and through immediate implementation. Specifically, the change would harm physician specialties that have higher work relative values and/or lower practice costs (e.g., cardiothoracic surgery, neurosurgery, emergency medicine), with significant overall Medicare payment reductions, while providing increases to specialties with higher practice expense costs (e.g., diagnostic testing facilities). In addition to the specialty redistribution, the changes in the MEI would also result in a geographic redistribution. CMS proposes to modify weights of the expense categories (employee compensation, office rent, purchases services and equipment/supplies/other) within the practice expense GPCI.

Given the significance of these impacts, CMS states that it will not rebase and revise the MEI cost share weights in 2023 and instead seeks public comment on the proposed changes. The

AAMC recognizes that the data currently utilized for the MEI is outdated and that there is a need to update this data. However, the AAMC has serious concerns with the proposal to use the 2017 SAS data from the “Offices of Physicians” industry, which was not designed for the purpose of updating the MEI. As a result, there are key areas, including physician work, nonphysician compensation, and medical supplies, where CMS must use data from other sources. There are several flaws in using this data. For example, 7% of the revenue for the “Offices of Physicians” on the 2017 SAS was from non-patient care sources, such as grants and investment income. Also, CMS used Bureau of Labor Statistics (BLS) data to split out the US Census SAS data using North American Industry Classification System (NAICS) 6211 “Offices of Physicians” category. This is problematic, since it excludes 36% of physicians who are employed in other health care settings, such as hospitals. For example, the “General Medical and Surgical Hospitals” category, which includes 158,880 employed physicians, was not included. Due to this exclusion, the CMS proposal would greatly underrepresent the cost share of physician work and professional liability insurance (PLI) relative to practice expense.

The American Medical Association (AMA) is currently working with Mathematica to develop a methodology to survey financial experts at physician practices to collect practice cost data at the specialty level and plans to reach out to both small physician practices and large health systems for data collection. This new data collection effort is expected to begin in 2023 and will be based on 2022 data. **Given the significant impact of rebasing and revising the MEI, we recommend that CMS collaborate with the AMA and other physician organizations on this extensive effort to collect new data to ensure that the data used for physician payment is valid and reliable and postpone any updates to the MEI weights using other practice cost data until this new survey data is available for consideration.**

SPLIT/SHARED VISITS

CMS proposes a one-year delay of its policy that for a split (or shared) visit the physician or nonphysician practitioner (NPP) who performs the “substantive portion” (which would be defined as more than 50 percent of the total time of the visit) would bill for the service. A split or shared visit refers to an E/M visit performed by both a physician and a non-physician practitioner (NPP) in the same group practice in the facility setting where “incident to” billing is not available. Under this proposal through calendar year 2023, physicians could continue to bill split or shared visits based on the current definition of “substantive portion” as one of the following: history, exam, medical decision-making, or more than half of total time.

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

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

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

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

In the 2022 MPFS final rule, CMS justified its decision that the practitioner responsible for more than half of the time should bill for the visit, by stating that "no key or critical portion of MDM is identified by CPT. Therefore, we do not see how MDM (or its critical portion, or other component part) can be attributed to only one of the practitioners." The AAMC believes that this

concern can be addressed through the use of attestations and documentation. For example, CMS could require that the physician or NPP attest in the medical record that he/she performed all aspects of the medical decision-making for the service as follows:

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

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

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

CRITICAL CARE CODES

In the 2022 PFS, CMS finalized a number of billing policies for critical care CPT codes 99291 and 99292. In the CY 2022 PFS Final Rule, CMS stated, “Similar to our proposal for split (shared) prolonged visits, the billing practitioner would first report CPT code 99291, and, if, 75 or more cumulative total minutes were spent providing critical care, the billing practitioner could report one or more units of CPT code 99292.” In this proposed 2023 rulemaking, CMS states that it made an error in last year’s rule regarding the total minutes required to report CPT code 99292. CMS states that CPT code 99292 (subsequent critical care) could be billed if 104 (not 75) or more cumulative total minutes were spent providing critical care. Specifically, CMS states that its policy is that CPT code 99291 is reportable for the first 30-74 minutes of critical care services and CPT code 99292 is reportable for additional 30-minute time increments furnished to the same patient (74 +30 =104 minutes). CMS clarifies that this policy is the same for critical care whether the patient is receiving care from one physician, multiple practitioners in the same group and specialty who are providing concurrent care, or physicians and NPPs who are billing critical care as a split (or shared) visit.

We urge CMS not to require 104 minutes before CPT code 99292 is billed. This policy directly conflicts with all prior definitions and guidance associated with billing for CPT codes 99291 and 99292. It is a significant policy change and would inappropriately result in a severe cut to Medicare payment for critical care services.

The American Medical Association (AMA), which is responsible for developing the CPT code set, has guidance that clearly states that CPT code 99291 is reported for the first 74 minutes of time and additional 30-minute increments are to be billed starting at minute 75 using CPT code 99291.

The table below includes the CPT guidelines published by the AMA, which have remained consistent over many years, regarding billing for critical care services.

Table 1. Reporting Critical Care & Appropriate E/M Codes

Total Duration of Critical Care	Codes
less than 30 minutes	appropriate E/M codes
30-74 minutes (30 minutes - 1 hr. 14 min.)	99291 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99291 X 1 AND 99292 X 1
105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.)	99291 X 1 AND 99292 X 2
135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.)	99291 X 1 AND 99292 X 3
165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.)	99291 X 1 AND 99292 X 4
195 minutes or longer (3 hr. 15 min. - etc.)	99291 and 99292 as appropriate (see illustrated reporting examples above)

This proposal is inconsistent with how most other time-based codes are used in the CPT code set. There are many instances in the CPT code set in which time-based codes have an implied range, without expressly listing the range in the code descriptor. As shown above, the discrete time reporting thresholds are provided in a Table in the CPT code guidelines. These critical care time reporting rules were in place when CMS and the RUC last reviewed CPT codes 99291 and 99292, and therefore the values are based on this guidance. This change would inappropriately modify the relativity between critical care and the values for all other E/M services.

Over the years, the Medicare Administrative Contractors (MACs)² have issued the same guidance regarding billing for these services to providers, and the Office of Inspector General and other auditors have followed this guidance when performing audits. We are deeply concerned that this new interpretation from CMS exposes physicians and health care facilities to erroneous allegations of false billing that they will have to defend. **Therefore, we request that CMS rescind this “technical correction,” which is erroneous and contradicts years of CMS regulations, guidance, and billing practices.**

EVALUATION AND MANAGEMENT CODES (E/M)

Effective January 1, 2021, CMS adopted revised office/outpatient E/M codes, relative value units, and changes in documentation requirements. For 2023, the CPT Editorial Panel has revised

²See Guidelines for Use of Critical Care Codes (CPT codes 99291 and 99292), available at: <https://www.cmsmedicare.com/partb/pubs/news/2020/05/cope17364.html>

the remaining E/M visit code families (referred to as “Other E/M” visits) to align with the framework adopted by the CPT Editorial Panel for office/outpatient E/M visits. “Other E/M” visits include inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive assessments and care planning, but excludes critical care services. CMS proposes to consolidate inpatient and observation care into a single code set, and to consolidate home and domiciliaries into a single home or residence-based services code set. Similar to the outpatient/office E/M codes, total practitioner time (including qualifying activities by the physician or non-physician practitioner/NPP) or medical decision-making (MDM) would be used to select the E/M visit level, and history and physical exam would no longer be used to determine visit level.

We commend CMS for listening to concerns and engaging with stakeholders over the past several years to refine the payment and coding approach for E/M visits. **The AAMC supports CMS’s proposal to adopt the coding changes and payment rates for “Other E/M services” recommended by the RUC.** These changes would help to ensure that payment more accurately reflects the resources used to provide services and to protect patient access.

The AAMC supports finalizing the policy that would allow physicians to select a visit level and document based on either medical decision-making or time, and the adoption of the new medical decision-making framework for these codes. Allowing physicians to document based on medical decision-making or time would lead to improved patient care, and better align with current medical practice and the use of electronic medical records.

CMS includes an impact analysis of the E/M relative value changes, changes to the clinical labor updates, and other proposed changes in Table 138 in the rule. The impact analysis shows that the changes to the RVUs for the “Other E/M” codes would result in payment shifts across specialties in order to maintain budget neutrality. While we support the changes to the RVUs for the E/M services, we are concerned about the redistributive impacts on specialties. Significant reductions in payment to some specialties could reduce access to medically necessary services and exacerbate workforce shortages. The reductions would be very difficult for some specialties to absorb in their practices. As stated previously in this letter, we urge CMS to work with stakeholders and Congress to develop a new framework for physician payment that does not mandate budget neutrality.

Prolonged Services

CMS proposes to create HCPCS G codes (GXXX1, GXXX2, and GXXX3) for each family of services to describe prolonged services (inpatient/observation services, nursing facility visits, and home or residence visits). For 2023, the CPT Editorial Panel created CPT code 993X0 for prolonged inpatient or observation E/M service(s) time) that is “15 minutes beyond the time required to report the highest-level primary service.” CMS proposes not to adopt CPT code 993X0.

CMS proposes that the G codes would describe the prolonged services for each additional 15 minutes and can only be applied to the highest-level E/M visit codes (e.g., for hospital/

observation CPT codes 99223, 99233, and 99236). CMS also proposes that these G codes would only be billed after an additional 15 minutes of services are provided beyond the total time (as established by the Physician Time File) for the “Other” E/M CPT codes.

We urge CMS to adopt the code created by the CPT Editorial Panel (CPT code 993X0) to describe prolonged services instead of establishing these G codes (GXXX1, GXXX2, and GXXX3). It will be very confusing and administratively complex for physicians to determine when they are able to bill for these prolonged service codes. This is counter to all the work that has been done over the last few years to reduce administrative complexity. First, physicians would be required to bill two different prolonged service codes, depending on whether the payer is Medicare or a private payer. Second, most physicians do not routinely check the physician time files, which are imbedded in a separate table in CMS rulemaking, to determine the time associated with specific CPT codes as instructed by CMS. Billing for prolonged services has never been based on the total time in the CMS time file. In addition, it is unclear as to whether the prolonged service time is only the time on the date of the encounter or over the whole service. It is much simpler to reference the time ranges in the CPT codes themselves.

In addition, we believe that this approach and the value of 0.61 work RVUs that CMS assigns to these G codes, inappropriately modifies the relativity between the prolonged visit codes and other services under the PFS. **Given the confusion that this would cause, we urge CMS not to implement this policy and to work with the CPT/RUC E/M Workgroup to address any concerns regarding CPT code 993X0 to align CMS and CPT prolonged services policies.**

Soliciting Public Comment on Strategies for Improving Global Surgical Package Valuation

CMS is seeking public comment on strategies to improve the accuracy of payment for global surgical packages under the PFS. CMS notes that in the past decade it has engaged with interested parties regarding concerns about the accuracy and validity of the valuation of global packages, with particular attention paid to the E/M visits to include in the services. CMS seeks comment on ideas for other sources of data that would help it to assess global package valuation, including the typical number and level of services. CMS is also interested in hearing about whether changes to health care delivery, including changes in coordination of care and use of medical technology have impacted the number and level of postoperative E/M visits. CMS also seeks comments regarding the impact of the E/M changes on global services.

In 2021, CMS made significant changes to the E/M outpatient office visit codes and their associated relative value units. In this rulemaking, CMS proposes changes to the “Other” E/M visits codes, including inpatient hospital, observation, nursing facility, and emergency departments. Yet, CMS did not adjust the global surgical package values to reflect the new updated office visit values. Similarly, CMS does not propose to make any updates to the global surgical packages to reflect the changes to the “Other” E/M services. **We recommend that CMS adjust the global period to reflect the new E/M values.**

REQUEST FOR INFORMATION: MEDICARE POTENTIALLY UNDERUTILIZED SERVICES

CMS invites stakeholder feedback and solicits comments regarding ways to identify and improve access to high value, potentially underutilized services by Medicare beneficiaries. CMS also seeks comments on ways to recognize possible barriers to improved access to high value services and how they might best mitigate some of the obstacles to care. Specifically, CMS invites the public to submit information about specific obstacles to accessing these services and how specific potential policy, payment, or procedural changes could reduce possible obstacles and facilitate better access to high value health services.

Interprofessional Consults

Remove Barriers to the Use of Provider-to-Provider Telehealth Modalities (Interprofessional Consults)

The use of provider-to-provider telehealth modalities and peer-mentored care is a way to improve access to care and extend the expertise of the primary care workforce. However, these services have been underutilized due to obstacles related to payment policies, particularly related to CPT codes 99451 and 99452.

By way of background, the AAMC has partnered with over 40 academic medical centers through Project CORE (Coordinating Optimal Referral Experiences) to pilot technology-enabled interprofessional consults (“eConsults”) and continues to engage new health systems and other health care organizations, including payers, interested in implementing and scaling this high value service. In the CORE model, eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist’s guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs. The evaluation of CORE through the CMMI Health Care Innovation Award (HCIA) project found that eConsults enabled timelier access to specialty input, led to a decrease in utilization of specialty services and costs, and resulted in positive patient and provider experience. eConsults can play a role, too, in helping to enable health care equity and removing some of the traditional barriers to access to specialty care that many patients face. When a specialty visit is averted with an eConsult, there are direct time and costs savings to patients who don’t have to pay for an additional specialty visit and associated costs, take time away from work and seek childcare, and incur transportation and parking costs. During the COVID-19 pandemic, eConsults played an important role in enabling specialty input for PCPs and their patients, particularly at the onset of the pandemic when clinics closed. eConsults enabled timely specialty input, reduced the risk of transmission and exposure for patients and providers, and reduced the need for PPE when patients could be managed without an in-person visit.

In 2019 CMS announced that it would allow coverage for two new CPT codes (99451 and 99452) created by the CPT Editorial Panel that describe consultative services (e.g., e-consults) between providers: These codes are:

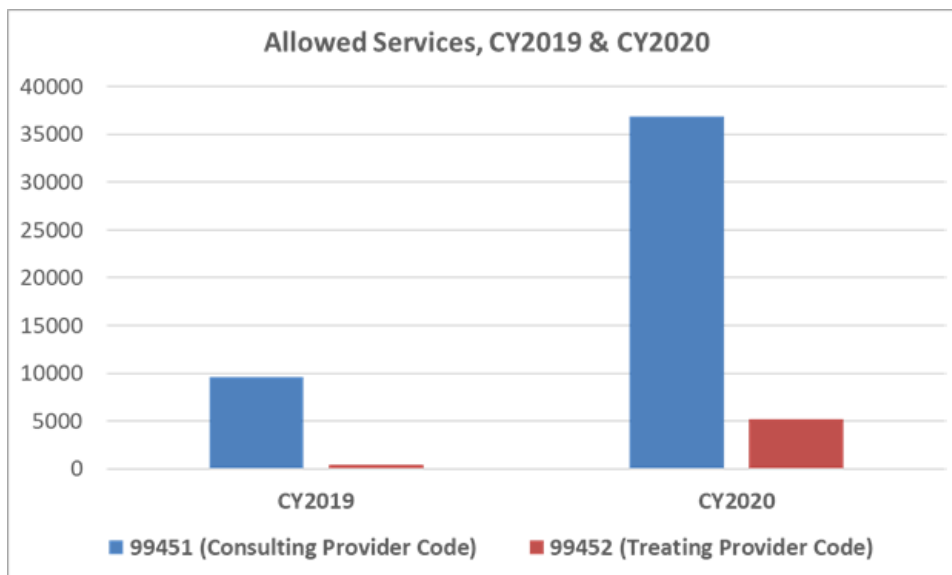
- *CPT code 99452 Interprofessional telephone/ Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes*
- *CPT code 99451 Interprofessional telephone/Internet/electronic health record assessment and management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

CMS requires that providers collect coinsurance from their patients when billing for CPT codes 99451 and 99452. While the AAMC understands that CMS may not have the authority to waive coinsurance for CPT codes 99451 and 99452 under the Medicare fee-for-service program, we remain concerned that the coinsurance requirement is a barrier to providing these important services for several reasons. First, given the structure of two distinct codes, patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider (99452), and one for the consulting provider (99451). While we believe that it is appropriate to reimburse both providers for their work in conducting the internet interprofessional consultation, two coinsurance charges to the patient for what they perceive is a single service would predictably induce confusion. Interprofessional consults are often used for patients with new problems who are not established within the consulting specialty's practice and therefore do not have an existing relationship with the consultant. A coinsurance bill for a service delivered from a provider that is unknown to the beneficiary could cause the patient to believe a billing error has occurred. This would place an undue burden on the practice's billing staff to address questions about billing. Additionally, if presented with the option of an interprofessional consult coinsurance payment versus a visit coinsurance payment, patients may elect to see the specialist in-person, which would be unnecessary and negatively impact the potential savings of these interprofessional consults.

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

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

Since 2019, Medicare claims data has shown that the time barriers to billing the treating provider (99452) code are limiting potential use by PCPs (and consequently use by specialty consultants, too). The charts below show the discrepancies in billing of CPT codes 99451 and 99452 in CY2019 and CY2020. For interprofessional consults to reach their full scale and impact, payment policies need to support the high value use of these codes by both the treating and consulting providers.



Source: *Evaluation and Management Codes by Specialty; Medicare FFS Part B E&M Data for 99451, 99452*

Remote Physiologic Monitoring

Eliminate Barriers to Use of Remote Physiologic Monitoring

Remote physiologic monitoring (RPM) involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. It allows patients to be monitored remotely while in their homes, and for providers to track patients' physiologic parameters (e.g., weight, blood pressure, glucose) and implement changes to treatment as appropriate. Physicians and practitioners may provide RPM services (CPT codes 99453,99454,99091,99457,99458) for patients with acute and chronic conditions.

Health care providers and their patients can experience many benefits from the use of RPM, including reduced readmissions, shortened hospital stays, improvements in quality of life, and lower costs. The continuous monitoring of RPM services is beneficial in academic medicine whose physicians serve patients who are often sicker than the average patient and from low social-economic backgrounds. These services allow physicians to track their patients' health metrics without requiring multiple in-person visits from patients whose schedules cannot accommodate greater time commitments. Despite these benefits, these services have been underutilized, in part, due to payment policies.

One of the barriers to their use is the requirement that to bill for the initial set-up and continued monitoring, monitoring must occur during at least 16 days of a 30-day period. Expenses associated with configuring systems to capture necessary documentation and the actual clinician time spent documenting time spent per calendar month greatly outweigh Medicare reimbursement for these services. The 16-day requirement prevents providers from using these codes when clinical indications are that the patient would require less than 16 days of monitoring. Additionally, the 16-day minimum threshold for transmitted physiologic data per 30 days undermines the value of time spent coordinating care and delivering needed services to patients who require monitoring less than 16 days in a 30-day period. Allowing fewer than 16 days of data transmission by a patient in a given month would greatly increase access to care and promote high value use. One option could also be to develop HCPCS or CPT codes for shorter time periods.

The AAMC also supports changing the rules to allow patients to manually enter their physiologic readings by a device into a platform for remote transmission. We ask CMS to consider additional flexibilities for patient reported home data codes (i.e., 99474), where the amount and frequency of data required to bill the code far exceeds the minimum amount to make clinically appropriate decisions and has greatly reduced the use of these value-oriented services. This would allow physicians to collect additional information that requires self-reporting data, such as pain, appetite, and other subjective metrics which could be beneficial when managing the patient's care. Self-reported codes are particularly important as they help patients overcome key digital equity barriers. Finally, these flexibilities also should apply to remote therapeutic monitoring

(RTM) codes and we ask CMS to consider removal of similar stringent data requirements for RTM.

MEDICARE TELEHEALTH AND COMMUNICATION TECHNOLOGY-BASED SERVICES

The AAMC appreciates the work that CMS has done to provide important flexibilities around telehealth during the COVID-19 public health emergency (PHE). The AAMC strongly supports the telehealth waivers and regulatory changes established by CMS in response to the PHE that have facilitated the widespread use of telehealth and other communication technology-based services that have improved access to health care. For the 2023 Physician Fee Schedule, we strongly support CMS's proposal to implement provisions in the CAA 2022 to ensure patients can continue to have access to telehealth services for 151 days beyond the PHE.

CAA 2022 COVID-19 Flexibilities Extension

AAMC Supports the 151-day Extension of the COVID-19 Flexibilities Provided for in the CAA 2022; We Strongly Recommend that CMS Permanently Implement these Policies

AAMC supports the 151-day extension of payment for telehealth services in any geographic location including the patient's home. We urge CMS to work with Congress to permanently waive the geographic site requirements. The AAMC strongly supports changes made in the CMS interim final rules related to the PHE that waived patient location restrictions that applied to telehealth services. Under this change, during the PHE, CMS pays for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home. This has allowed patients to remain in their home, reducing their exposure to COVID-19 and reducing the risk that they expose another patient or their physician. It also means that patients who find travel to an in-person appointment challenging can receive care, which may be particularly important to patients with chronic conditions or disabilities who need regular monitoring. It also helps those who, because of their job, lack of care for dependents, transportation issues, and other limitations, find it difficult to attend an in-person visit to receive care. The AAMC acknowledges that CMS does not have the authority to make permanent the changes related to geographic locations and originating sites. **We encourage CMS to work with Congress to permanently eliminate the geographic site requirements and allow the home to be an originating site. AAMC strongly supports the 151-day extension of payment for audio-only services, and strongly recommends CMS permanently allow payment for audio-only/telephone-only evaluation & management codes.** The AAMC commends CMS for extending payment for audio-only technology for 151 days and permanently allowing payment for audio-only technology for mental health services. However, we strongly believe that payment for Audio-only/Telephone-only E/M Codes should be permanently extended. In the March 31st COVID-19 IFC, CMS established separate payment for audio-only E/M services, CPT codes 99441-99443. CMS recognized these services as telehealth services and added them to the Medicare telehealth

list for the duration of the PHE. CMS will not allow payment for these codes under the PFS after the 151 days following the end of the PHE.

Eliminating coverage for these important audio-only services will result in inequities in access to services for specific populations. Coverage of these audio-only services is particularly important for Medicare beneficiaries who may not have access to, or may not feel comfortable with, interactive audio/video technologies. Reports suggest that lack of video services or discomfort regarding the use of video may particularly affect certain populations some of whom have high-risk and chronic conditions, including the older adults, those with low socioeconomic status, those in rural communities, and certain races and ethnicities. Data from the Clinical Practice Solutions Center (CPSC),³ which contains claims data from 90 physician faculty practices, shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient, with 17% of visits delivered via audio-only interaction for patients 41-60 years of age, 30% for patients 61-80 years of age, and 47% of visits for patients over 81. CMS also released data showing that nearly one third of Medicare beneficiaries received telehealth by audio only telephone technology.^{4, 5} This demonstrates the importance of continuing to allow equitable coverage and payment for telephone services to Medicare beneficiaries.

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

Finally, we note and applaud TRICARE and the Defense Health Agency's updated regulations to cover audio-only services after the end of the PHE. Modifications to 32 CFR 199.4(c)(1)(iii) Telehealth Services added coverage for medically necessary telephonic office visits in all geographic areas where TRICARE beneficiaries reside. Medicare beneficiaries also should have access to this tool when clinically appropriate or when video-based telehealth is not feasible for an individual patient.

AAMC supports the 151-day delay of the in-person requirement for mental health services and recommends that the in-person visit requirement for mental health services be eliminated permanently. AAMC commends CMS for providing coverage and payment of telehealth for mental health services. In previous rulemaking, CMS implemented provisions in the Consolidated Appropriations Act, 2021 (CAA) that removed geographic restrictions and permitted the home to be an originating site for telehealth services for the treatment of mental

³ The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.

⁴ HHS ASPE Issue Brief: [Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic](#) (July 27, 2020).

⁵ Seema Verma, [Health Affairs Blog: Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19](#). (July 15, 2020)

health disorders, as long as the practitioner furnishes an initial in-person visit 6 months prior to the first telehealth visit and then every 12 months thereafter. During the PHE, the removal of Medicare's geographic and site of service limitations for services furnished via telehealth have significantly increased access to care, particularly for behavioral telehealth services. In April 2020, at the height of the PHE, telehealth visits for psychiatry and psychology surpassed 50% of the total services. According to data from faculty practices included in the Clinical Practice Solutions Center (CPSC)⁶, the use of telehealth for mental health services remained high throughout 2020 and 2021, at roughly 50%. In addition, there has also been a reduction in missed appointments for behavioral health services because telehealth expansion has made it easier for patients to access care. This is particularly important in mental health because there is a shortage of providers.

AAMC supports the proposed 151-day delay of the 6 month in-person visit requirement before the first telehealth service; however, we believe mental health services furnished via telehealth should be permitted without requiring a prior in-person visit. While we recognize that the statute requires an initial in-person visit prior to the telehealth visit, we believe that an in-person requirement acts as a significant barrier to care for mental health services. This barrier disproportionately affects those who, because of their job, lack of others to help care for their dependents, transportation issues and other limitations, are not able to attend an in-person visit. Continuation of care is crucial for mental health services, and this in-person visit requirement may result in a lapse of care and ultimately negative clinical outcomes for patients. Furthermore, mental health services are the only type of service provided by telehealth which would require an in-person visit at a specific interval, which is arbitrary and discriminatory against this particular type of service. AAMC acknowledges that CMS does not have the authority outside of the PHE beyond the 151 days to make the changes related to the 6 month in-person requirement. We encourage CMS to work with Congress to permanently waive the 6 month in-person requirement.

AAMC supports the proposed 151-day delay for the 12 month in-person requirement; however, we strongly recommend CMS require a subsequent in-person visit only when deemed necessary by the provider. Providers are responsible for the quality of care delivered to their patients. As such, providers in partnership with their patients should be responsible for determining when, if at all, it is appropriate for the patient to have an in-person visit. At a minimum, we believe that the interval should be longer than 12 months to ensure access to care and lessen the burden on patients and providers. The 12 month in-person requirement does not seem to be medically driven and is instead being offered as a billing requirement, which conflicts with CMS's patient first objectives. The 12 month requirement will also increase wait times for those in need of an in-person visit due to workforce shortages. Furthermore, the 12 month requirement adds the additional burden of commuting to see the provider every 12 months. This

⁶ The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance.

burden will disproportionately affect those in underserved or rural areas and anyone who does not have reliable transportation.

If CMS is going to implement a 12 month subsequent in-person visit requirement for mental health services, we appreciate CMS's decision to allow exceptions for a particular 12-month period when the provider and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record. Nonetheless, even with an exception there is an unnecessary administrative burden for providers to track exceptions on an annual basis. We believe that if a patient has received appropriate, medically necessary mental health services and they wish to continue receiving care virtually, they should be able to do so.

AAMC supports the 151-day extension of the expanded definition of eligible telehealth providers to include physical therapists, occupational therapists, speech-language pathologists, and audiologists, and strongly recommends CMS permanently extend the expanded definition. The COVID-19 pandemic has contributed to the already strained workforce shortages. Addressing the workforce shortage will require a multipronged approach, including innovation in care delivery; greater use of technology; as well as improved, efficient use of all health professionals on the care team. Physical therapists, occupational therapists, speech-language pathologists, and audiologists have proven throughout the PHE that they are able to furnish care via telehealth effectively, safely, and efficiently to patients. Expanding the definition of eligible providers has resulted in increased access to care, making it obtainable to those who might not otherwise be able to receive it. Patients have come to rely on being able to obtain these services virtually. If physical therapists, occupational therapists, speech-language pathologists, or audiologists are no longer able to furnish telehealth services to patients 151 days after the end of the PHE, it will result in lapses in care that may negatively impact patient health. AAMC acknowledges that CMS does not have the authority outside of the PHE beyond the 151 days to make changes related to which providers can furnish telehealth services. We encourage CMS to work with Congress to permanently expand the definition of eligible telehealth providers.

AAMC supports the 151-day extension of payment to FQHCs and RHCs for telehealth services; however, we strongly recommend that CMS permanently allow payment for telehealth services furnished by FQHCs and RHCs. During the PHE, the CARES Act established Medicare payment for telehealth services when RHCs and FQHCs serve as the distant site. RHCs and FQHCs were able to effectively furnish telehealth services and treat patients via telehealth during the PHE and should be allowed to continue to do so. If FQHCs and RHCs are no longer able to furnish telehealth services to patients 151 days after the end of the PHE, this will limit access to care, which may negatively impact patient health. AAMC acknowledges that CMS does not have the authority outside of the PHE beyond the 151 days to make the changes related to payment of FQHCs and RHCs for telehealth services. We encourage CMS to work with Congress to permanently continue payment for telehealth services furnished by FQHCs and RHCs.

Category 3

AAMC Strongly Supports CMS's Proposed Addition of Services to the Medicare Telehealth Category 3 list

CMS's authority to add services to the telehealth list based on their similarity to other services already on the telehealth list (Category 1) or based on an assessment of whether the services would provide clinical benefit to the patient if provided by telehealth (Category 2) is not dependent on the declaration of a PHE. In 2021 CMS finalized a new Category 3 group of services which would be included on the Medicare telehealth list to allow more time to study the benefit of providing these services outside the context of the pandemic. This Category 3 provided a basis for adding or deleting services from the Medicare telehealth list on a temporary basis where there is likely clinical benefit, but where there is not yet sufficient evidence available to permanently consider the services under Category 1 or 2 criteria.

The AAMC strongly supports adding the proposed services to the telehealth Category 3 list to allow services to be billable, while the benefits are studied. The AAMC commends CMS for extending the Category 3 list of services until the end of calendar year 2023 in previous rule making. This will give providers additional time to gather more data to determine if these services can be provided safely, effectively, and efficiently via telehealth.

We strongly recommend CMS consider implementing the Category 3 list as a permanent option. In the future, CMS may identify additional services that could benefit from being studied in order to determine whether or not they should be added to the telehealth list on a permanent basis. The Category 3 list has proven to be an effective means of assessing potential telehealth services.

Other Telehealth Services

AAMC Supports CMS's Proposal to Extend Telehealth Services that are not Included on a Category 1, 2, or 3 Basis for a Period of 151 Days to Match Flexibilities in the CAA 2022; We Also Strongly Recommend that CMS Allow Providers to Permanently Receive Payment for These Services when Provided by Telehealth

The AAMC has significant concerns with the list of services that CMS is proposing to exclude from the telehealth list on a permanent basis 151 days after the end of the PHE, such as critical care services, inpatient neonatal and pediatric care services, initial nursing facility visits, and others. Providers have found these telehealth codes beneficial when providing care.

Inpatient neonatal and pediatric care services, and other critical care services have been essential in the care of more complex patients. Telehealth is increasingly being used to provide specialty consultants to infants, children, and adults receiving care in community and rural hospitals. It is often used for patients with unanticipated, urgent specialty needs, including newborn infants, and those presenting to emergency departments with acute medical emergencies. The use of this technology allows specialists to bring their skills to the bedside of the child or adult in need

when travel to the specialist could delay care for many hours. The use of telehealth in these situations has shown to be lifesaving and to reduce unnecessary patient transports⁷.

Many academic medical centers have arrangements in place to provide care via telehealth to rural or community-based hospitals that do not have pediatric or neonatal critical care specialists, or pediatric intensive care units. When critically ill infants are born, or when critically ill children are admitted to their local hospital, the local physician is able to contact the academic medical center and have a pediatric or neonatal critical care physician provide expert consultation, via telehealth, offering a diagnosis or other recommendations about care. This allows optimal care to be provided quickly, and often this means that the local hospital is able to care for the patient. This saves resources by removing the need for an expensive medical transport, and allows patients to stay in their community, close to family. While these services (CPT 99468- 99472, 99475-99476, 99477-99480) are not generally provided to Medicare beneficiaries, the AAMC is concerned that if these services were added to a list of services specifically not permitted to be billed via telehealth, other payers such as Medicaid or commercial payers, may be disinclined to provide payment for them. This could lead to negative outcomes for critical patients; therefore, we strongly encourage CMS to keep these important services on the Medicare telehealth list on a permanent basis.

Adequate evidence exists about the value of these services, particularly in rural and other communities that do not have ready access to them. Throughout the PHE, these telehealth services have been provided safely, effectively, and efficiently and have expanded access to care. As such, providers should continue to receive payment for providing these services. They have spent resources establishing effective telehealth programs in response to the PHE, and these programs have generated positive impacts for both patients and providers. Therefore, the AAMC recommends that CMS allow providers to permanently receive payment for these services when provided by telehealth, or, at a minimum, these services should be added to the Category 3 list to permit further study.

Direct Supervision

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

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

⁷ See Burke et al., [Telemedicine: Pediatric Applications](#), Pediatrics (July 2015)

care. For example, virtual supervision allows physicians to supervise APPs across multiple campuses, which increases patients' access to care.

CMS asks whether virtual supervision should be limited to a subset of services. AAMC opposes limiting virtual supervision to a subset of identified services. This policy would be very difficult to operationalize. The use of virtual supervision should be left up to the discretion of the providers. Clinical appropriateness of virtual supervision can differ situation by situation, and the provider is in the best position to make a determination regarding whether virtual supervision is appropriate.

Payment Rate for Telehealth Services

The AAMC Strongly Recommends CMS Continue to Pay Providers the Same for Telehealth Services as Services Delivered In-Person

CMS proposes, 151 days after the end of the PHE, to pay the “facility rate” instead of the “non-facility” rate for telehealth services as CMS believes that the facility payment amount “best reflects the practice expenses, both direct and indirect, involved in furnishing services via telehealth.” During the PHE, CMS has been paying the non-facility rate for telehealth services, as it recognized that the cost of furnishing these services via telehealth may not significantly differ from resource costs involved when those services are furnished in person.⁸ In its rationale in the interim final COVID-19 rulemaking, CMS stated “we expect that physician offices will continue to employ nursing staff to engage with patients during telehealth visits or to coordinate pre- or post-visit care, regardless of whether or not the visit takes place in person, as it would have outside of the PHE for the COVID-19 pandemic, or through telehealth in the context of the PHE for the COVID-19 pandemic.”⁹ The AAMC agrees with this statement.

The AAMC strongly urges CMS to permanently pay providers at the non-facility rate for telehealth services post PHE. It is important to recognize and reimburse for the infrastructure and staffing costs for telehealth care, beyond the clinicians' time and clinical expertise. For example, providers must establish a video platform that is HIPAA compliant, accessible, user-friendly, and compatible with patient-owned devices, and that integrates with EMR scheduling and enables multiple concurrent participants (e.g., learners, patients' family members). Providers must ensure that both they and their patients have sufficient internet access and bandwidth, and in some instances must supply the appropriate devices, for example webcams, headsets, smartphones, for patients and clinicians. They must establish workflows and staffing to ensure effective appointment scheduling, notifications, reminders for providers and staff, and learner supervision, as necessary. Protocols and infrastructure must be in place for managing patients' emergencies. Providers must also offer effective technology training for providers and staff, including real-time technical support for providers and patients, with contingency plans in place for when failures occur, as well as private locations where others cannot hear or see the patient during the video visit. As stated, and acknowledged previously by CMS, providers need to employ nurses,

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

⁹ *Ibid.*, at 19233.

medical assistants, and other staff to engage patients before, during, and after telehealth visits to coordinate care pre- and post-visit and ensure a seamless experience.

For telehealth to effectively enable access to care for patients and the timely and effective management of their needs, reimbursement for services must be commensurate with the costs of providing care through video visits. For many providers, telehealth will no longer be sustainable if CMS pays the facility-based practice expense rate. The discontinuation of these virtual services could have large impacts on access to care for patients. For example, many mental health providers are furnishing approximately half of their services via telehealth. Mental health providers most likely will not be able to cover costs of providing these services if they are receiving the facility-based payment rate for telehealth services. Before the PHE, providers received the facility-based payment rate, and telehealth was for the most part unavailable to patients. Returning to pre-pandemic payment policy would have a chilling effect on telehealth services. This would result in an overall decrease in access to care for Medicare patients.

In addition, we recommend CMS continue to pay the “originating site” fee to facilities as it has done during the PHE when telehealth services are provided by physicians that otherwise would have been provided in the provider-based entity.¹⁰ Similar to the physician office-based setting, the provider-based entity will continue to employ nurses, medical assistants, and other staff to engage patients during telehealth visits or to coordinate pre-or-post visit care. The provider-based entity incurs these costs associated with providing the telehealth service and should be reimbursed as if the services were provided in-person.

CMS Should Continue to Allow Payment for Telehealth Services Delivered Across State Lines

As part of the COVID-19 PHE response, CMS has allowed providers to be reimbursed by Medicare for telehealth services across state lines with permission from the individual states. This waiver creates an opportunity to improve patient access to services and to help improve continuity of care for patients that have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment, states need to act to allow practice across state lines to occur. **We urge CMS to continue this flexibility regarding payment for services and to study opportunities for national medical licensing. Until this is available, we encourage CMS to work with states to participate in interstate medical licensure compacts or other mechanisms that would allow care delivery across state lines in the future after the pandemic ends.** In addition, we urge CMS to support the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 4421, HR. 8283), which would provide temporary licensing reciprocity for health care professionals in all states for all types of services during the COVID-19 pandemic

¹⁰ See 85 Fed. Reg. 27550 (May 8, 2020), where CMS decided to pay an originating site fee to recognize the costs incurred by hospitals.

Remote Therapeutic Monitoring (RTM) Codes

AAMC Commends CMS for Establishing Four New Remote Therapeutic Monitoring (RTM) Codes

These codes are for monitoring health conditions, including musculoskeletal system status, respiratory system status, therapy (medication) adherence, and therapy (medication) response, and as such, allow non-physiologic data to be collected. We commend CMS's decision in previous rulemaking to allow RTM data to be self-reported as well as digitally uploaded. This will allow physicians to collect additional information from the patient such as pain, appetite, and other subjective metrics that could be beneficial when managing the patient's care. We urge CMS to apply the changes proposed for RPM, which include additional flexibilities for patient reported home data codes and reassessment of the reimbursement model, in terms of days and data required, to allow for program sustainability and adoption. As stated earlier, self-reported codes are particularly important as they help patients overcome key digital equity barriers.

The first two HCPCS G codes, GRTM1 and GRTM2 are billable by physicians and NPPs. These codes can be furnished by auxiliary personnel under general supervision. To further increase access to RTM services, CMS also proposed HCPCS G codes GRTM3 and GRTM4. These two codes would allow qualified nonphysician health care professionals to bill RTM Services. **We strongly support allowing auxiliary staff to bill GRTM1 and GRTM2 under general rather than direct supervision. However, we recommend that CMS clarify that the work of the auxiliary personnel would count towards the required 20 minutes necessary to bill the codes.**

The AAMC also supports allowing qualified nonphysician health care professionals such as physical therapists, occupational therapists, and speech language pathologists to bill GRTM3 and GRTM4. There is currently a shortage of health care providers. Allowing these licensed professionals to bill to GRTM3 and GRTM4 would improve access and be an effective use of RTM services.

The AAMC opposes the 16-day monitoring requirement to bill RTM services, and we strongly recommend that CMS allow the provider to determine the appropriate duration for monitoring based on the clinical needs of the patient. The 16-day requirement prevents physicians from using these codes when clinically the patient would require less than 16-days of monitoring. Allowing fewer than 16-days of data transmission by a patient in a given month would greatly increase access to care and promote high value use. As an alternative option, CMS should consider creating new RTM codes that allow for shorter time frames.

AAMC strongly supports CMS's proposal to include CPT 989X6, monitoring for cognitive behavioral therapy. We recommend that CMS establish a federal rate instead of a contracted rate to ensure equitable access to these services.

BEHAVIORAL HEALTH SERVICES

AAMC Strongly Supports CMS's Proposal to Create a New G Code for General Behavioral Health Integration Service Performed by Clinical Psychologists (CP) or Clinical Social workers (CSWs) to Account for Monthly Care Integration.

We commend CMS for recognizing the value of integrated behavioral health services and the key role that clinical psychologists and clinical social workers play in providing this care by creating a new G-code for 2023 to allow CPs and CSWs to furnish and bill for IBH when they are the patient's primary treating clinician for covered behavioral health services. Coverage and payment for their services will increase access to integrated behavioral health and benefit patients needing these services.

Integrated behavioral health (IBH) involves medical and behavioral health clinicians working as a multidisciplinary team partnering with their patients and patient families to address medical conditions and behavioral health factors that affect health and well-being. The general aim is to integrate mental/behavioral health with primary and/or specialty medical services. This multidisciplinary team can include mental health care providers with a range of training/credentials including licensed clinical social workers, licensed mental health therapists, psychologists, psychiatrists, peer support, and community health workers. These providers can function in many different roles including direct care, care coordination, providing consultation to the medical team, and through the use of different care modalities—in-person and telehealth.

IBH models help to reduce the stigma around mental health services, as patients can conveniently receive mental health care within the primary care (medical home) or specialty care clinical setting, rather than seeking out a mental health provider in another setting. This model is especially beneficial in rural settings where many patients may be reluctant to seek care in community behavioral health settings because it may be obvious in their small communities that they are receiving mental health care. This model also reduces the risk of fragmentation and improves care coordination, as medical and mental health conditions are co-managed. There is significant research that shows that this model improves mental health outcomes, patient satisfaction, and reduces health care costs. IBH models can also incorporate services for substance use disorders (SUDs). Integrated care including medication assisted treatments, and support services—hold potential to offer tangible clinical benefit in the form of reductions in substance use and marginalization and stigmatization of SUDs.

Integrated behavioral health care may also prevent emergency room overcrowding. IBH addresses the emergency department (ED) over-crowding by expanding the availability of mental/behavioral health providers within health plan networks to ensure enough providers are available to patients and that the patients receive coordinated care reducing the need for ED visits. The ED is usually not the most appropriate care site for such patients and can result in fragmentation of care. Most EDs are not equipped to develop a coordinated care plan including follow-up outpatient care, and many such patients return to the ED frequently. This can also

result in ED overcrowding and diversion of resources from cases that need emergency/urgent medical intervention.

AAMC Strongly Supports CMS’s Proposal to Allow Psychiatric Diagnostic Evaluation (CPT 90791) to Serve as the Initiating Visit for the New General IBH Service

This proposed expansion is in part because many of the existing eligible “initiating visit” codes are outside the scope of practice for clinical psychologists. Expanding codes that satisfy the “initiating visit” requirement would better enable clinical psychologists to participate in integrated behavioral health care and improve access to these services.

General Supervision

AAMC Strongly Supports CMS’s Proposal to Allow Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs) and Other Behavioral Health Practitioners to Provide Services Under General Supervision

There is currently a shortage of mental health providers. Data from the Health Resources and Services Administration shows that an estimated 122 million Americans, or 37% of the population, lived in one of 5,833 mental health professional shortage areas as of March 31, 2021, and an additional 6,398 mental health providers would be needed to fill these gaps. In many cases, providers that do offer behavioral health services do not accept insurance, which further exacerbates the shortage of available providers. Allowing licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs) and other behavioral health practitioners to provide services under general (rather than direct) supervision would increase access to behavioral health services.

VACCINE ADMINISTRATION SERVICES

AAMC supports CMS’s proposal to continue covering COVID-19 Vaccinations

The AAMC commends CMS for adding the COVID-19 vaccine and its administration to the list of preventive vaccines, including the influenza, pneumococcal, and HBV vaccines covered under Part B. Since there is no applicable beneficiary coinsurance, and the annual Part B deductible does not apply for these vaccinations or the services to administer them, inclusion on the preventive services list will help to incentivize Medicare beneficiaries to be vaccinated. The AAMC also commends CMS for establishing an add-on payment for the administration of the COVID-19 vaccine in the beneficiary’s home for beneficiaries who have difficulties getting the vaccine in other settings.

We believe the option for home vaccination will greatly improve access to the vaccine. Increasing the vaccination rate is crucial to preventing the spread of COVID-19. The AAMC is partnering with the Centers for Disease Control and Prevention (CDC) on a cooperative agreement, Improving Clinical and Public Health Outcomes through National Partnerships to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats (Award # 6

NU50CK000586-02-02). This initiative is part of the AAMC's efforts to improve health care access, collaborate with communities, and advance health equity. The cooperative agreement supports the AAMC and its member medical schools and teaching hospitals to build trust and promote confidence in COVID-19 vaccines in health care personnel and communities disproportionately impacted by the pandemic.

CHRONIC PAIN MANAGEMENT

AAMC supports CMS's proposal to create separate coding and payment for chronic pain management (CPM) services, beginning CY 2023.

The AAMC commends CMS for recognizing that the resources involved in furnishing comprehensive care to patients with multiple chronic conditions are extensive. Currently, there are no codes that reflect the work necessary to provide patients with chronic pain management care. The creation of HCPCS code GYYY1 and GYYY2 will improve patient care by allowing providers to coordinate care to ensure that a patient suffering from chronic pain receives holistic care. The proposed CPM codes may also lower costs by preventing hospital admissions and worsening of co-occurring conditions that require additional treatment, would allow providers to customize treatment based on patient needs and responses to care.

We also recommend permitting use of the CPM codes for acute pain management.

Patients with acute pain will also benefit from diagnosis, assessment and monitoring, administration of a validated pain rating scale, a person-centered treatment plan, and the other elements included in the proposed chronic pain management bundle. The CPM codes should not be limited to chronic pain.

The AAMC recommends that CMS add both the initial visit and subsequent visit CPM codes to the telehealth list. If a patient does not have access to or is unable to use audio-video technology, CMS should permit the use of audio-only technology.

Throughout the PHE, providers have proven that telehealth services can be furnished efficiently, effectively, and safely. Chronic pain management requires effective communication and sustained dialogue with patients. Telehealth has proven to be an effective tool for maintaining the patient-provider relationship. As CMS notes, according to the Institute of Medicine (IOM) blueprint, consistent involvement from the primary care provider can prevent patients who are suffering chronic pain from seeking relief from multiple providers or treatment modalities. If the care is not coordinated, it often results in fragmented, duplicative, and potentially dangerous care which leaves patients "feeling frustrated and falling into a downward spiral of disability and hopelessness." Those who suffer from chronic pain often find it difficult to travel which can prevent them from seeking the care and treatment that they need. Telehealth can bridge this gap by giving patients the ability to speak with their providers consistently about any changes in their pain or response to treatment allowing their providers to better coordinate their care.

The AAMC supports the use of and documentation of validated pain assessment tools, but we caution against CMS being overly prescriptive regarding which tools to use. We also suggest that validated pain assessment tools be used in conjunction with Patient-Reported Outcome Measures (PROMS).

The subjectivity of pain and therefore the assessment of its control makes CPM a difficult task. The use of validated pain assessment tools and PROMs will enable more objective measurement of pain and outcomes from treatment.

A validated pain assessment tool allows providers to measure the severity of the pain and track and record any changes to pain levels over a period of time. Providing a repository or list of validated pain assessment for providers would be helpful. Although valid pain assessment tools are great instruments for collecting data, other information should also be considered in assessing pain. PROMS would enable a more complete picture of the patient's condition, which should then be used to determine an appropriate care plan.

AAMC supports allowing CPM codes to be furnished by auxiliary staff under general rather than direct supervision.

There is currently a shortage of providers. Addressing the workforce shortage will require a multipronged approach, including innovation in care delivery; greater use of technology; as well as improved, efficient use of all health professionals on the care team. Many of the components of the CPM codes can safely and effectively be performed by auxiliary staff under general rather than direct supervision. For example, auxiliary staff can administer a validated pain management tool, pain and health literacy counseling, assessment, and monitoring. Allowing auxiliary staff to furnish these components with general supervision would expand access to care.

AAMC supports allowing billing by another practitioner after GYYYI has already been billed in the same calendar month by a different provider.

As CMS notes, although in most situations the CPM codes will be billed by primary care providers, if a patient's chronic pain is particularly complex, a patient may wish to see in the same month another provider who has received special training or certification.

The AAMC urges CMS to allow flexibility around the process for obtaining patient consent.

CMS proposes to require that the beneficiary's verbal consent to receive CPM services at the initiating visit be documented in the beneficiary's medical record and seeks comments on whether consent should be given at each visit, and whether it should be obtained by the practitioners with whom CPM billing practitioners coordinate other services. To promote the use of these CPM codes, the AAMC urges CMS to allow flexibility around the process for obtaining patient consent. To address the need for patient consent in a way that is practical for providers and practices, and to minimize inefficiencies and confusion for beneficiaries, we urge CMS to allow physicians to obtain blanket consent at the practice level for the CPM codes on an annual basis. Operationally, this could be a one-time annual consent per practice that is part of the practice's existing terms and conditions or general consent to care documents that patients sign

each year. Physicians should also be given flexibility around how the advance consent is obtained as many practices use a mix of approaches (e.g., through the patient portal or at sign-in at an annual visit).

We also urge CMS not to require that consent be obtained from other practitioners with whom CPM billing practitioners coordinate other services as this would be overly burdensome. It could be nearly impossible if the other practitioner does not have a direct relationship with the patient, (e.g., in the case of provider-to-provider consults). Requiring consent in these situations creates inefficiencies and could further delay patient care if consent is required before treatment.

The AAMC commends CMS’ recognition of the need to improve coverage and payment for chronic pain care. In addition to establishing new CPT codes for chronic pain management, we recommend that CMS and other federal policymakers also focus efforts on removal of payment policies that act as barriers to pain management, such as prior authorization and prohibitive cost-sharing. CMS should consider working to improve access to other non-opioid options, such as behavioral health approaches, physical therapy, and other strategies.

OPIOID USE DISORDERS

AAMC Strongly Supports Payment for Opioid Treatment Programs (OTP) Mobile Units

Effective July 28, 2021, the Drug Enforcement Administration (DEA) issued a final rule (86 FR 33861) that authorized OTPs to add a “mobile component” to their existing registration, which eliminated a requirement for mobile medication units of OTPs to have a separate registration. The AAMC is pleased that CMS recognized that OTP mobile units are a great opportunity to expand access to medications for treatment of OUD for Medicare beneficiaries by extending the reach of OTPs, particularly in remote or underserved areas and that CMS is providing the necessary payment to promote the use of mobile units.

AAMC Strongly Supports Extending the COVID-19 Flexibilities for the Opioid Treatment Programs (OTP)

The AAMC commends CMS for permanently allowing OTPs to furnish substance use counseling and individual therapy and group therapy via audio-video and audio-only telephone calls when the patient cannot access or does not consent to the use of audio-video technology. For the duration of the PHE, OTPs have also been permitted to provide periodic assessments furnished by audio-video communication technology, and through audio-only technology if the patient does not have access to audio-video technology. After the PHE, CMS will continue to allow the periodic assessment to be performed via audio-video technology, but providers will not be able to use audio-only technology.

The AAMC recommends allowing periodic assessments via audio-only technology in OTP for patients who are receiving treatment such as buprenorphine

Audio-only services improve access to virtual care for patients who do not have access to the devices or broadband for audiovisual calls, are not comfortable with digital technology, or do not have a caregiver available to assist them. During the PHE, coverage and payment for audio-only technology has been critical to ensure access to care for patients who are participating in OTPs. Eliminating coverage for audio-only periodic assessments will result in inequities in access to services for specific populations. Reports suggest that lack of video services or discomfort regarding the use of video may particularly affect certain populations, including the elderly, those with low socioeconomic status, and certain races and ethnicities.

Data from the Clinical Practice Solutions Center (CPSC),¹¹ which contains claims data from 90 physician faculty practices, shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient, with 17% of visits delivered via audio-only interaction for patients 41-60 years of age, 30% for patients 61-80 years of age, and 47% of visits for patients over 81. CMS also released data showing that nearly one third of Medicare beneficiaries received telehealth by audio only telephone technology.^{12, 13} This demonstrates the importance of continuing to allow equitable coverage and payment for telephone services to Medicare beneficiaries.

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

AAMC strongly supports CMS's proposal to permit OTP intake add-on codes to be furnished via two-way audio-video and audio-only technology to initiate treatment with buprenorphine as clinically appropriate, and in compliance with all applicable requirements

Patients who seek treatment of opioid use disorder continue to have significant difficulty in accessing treatment options that reflect the most current science. In 2018, for a variety of reasons, only 11.1% of people who needed treatment for substance use actually received it.¹⁴ Studies have shown the effectiveness of buprenorphine in safely treating opioid use disorder;

¹¹ The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.

¹² HHS ASPE Issue Brief: [Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic](#) (July 27, 2020).

¹³ Seema Verma, [Health Affairs Blog: Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19](#). (July 15, 2020)

¹⁴ The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plans to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.

however, clinicians need to receive a federal “X waiver” from DEA to prescribe buprenorphine. While the number of waived clinicians has increased in recent years, only a small fraction of physicians have completed the waiver process, leaving a limited number of clinicians able to prescribe buprenorphine despite the overwhelming demand for this evidence-based treatment.

In [previous communications](#) with the Department of Health and Human Services (HHS), AAMC has recommended suspending the waiver requirement under the Drug Addiction Treatment Act of 2000 to help minimize the hurdles for qualified clinicians to provide medications for treatment of opioid use disorder. ., This outdated waiver disincentivizes clinicians from providing evidence-based treatment, and, furthermore, limits waived clinicians in the number of patients they can treat. In April 2021, the Biden administration eased the waiver requirement; however, the overall number of patients that can be treated is still limited. In the beginning of 2021, the bipartisan House and Senate sponsors of the Mainstreaming Addiction Treatment Act of 2021 ([H.R. 1384](#), [S. 445](#)) reintroduced their bill to fully suspend the waiver requirement, which the AAMC praised [in an April 21 letter](#). In addition to waiver restrictions, another limiting factor for access includes the overall shortage of providers in this country. The demand for providers continues to grow faster than supply, leading to shortages in both primary and specialty care.

The use of audio-video and audio-only technology is critical while these waivers and general workforce shortages limit the number of providers who can prescribe buprenorphine. Without audio-video and audio-only technology many patients may have to travel long distances to find a provider who can prescribe buprenorphine. For the reasons discussed above, we believe that OTP intakes should be permitted via two-way audio-video and audio-only technology to initiate treatment with buprenorphine.

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCE (EPCS)

In the 2022 Medicare payment final rule, CMS established a number of EPCS policies. Specifically, CMS stated that physicians were required to electronically prescribe Medicare Part D controlled substances in 2022 with compliance enforcement starting in 2023 with several exceptions. One exception is for physicians who prescribe fewer than 100 Part D prescriptions annually. We support the proposal to make the 100-prescription exception permanent.

As finalized in the 2022 PFS final rule, CMS will only issue noncompliance letters in 2023 for prescribers who violate EPCS requirements. The letters notify prescribers that they are violating an EPCS requirement; provide information on how to come into compliance with the requirement; describe the benefits of EPCS; include an information solicitation as to why they are not conducting EPCS; and provide a link to the CMS portal to request a waiver. CMS proposes to extend its policy of only sending noncompliance letters to noncompliant prescribers for the EPCS program implementation year (i.e., 2023) for another year. Thus, the only noncompliance action the agency would take with respect to EPCS violations in 2023 and 2024 would be the issuance of a noncompliance letter. **The AAMC supports this proposal to extend the enforcement policy of sending a letter to physicians who are not in compliance with the requirement.** This will give

providers more time to recover from the impact of the pandemic and ensure that they are meeting the standards for compliance. The AAMC commends CMS for engaging stakeholders in the conversation surrounding electronic prescribing, and we believe that it is important to provide further education and assistance for providers.

OTHER PROVISIONS OF THE PROPOSED RULE

MEDICARE SHARED SAVINGS PROGRAM

The AAMC appreciates CMS's responsiveness to stakeholder feedback on prior policies finalized for ACOs in the Medicare Shared Savings Program. Comments on the specific ACO proposals in the rule follow.

Participation Options and Policies

CMS Should Allow All New Inexperienced ACOs to Receive Advance Investment Payments

CMS proposes to adopt a new system of advance investment payments (AIPs) in the MSSP to help ACOs new to Medicare ACO programs with upfront capital to invest in the capacity to succeed and generate savings. However, CMS proposes to limit participation in AIPs to new ACOs that qualify as "low revenue" ACOs (as defined § 425.20, an ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants is less than 35 percent of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries). CMS states that it has broadened eligibility for AIPs from prior investment models (which generally limited participation to ACOs in rural areas) to "provide an incentive for providers and suppliers who serve high needs beneficiaries in all areas to form ACOs."¹⁵ CMS also suggests that limitations to rural communities of prior models would leave out incentives for providers caring for underserved beneficiaries who have not previously participated in ACOs in markets with greater alternative payment model participation.¹⁶

The AAMC commends CMS for recognizing the significant up-front resources needed to establish an ACO and proposing to provide advance investment payments (AIPs) to ACOs in the MSSP. The AAMC agrees with CMS that there should be an opportunity for new ACOs, including safety net providers, to receive AIPs to expand the provision of accountable care for underserved beneficiaries and address health equity. To address this aim, we recommend CMS expand eligibility to receive AIPs to all new, inexperienced ACOs working to address health inequities rather than limiting these payments only for low revenue ACOs. The calculation of fee-for-service revenue to determine whether an ACO is high or low revenue is inclusive of add-on payments such as graduate medical education, indirect medical education, new-technology, and uncompensated care payments. Due to this policy, it is

¹⁵ 87 Fed. Reg. 45860, at 46100.

¹⁶ See *Ibid*, stating "underserved beneficiaries may receive care from providers and suppliers within a geographic area with high alternative payment model penetration. Generally, such providers and suppliers and the beneficiaries they serve are not or have not been part of an ACO previously."

impossible for a new ACO including a teaching hospital or safety net hospital serving high need beneficiaries to qualify as a low revenue ACO that could be eligible for AIPs.

AAMC Supports CMS's Proposals to Slow the Glide Path to Risk to Ensure All Safety Net Providers Have Reasonable Progression to Risk

CMS proposes several changes to ACO participation options to limit the rapid increase in performance-based risk that new ACOs must assume under prior rulemaking for the program.¹⁷ This includes allowing new, inexperienced ACOs to participate in Level A of the BASIC Track (for which an ACO does not assume any downside financial risk) for two full five-year participation agreements before transitioning to the glide path for assuming risk under the BASIC Track's Levels A-E. It also allows all experienced ACOs, regardless of revenue, to remain at BASIC Level E, rather than be forced into the ENHANCED Track. CMS believes these changes to slow the glide path to risk will help provide greater incentives for new ACOs to join the program and experienced ACOs to rejoin or remain in the program for long-term participation. The AAMC supports CMS's efforts to create a longer glidepath to risk and to make the Enhanced Track optional for all ACOs. We also support CMS's decision to not limit this proposed policy based on an ACO's status as a high-or low revenue ACO. **The AAMC agrees that these changes would help ensure greater participation in the program and greater access to accountable care for Medicare beneficiaries.**

Quality Reporting & Performance Standards

CMS Should Not Require eCQM Reporting Until the Majority of ACOs are Able to Report Successfully and Not Increase Data Completeness Requirements for eCQM Reporting

Current policy requires ACOs to transition to the Quality Payment Program's APM Performance Pathway (APP) measure set, which includes three all-payer eQMs/MIPS CQMs, beginning with PY2025. The AAMC has previously commented on the challenges of implementing this change in quality reporting, and our understanding is that few ACOs have transitioned to eCQM reporting.¹⁸ For ACOs with participants that do not use the same EHR platform, it is challenging to merge the data from the various EHRs to report eQMs. It is necessary to determine how to combine the data from each system, which requires the use of an outside vendor and is costly. In addition, an ACO that submits eCQM quality data to CMS must de-duplicate the patient level measures data across its ACO providers to ensure that the aggregated QRDA III file that is submitted to CMS incorporates only quality data that meets the intent of the measure. QRDA III files are aggregate files with no patient identifier. Providers will need to work with their EHR vendors to develop systems that will enable de-duplication of the measures. At this time, most EHR vendors have not developed systems that aggregate data from all the practices and deduplicate at the ACO level. CMS should evaluate whether the current transition deadline might reduce overall participation in the program if a significant proportion of ACOs are unable to

¹⁷ See 83 Fed. Reg. 67816 (December 31, 2019), beginning at 67826, generally describing a new "Pathways to Success" under a new BASIC Track and the renaming of prior Track 3 as the ENHANCED Track.

¹⁸ The AAMC is awaiting the publication PY2021 Public Use File to confirm the number of ACOs in the program who reported eQMs in the first year they were able to do so.

successfully report eCQMs. **CMS should not require APP measure reporting for PY2025 if the majority of ACOs are not able to successfully transition to eCQM reporting.**

Another challenge with reporting eCQMs relates to the data completeness standards, which will be 70 percent in performance year 2023. We are concerned with the proposal in the rule to increase the data completeness threshold even further to 75 percent in performance years 2024 and 2025. This threshold is especially difficult to meet due to the requirement that quality scoring for eCQMs is based on the ACO's patients from all payers. The ACO does not have the same flexibilities to design care interventions for all patients treated by the ACO's participant clinicians nor the ability to readily access patient data for the patients not attributed to the ACO but treated by ACO participants. We urge CMS to retain the 70 percent data completeness level for the foreseeable future to give ACOs the flexibility and time to become familiar with the new quality reporting requirements and address any administrative challenges as they are identified.

CMS Should Incorporate the Health Equity Adjustment to Quality Performance Scoring for All ACOs

CMS proposes to adopt a new health equity bonus for ACOs that report the APP measures in part as an incentive for transitioning to reporting under the APM Performance Pathway. This bonus would allow high performing ACOs serving beneficiaries with greater social need or residing in economically disadvantaged areas to earn up to ten bonus points to increase their quality performance score for meeting the standard to share in savings. CMS proposes to evaluate an ACO's proportion of beneficiaries who are either dual eligible for Medicare and Medicaid or who reside in an Area Deprivation Index census block group equal to or greater than the 85th percentile nationally. That proportion would serve as a multiplier on measure performance scaling, up to a maximum of 10 bonus points. **The AAMC supports the concept of an equity adjustment for ACO quality performance scoring, though believes it should be available to all ACOs to recognize high quality care regardless of ACO reporting APP measures or quality measures through the Web Interface.** We appreciate the expansion beyond dual eligibility to assess social risk. CMS should consider also using the Part D plan low-income subsidy as a measure of beneficiaries with greater social need, as it has national eligibility criteria. CMS should commit to evaluating the use of ADI and determine whether 85th percentile nationally is too high a bar for ACOs to meaningfully benefit from the adjustment, as the proposed rule notes that roughly only 30 percent of existing ACOs would qualify for points based on their analysis.¹⁹ Finally, CMS should consider whether other data in the future could be appropriate as data collection efforts are expanded across Medicare programs.

CMS Should Incorporate an Alternative Quality Performance Standard to Allow Greater Opportunity for ACOs to Share in Savings

CMS proposes to adopt an alternative quality performance standard to allow ACOs to share in a portion of shared savings if they are unable to meet the quality performance standard necessary to achieve maximum shared savings. Under the proposed alternative, ACOs would need to meet

¹⁹ 87 Fed. Reg.46139.

the 10th percentile on one outcomes measure in the APP measure set to receive pro-rated savings. **We appreciate CMS crafting an alternative to the current “all or nothing” approach tying quality performance to shared savings.** The AAMC supports this proposal and urges CMS to provide greater transparency in the quality performance standard calculations, in part by providing ACOs benchmarks for MIPS quality scores.

Request for Feedback: Inclusion of Screening for Social Drivers of Health Measures in the MSSP

CMS seeks feedback on the potential future inclusion of the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health structural measures in the APP measure set. Elsewhere in these comments the AAMC is supportive of the proposal to adopt the former measure in the MIPS Quality Performance Category set of measures, with modification to the measure specifications to focus screening efforts within primary care and address the frequency of screening. Similarly, the AAMC notes concern with the use of the screen positive measure. CMS has previously noted that the screen positive measure is not intended for performance comparison,²⁰ and thus we strongly believe it should remain a pay-for-reporting measure if adopted in the APP measure set. We refer CMS to those comments for full detail in the Quality Payment Program section of our letter.

CAHPS for MIPS Survey

CMS seeks feedback to inform future rulemaking to support the Agency’s goals of incorporating equity and price transparency into assessment of patient experiences of care. Additionally, CMS asks questions regarding the inclusion of several questions specific to primary care practices that might not be applicable to specialty groups administering the survey. Comments specific to topics raised in these RFIs follow.

CMS Should Thoroughly Study Patient and Provider Perspectives Before Incorporating New Questions into Patient Experience Survey

CMS seeks feedback on incorporating two new questions for the survey, focusing on health equity and price transparency.

Health Equity

CMS seeks feedback on the inclusion of a new question that asks a patient about their personal experience with discrimination in the health care setting. Specifically, the new question asks patients whether they have experienced unfair or insensitive treatment in the past six months on the basis of the following applicable responses: health condition, disability, age, culture, sex (including sexual orientation and gender identity), and income. The question would not be

²⁰ See “Medicare Program, FY 2023 Inpatient Prospective Payment System Proposed Rule,” 87 Fed. Reg. 28108 (May 10, 2022), at 28505, stating that the measure as proposed for the inpatient setting is “intended to provide information to hospitals on the level of unmet social needs amount patients served, and not for comparison between hospitals.”

specific to the clinician office setting, but rather “anyone from a clinic, emergency room, or doctor’s office where [the patient] got care.”²¹

The AAMC supports the value of patient experience in driving health equity. We urge CMS to take a cautious approach to incorporating questions related to experience with discrimination. There are two critical perspectives that CMS must evaluate to ensure such a question would be meaningful: that of patients and that of providers. First, patient trust is paramount. Patients must have trust that responding to this question will not have any negative impact on their future care. Furthermore, CMS must evaluate whether this question might dissuade patients who have experienced discrimination from completing the survey out of concerns over whether the survey is anonymous. Aspects of the question that may potentially make a patient more comfortable responding (six months timespan, non-specific healthcare setting or care team member, anonymity) are precisely those which might make the responses less actionable for providers. The inability of providers to determine where a patient experienced unfair or insensitive treatment limits the precise steps that can be taken to address the problem and prevent reoccurrence. It is possible that the responses could give them insight into the basis of discrimination of patients they treat, though it could also represent the proportion of patients who are made vulnerable to stigma and discriminating behavior in our society. That is, it is possible that providers who treat patients from majority communities might see little experience of discrimination, whereas providers who treat greater proportions of patients from communities disadvantaged by racism and stigma might see higher numbers of such experience. Furthermore, it would not give providers insights into whether discrimination occurred in their setting or system. This leads to the need for further information about how the question might be scored for performance or used for comparisons between providers, and whether it is reflective of discriminatory behavior on the part of the attributed provider. Because of these concerns, we urge CMS to commit to ensuring the measure undergo rigorous field testing and to sharing the results of such testing with stakeholders before CMS proposes to adopt this question.

Price Transparency

The survey currently includes questions regarding whether patients have discussed prescription drug costs with their health care team in the past six months. CMS seeks feedback on whether to also include a question regarding discussions with their health care team on the cost of health care services and equipment. While the AAMC agrees that patients should have discussions with their care team about the cost of care, we urge CMS to fully examine the adoption of such a question to ensure it does not have unintended consequences on patient care. We are concerned that if providers are unable to act on information from the patient during cost conversations (for example, unable to identify an effective treatment option with lower out-of-pocket cost or patient support services to help reduce costs of preferred treatment), these conversations could result in patients foregoing health care services or equipment to the detriment of their health.²² Or, the question could lead a patient to become dissatisfied with their care for something beyond the

²¹ 87 Fed. Reg. 45860, at 46156.

²² See Kaiser Family Foundation, “[Americans’ Challenges with Health Care Costs](#)” (July 14, 2022) dinging that “four in ten U.S. adults say they have delayed or gone without medical care in the last year due to cost,” and that “substantial shares of adults 65 or older report difficulty paying for various aspects of health care.”

clinician's control. CMS should thoroughly test questions of cost to ensure the benefits of the question outweigh any potential unintended consequences. As part of such testing, CMS should evaluate whether appropriate to directly link the question with an encounter in which durable medical equipment was prescribed or whether it should be addressed in surveys of Part D plans, rather than of clinicians.

CMS Should Allow Specialist Groups to Use a Modified CAHPS for MIPS Survey

CMS seeks feedback on addressing the length of the CAHPS for MIPS Survey for specialist practices for whom several primary care-focused questions are not applicable. **The AAMC appreciates CMS's willingness to evaluate the CAHPS for MIPS Survey and its broad applicability to all clinicians.** We agree that not all questions are applicable to specialty practices, and that it would be beneficial to such practices to allow them to administer a pared down CAHPS for MIPS Survey to meet reporting requirements under the Quality Payment Program.

Financial Benchmarking

CMS Should Allow All ACOs in the BASIC Track to Share in Scaled Savings in the First Agreement Period for Performance Years Where They Fail to Meet the Minimum Savings Rate

CMS proposes to allow low revenue ACOs participating in BASIC Track to share in pro-rated savings, between 20 and 25 percent of savings relative to their financial benchmark, where the ACO does not meet the minimum savings rate (MSR) necessary to share in the maximum 40 to 50 percent sharing rates available under the BASIC Track. This proposed change to policy would be limited to ACOs entering agreements beginning January 1, 2024. CMS believes in limiting this proposal to only low revenue ACOs in the BASIC Track "in order to direct payments to ACOs with the greatest need for capital, in particular smaller, rural ACOs[.]"²³ CMS differentiates this from the proposed eligibility criteria for the Advance Investment Payments, which CMS believes are intended to lower barriers of entry to the program. CMS further describes a belief that high revenue ACOs "which tend to include institutional providers and are typically larger and better capitalized...have a greater potential to achieve the level of savings necessary to meet the MSR."²⁴

Earlier this year CMS released the CMS Health Equity Strategy, which includes evaluation of policies to determine how CMS can support safety net providers.²⁵ Additionally, CMS notes the need to expand accountable care to underserved beneficiaries in its discussion of the proposed Advance Investment Payments for the program, suggesting CMS is aware that not all providers

²³ 87 Fed. Reg. 45860, at 46197.

²⁴ *Ibid.*

²⁵ See CMS Press Release, "[CMS Outlines Strategy to Advance Health Equity, Challenges Industry Leaders to Address Systemic Inequities](#)," (April 20, 2022), which include the following action: "Evaluate policies to determine how CMS can support safety net providers caring for underserved communities, and ensure care is accessible to those who need it."

are able to make the investments necessary to participate in the MSSP.²⁶ Including a revenue distinction for ACOs regarding the ability to share in pro-rated savings when unable to meet the MSR limits ACO participation incentives for under resourced institutional providers. This in turn limits the expansion of accountable care to patients primarily served by such providers. **The AAMC suggests that CMS modify this proposed policy to allow all new ACOs in their first agreement period of the BASIC Track to share in scaled down savings where they fail to meet the MSR.** This includes expanding the policy for ACOs currently participating in the program in their first agreement period. The expansion of the proposal would provide a greater incentive for new providers to join ACOs and provide them an onboarding opportunity to invest in care transformation necessary to generate savings greater than the MSR.

CMS Should Delay Adoption of a New Three-Way Blended Growth Factor Using a Prospective Trend Until There is More Clarity About its Potential Impact and More Discussion with Stakeholders

CMS proposes to adopt a new Accountable Care Prospective Trend (ACPT) to blend with the current regional and national growth rates used to update an ACO's historical benchmark beginning with agreements that start January 1, 2024. The ACPT would be based on the United States Per Capita Cost and be established for each enrollment type at the start of an ACO's five-year agreement. CMS proposes a limited guard rail for ACOs that see a lower benchmark under this policy than under the current two-way blend. In this scenario, if an ACO generated savings using the two-way blend but not under the three-way blend, the ACO would neither be responsible for shared losses nor eligible for shared savings for the applicable performance year. Additionally, CMS proposes to retain discretion to adjust the weight of the ACPT if actual spending significantly deviates from projections. CMS proposes to give itself sole discretion to determine whether unforeseen circumstances exist that would warrant adjustments to these weights, as well as the extent to which the components of the three-way blend would be re-weighted.

The AAMC appreciates CMS efforts to refine benchmarks and incorporate prospective updates to balance with observed growth that can only be known at end of year reconciliation. However, we are concerned that this three-way blend could potentially generate unwarranted gains for some ACOs while driving other ACOs from the program if there is short-term regional variation in spending growth. One nationally set number is not reflective of the annual growth every ACO experiences. CMS should amend the guard rail proposed, by using the more favorable of the proposed three-way blend and current two-way blend for a given ACO and allowing the ACO to share in savings under use of the two-way blend. Another critical fix would be to also remove ACO beneficiaries from the regional trend in the two-way blend. This is known as the "rural glitch" and penalizes an ACO for reducing costs relative to its regional competitors and is most dramatic for rural ACOs who tend to care for a greater proportion of their region's population. Additionally, CMS should consider additional adjustments to mitigate the impact of regional spending variation in the three-way blended trend, for example looking at the use of case mix and geographic adjustments. CMS should, at a minimum, define what constitutes an "unforeseen

²⁶ *Supra*

circumstance" and what situation might require notice and comment to change the weights. Considering the many unknowns of this new ACPT, the AAMC urges CMS to delay adoption until there is more information about its potential impact and more discussion with stakeholders.

CMS Should Adjust Benchmarks to Avoid Penalizing an ACO for Prior Success Generating Savings Under the Program

CMS proposes to begin to adjust ACO benchmarks for renewing ACOs to account for prior savings when rebasing benchmarks under the new agreement period. CMS would use average savings during the three benchmark years and compare to the ACO's regional adjustment. For ACOs with spending lower than their region, CMS would apply either the greater of the positive regional adjustment or the prior savings adjustment (capped at 50 percent of prior savings and 5 percent of national fee-for-service spending for assignable beneficiaries). ACOs with spending higher than their region would receive a full prior savings adjustment if prior savings are lower than the regional adjustment (and reduced to 50 percent of prior savings if prior savings are greater than the regional adjustment). **The AAMC appreciates CMS's recognition of the ratcheting effects renewing ACOs face the longer they remain in program. However, we believe CMS should consider instead to use the ACO's actual maximum sharing rate in this adjustment, as it creates a greater incentive for ACOs taking on the greatest risk to remain in the program.**

CMS Should Reduce the Cap on Negative Regional Adjustments and Further Offset Such Negative Adjustments with Equity-Related Factors

CMS proposes to reduce the cap on negative regional adjustments from -5 percent to -1.5 percent for ACO benchmarks beginning with agreements that begin on January 1, 2024. Additionally, CMS proposes to apply an offset factor based on the proportion of an ACO's Medicare and Medicaid dually eligible beneficiaries or its weighted-average HCC risk score increases. **The AAMC applauds CMS's efforts to address the impacts of negative regional adjustments, though we believe that CMS should expand the policy to apply to ACOs currently participating in the program.** We believe this policy could reduce the barrier to entry for future ACOs whose spending is higher than their region.

CMS Should Increase the Cap on Risk Adjustment in Addition to Accounting for Demographic Risk Score Changes Prior to Applying the Cap

CMS proposes to modify risk adjustment beginning with benchmarks set for ACOs with agreements starting January 1, 2024. Under this proposed policy, CMS would account for demographic risk score changes before applying the 3 percent cap. The 3 percent cap on risk score growth would apply in aggregate across the four enrollment types. **The AAMC appreciates that CMS is evaluating options to address risk score growth in the program. However, we believe that CMS should also increase the cap to 5 percent for each agreement period to more meaningfully address ACO concerns. Additionally, CMS should reevaluate the use of the cap across each enrollment type, as we believe that the current policy drives inequity.** Disabled and Medicare and Medicaid dually eligible beneficiaries are often more likely

to see risk score growth above the 3 percent cap than those beneficiaries enrolled in the aged/non-dual category. Therefore, ACOs that treat higher proportions of dually eligible or disabled patients may be disproportionately penalized by the current 3 percent cap applied across all four enrollment types. Finally, CMS should evaluate the implications for those ACOs currently participating in the program, especially those ACOs under agreements that began in January 2022, as their risk score growth is significantly impacted by the COVID-19 public health emergency. This is because their third benchmark year, for which risk score growth is compared, is CY2021, which is based upon diagnoses captured in CY2020. The reduction in services in 2020 due to the pandemic may also have results in an artificial reduction in risk scores that results in those ACOs more likely to be subject to the 3 percent cap.

Request for Comment: Future Use of Administrative Benchmarks

CMS seeks feedback on the potential future use of an administrative benchmarking approach to move away from the direct link to historical fee-for-service spending. **The AAMC applauds CMS for recognizing the program needs a long-term solution to the benchmarking that asks providers to ratchet down spending and appreciates efforts to solicit feedback on administrative benchmarks.** We recognize that administrative benchmarks are a necessary step to ensure the long-term viability of the program. However, there are inherent challenges in designing administrative benchmarking; for example, accounting for regional variations in spending so that ACOs are not penalized due to their geography. We support the concept of administrative benchmarks and ask that CMS engage stakeholders throughout development.

Request for Comment: Incorporating Health Equity into Benchmarks

CMS seeks feedback on ways it could address health equity directly via ACO financial benchmarking. CMS cites the Innovation Center's ACO REACH Model and its health equity benchmark adjustment as an example of an approach CMS could take in the MSSP. In particular, the ACO REACH Model seeks to address inequity created by primary use of historical expenditures in benchmarking, as it preserves historical underspending for underserved beneficiaries. CMS additionally seeks feedback on data collection and how best to identify underserved communities to adjust ACO benchmarks.

The AAMC applauds CMS for considering efforts to address health equity specifically through financial benchmarks. We agree that use of historical spending can have the unintended effect of preserving underspending for beneficiaries with greater need yet less access to care and services. The ACO REACH method of a per-beneficiary per-month (PBPM) upward adjustment based on the ACO's beneficiary population (using dual-eligibility and the ADI as identifiers) is a concept that could work well in the MSSP, though CMS should look to the Center's model evaluation for additional guidance on its success. Similarly, if CMS is interested in seeking additional health equity data, it should consider Innovation Center model experience with data collection burden to avoid any unintended consequences prior to adopting any data collection requirements in the MSSP.

The AAMC believes that ICD-10 Z codes are a potential tool to provide better data to providers and payers alike on the health-related social needs (HRSNs) of patients that influence health care outcomes and utilization of services. We recommend CMS evaluate using Z Codes to both identify beneficiaries with greater need for services for a PBPM benchmark adjustment and to incorporate in demographic risk adjustment. Z codes can be submitted on claims, allowing providers to capture more of the data that is already available in electronic health records (collected from patient screening) in a meaningful way. This has potential to reduce data collection and reporting burden.

Reducing Administrative Burden and Other Policy Refinements

CMS proposes to eliminate the requirement for an ACO to submit marketing materials to the agency for review and approval, reduce required beneficiary notifications to once per agreement period, and streamline the process for eligible ACOs to request a waiver of the skilled nursing facility 3-day rule. **The AAMC commends CMS for recognizing the need to reduce burden on ACOs and appreciates efforts to reflect stakeholder feedback in policy refinements.**

Regarding beneficiary notifications, the AAMC supports the reduction of a beneficiary information notice to a minimum of once per agreement period. However, we urge CMS to consider additional refinements. First, we encourage CMS to allow flexibility for ACOs to tailor the language in the notice to reduce beneficiary confusion. CMS could create standards for what must and what cannot be included in the notification. Second, CMS should reconsider the additional policy to require a follow-up at the beneficiary's next primary care service visit to engage with the ACO. Specifically, ACOs would need to provide the beneficiary an opportunity to engage with an ACO representative and to ask questions no later than 180 days following the required notification. We believe this policy, if finalized, creates significant operational burden without meaningful benefit, as it requires significant administrative cost to coordinate, train, and document and is unclear whether beneficiaries wish to have such an opportunity. Instead, CMS should explore alternate strategies to promote beneficiary education and engagement.

QUALITY PAYMENT PROGRAM

The AAMC appreciates CMS' s efforts to continue to develop Quality Payment Program (QPP) policies that more effectively reward high-quality care of patients and increase opportunities for Advanced APM participation. We commend CMS's efforts to support clinicians on the front lines during the COVID-19 pandemic by providing burden relief through the extreme and uncontrollable circumstances policy. We also appreciate CMS's decision not to make significant changes to the Traditional MIPS program to limit the burden on providers. **The AAMC recommends that all measures used in the quality payment program be appropriately adjusted to account for the clinical and social complexity of patients. We encourage CMS to work with key stakeholders to identify longer term policy solutions in the future that would attain health equity for all beneficiaries and minimize unintended consequences.** Our comments on the proposals in the rule related to the QPP follow.

TRADITIONAL MIPS

MIPS Performance Category: Quality

For the 2023 performance year CMS proposes to maintain the same quality performance relative weights as set for the previous year. As in the past, eligible clinicians must report a minimum of six measures, unless fewer applicable measures are available, and one of those six measures must be an outcomes measure or a high priority measure. CMS is proposing to expand the definition of the term “high priority measure” to include health equity quality measures. CMS is also changing the CAHPS for MIPS case-mix adjustor for “Asian language survey completion” to use instead the “language other than English spoken at home” variable. Further, CMS proposes to increase the data completeness threshold from 70 percent to 75 percent for the CY 2024 and 2025 performance periods. Finally, CMS is proposing substantive changes to 75 measures, adding 9 new quality measures, and removing 15 quality measures and partial removal of 2 quality measures.

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

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

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

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

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

CMS Should Provide a Gradual Transition Away from GPRO Web Interface Reporting Option

In the 2022 PFS, CMS finalized an extension of the GPRO Web Interface (Web Interface) Reporting Option until the end of 2022. The AAMC commends CMS for the extension of the Web Interface reporting option; however, we believe that it should be extended an additional year until the end of CY 2023. Many faculty practice plans report quality in the MIPS program via the Web Interface. When the Web Interface is eliminated, eligible clinicians will need to use a different reporting mechanism. It will take considerable time, money, and effort to change workflows, pay for registries, and adapt and modify EHRs to comply with electronic clinical quality measure (eCQM) standards. For these reasons, we strongly urge CMS to provide a gradual transition away from the use of the Web Interface reporting option. More time and thought must be given regarding how this will be implemented, and for group practices to assess their alternatives. At a minimum, the Web Interface should be continued for at least one additional year to give sufficient time for affected practices to implement a new reporting method.

CMS Should Maintain a Data Completeness Threshold at 70 Percent

CMS proposes to retain the current data completeness thresholds at 70 percent through performance year 2023 and to raise the threshold to at least 75 percent for performance year 2024 and 2025. The AAMC recommends maintaining the data completeness threshold at 70 percent instead of increasing it to 75 percent in 2024 and 2025. The 70 percent threshold is already very high, and providers need to focus efforts on addressing the COVID-19 PHE instead of taking on greater reporting requirements at this time. Some physicians under the same TIN provide services at multiple sites and not all sites have the same electronic health record (EHR) platform or use the same option for reporting under MIPS. In these instances, the data needs to be seamlessly integrated across settings to facilitate reporting, which can be difficult. It is important to maintain the threshold at 70 percent until systems are better able to integrate data for reporting.

AAMC Supports the Adoption of the Screening for Health-Related Social Needs Measure with Modifications

CMS proposes to adopt a screening measure assessing a clinician or group's rate of screening patients for five health-related social needs (HRSNs) beginning with CY 2023 reporting. The five HRSNs are food insecurity, housing instability, transportation needs, utility difficulties, and

interpersonal safety, and are based on the five domains screened as part of CMS's Accountable Health Communities (AHC) model. While based on the screening in the AHC model, CMS does not mandate the use of AHC's screening tool or other standardized, validated screening tool by providers to report this measure.

The AAMC supports the intent of this measure as a targeted step towards expanding data collection to provide actionable information on patient's social needs, though CMS should modify measure specifications for appropriate measurement of clinicians and clinician groups. We agree that screening to identify unmet HRSNs can be a useful first step in identifying necessary community partners and connecting patients to community resources but worry that encouraging *all* clinicians to do so without the ability to address those needs may impede progress. **When it comes to clinician screening of HRSNs, we believe CMS should focus first on adoption by primary care specialties that are more likely to have an ongoing treatment relationship with the patient.** Requiring all clinicians, including specialists, to screen, has the potential to overload patients with screenings without benefitting the patient. Additionally, CMS should consider the frequency of screening patients for social drivers. Unlike screening all inpatients within a hospital, **we believe that clinician screening should be done annually or semi-annually at most to balance capturing changing social situations with potential over screening for patients with more frequent physician care needs.**

MIPS Quality Performance Category and APP Measure Set - Health Equity

CMS seeks feedback on future inclusion of additional health equity measures in MIPS, including specifically the Screen Positive Rate for Social Drivers of Health measure that was finalized in the Hospital Inpatient Quality Reporting Program and priorities for patient-reported data. Broadly, the AAMC recommends that CMS consider the work of the Core Quality Measures Collaborative's (CQMC) Health Equity Workgroup for direction on incorporating health equity into clinician quality measurement.

Screen Positive Rate for Social Drivers of Health

This measure would be reported as five separate rates, for each health-related social need (HRSN) screened under the related screening rate measure, as the number of patients who screened positive for the HRSN out of the overall number of patients screened. CMS noted when the measure was proposed for the Inpatient Quality Reporting Program that it believes a separate measure on the results of screening for HRSNs will help to quantify the levels of HRSNs in local communities and will offer visibility into the interaction between HRSNs and health status, healthcare utilization, and quality of care.²⁷ However, CMS was also clear that the measure is not intended for comparison between providers.²⁸

The AAMC agrees that the results of screening could be an additional data point that can help inform provider collaboration with community partners and community investment, and for use by local, state, and federal policymakers in their efforts to improve health equity. We urge CMS

²⁷ 87 Fed. Reg. at 28504.

²⁸ *Supra*

to commit to evaluating the interaction between positive rates for these five HRSNs and quality, and to consider how positive rates of HRSNs could be incorporated into measure stratification and risk-adjustment. **Additionally, as an acknowledgement that the measure is not meant for comparisons, CMS should designate the measure as pay-for-reporting if adopted in the QPP or any other pay-for-performance quality program.** Simply put, it is unclear how this measure data might be interpreted or what it says about a clinician, clinician group, or ACO. Providers treating patients in communities historically underserved and underinvested are inherently more likely to have higher proportions of patients screening positive for social needs. Therefore, it is critically important that this measure not be pay-for-performance so that it does not penalize providers and increase inequity. Furthermore, CMS should monitor use of the measure performance data to evaluate whether there are unintended uses of the data that might misinform patients and providers or inhibit the measure's value.

Assessing the Collection and Use of Self-reported Patient Characteristics

CMS acknowledges that a prerequisite for measuring and reporting quality for patients with social risk factors is collecting standardized, complete, and accurate patient data. CMS is considering ways to encourage clinicians to collect social risk factors through the development of a measure that tracks the completeness of self-reported patient characteristics.

The AAMC strongly supports the collection of self-reported information from patients to inform policies to address healthcare inequities. We believe self-reported data is the gold standard, especially when it comes to data regarding patient demographic characteristics (e.g., race and ethnicity, gender identity, sexual orientation, and disability status). However, we believe it is too soon for CMS to consider quantifying and measuring data collection as providers are only beginning to collect self-reported information from patients. Measuring "completeness" of patient-reported information too soon could have the unintended consequence of placing more focus on the measure rather than establishing an environment to understand data collection efforts and establish best practices. In time, measurement to qualify self-reported data could be useful, but not at the outset.

MIPS Performance Category: Cost

For the 2023 performance year, CMS proposes to weight the cost category at 30 percent as required by statute. We recognize that the statute requires that cost be set at 30% in performance year 2023. However, the AAMC urges CMS to use its administrative authority under policies (such as the Extreme and Uncontrollable Circumstances policy) to reweight the Cost Performance Category to 20 percent or less. The Cost Performance Category has been significantly impacted by the COVID-19 pandemic. In recognition of this impact, CMS reweighted the cost performance category to zero percent of MIPS final scores for the 2020 and 2021 performance periods. We greatly appreciated CMS's decision to reweight cost for those years as we were very concerned that clinicians would not be reliably and fairly scored under this measure. However, this means that clinicians have had two less years to familiarize themselves with the new cost measures to be prepared for the increase in the cost measure weight.

We are also not sure whether in 2023, CMS will be able to reliably calculate scores for select cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians. At a minimum, CMS should suppress certain cost measures in 2023 to avoid inappropriately penalizing providers.

Given the challenges with cost measures, AAMC supports CMS’s proposal to establish a maximum cost improvement score at 1 percent out of 100 percentage points available for the cost performance category starting with the 2022 performance period to satisfy statutory requirements. As CMS is aware, it would not be feasible for clinicians to receive an improvement score this coming year since cost was weighted at zero percent in the last two years.

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

The AAMC recommends that all cost measures used in the MIPS program be appropriately adjusted to account for clinical complexity and social risk factors. The episode cost measures are risk-adjusted based on variables such as age and comorbidities by using Hierarchical Condition Categories (HCC) data and other clinical characteristics. While the Total Per Capita Cost (TPCC) measure and the Medicare Spending Per Beneficiary (MSPB) measures are risk adjusted to recognize demographic factors, such as age, or certain clinical conditions, these measures are not adjusted for other social risk factors. In addition to differences in patient clinical complexity, social risk factors can drive differences in average episode costs. A recent report from the National Academies of Science, Engineering and Medicine²⁹ clearly acknowledged that sociodemographic status variables (such as low income and education) may explain adverse outcomes and higher costs.

The COVID-19 pandemic has demonstrated the importance of accurate risk adjustment. The virus has a disproportionate impact on racial and ethnic minorities, the homeless, individuals in long-term care facilities, the elderly, and those with underlying conditions. Literature has shown that patients who are already at high-risk due to social factors are at increased risk of serious illness related to COVID-19.³⁰

Without accurately accounting for clinical complexity, and social risk factors, the scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their

²⁹ National Academies of Sciences, Engineering, and Medicine. *Accounting for social risk factors in Medicare payment: Criteria, factors, and methods*. The National Academies Press. 2016. Doi: 10.17226/23513.

³⁰ Koma, W. et al. [*Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*](#). Kaiser Family Foundation. May 7, 2020.

performance will not be adequately reflected in their MIPS score. Physicians at academic medical centers care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere. We request that these measures be adjusted to account for these risk factors.

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

CMS Should Address Ongoing Concerns with Medicare Spending Per Beneficiary (MSPB) Measure and Total per Capita Cost Measure (TPCC)

Despite concerns previously raised by many stakeholders, including AAMC, CMS plans to continue to include the MSBP and TPCC measures in the MIPS program for the cost category. While we appreciate CMS's recent efforts to refine this measure, we continue to have significant concerns. For cost measures, an accurate determination of the relationship between a patient and a clinician is critical to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated since most patients receive care from numerous clinicians across several facilities. The MSPB measure and the TPCC measures holds physicians accountable for costs related to patients' medical conditions that are managed outside of their organization, and for costs they cannot control, such as drug prices. The measures also fail to risk-adjust for health-related social needs. In addition, the measures capture the same costs as the episode-based measures, effectively "double counting" the costs. Attribution, benchmarks, and risk adjustments for both measures also need to be reexamined in light of the COVID-19 pandemic. In light of concerns³¹ raised by stakeholders, and the impact of COVID-19 on these measures, we recommend that CMS address the ongoing concerns with the validity, reliability, and risk adjustment for the MSBP and TPCC measures.

MIPS Performance Category: Improvement Activities

CMS proposes four new improvement activities (IAs): (1) Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Patients, (2) Create and Implement a Language Access Plan; (3) Use Security Labeling Services Available in Certified Health Information Technology (IT) for Electronic Health Record (EHR) Data to Facilitate Data Segmentation; and (4) COVID-19 Vaccine Promotion for Practice Staff.

We appreciate CMS's attention to incorporating health equity, improved health IT capability, and vaccine promotion into the IAs. Regarding the health equity related IAs for

³¹ [NOF Cost and Efficiency Standing Committee Draft Report](#) – Spring 2020 Cycle.

improving care for the LGBTQ community and improving language access, we believe it best to provide clinicians and clinician groups the opportunity to report and measure health equity efforts in a targeted and meaningful way to meet the needs of the patients and communities they serve. Similarly, we support the inclusion of health IT related IAs that help clinicians and groups address critical improvements to the use of EHR technology separate from the Promoting Interoperability performance category scoring and activities. Improving the use of data segmentation capabilities is critical to protecting the privacy and security of personal health information as we work to expand the transfer and use of health information to improve care delivery. Finally, regarding COVID-19 vaccination rates, the AAMC strongly supports efforts to improve trust in vaccines for both providers and the communities they serve.³² **The AAMC supports the adoption of all four as optional IAs a clinician or clinician group may choose to report and measure under Traditional MIPS.**

MIPS Performance Category: Promoting Interoperability

CMS Should Maintain the Query of Prescription Drug Monitoring Program (PDMP) Measure as Optional for the Electronic Prescribing Objective

A measure for the Query of Prescription Drug Monitoring Program (PDMP) exists under the Electronic Prescribing objective and has been optional and eligible for 10 bonus points in recent years, including the 2022 performance period/CY 2024 payment year. CMS proposes beginning with performance year 2023 to require the reporting of the Query of the PDMP measure for MIPS eligible clinicians participating in the Promoting Interoperability performance category with a couple of exclusions. These exclusions are MIPS eligible clinician who is unable to electronically prescribe schedule I opioids and Schedule III and IV drugs in accordance with applicable law, and any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period. CMS proposes to maintain the associated points at 10 points for reporting a “yes/no” response for the Query of PDMP measure. CMS also proposes changes to the Query of PDMP Measure to include not only Schedule II opioids but also Schedule III and IV drugs. CMS invites feedback on these proposals and on barriers to reporting on this measure as well as any other exclusions that should be considered for this measure.

The AAMC urges CMS to maintain the PDMP measure as an optional measure in the Promoting Interoperability Performance Category and supports providing a 10-point bonus if reported, and the yes/no attestation instead of numerator/denominator for this measure. CMS points out that physician registration and use of PDMPs has increased in every state whether there is a mandate or not, which demonstrates that making it an optional requirement has still been effective.

The AAMC recognizes the value of new tools to assist with the opioid addiction epidemic but cautions against making this measure required until there is better evidence of integration of these tools in certified electronic health record technology (CEHRT) by vendors and into clinical

³² The AAMC strongly supports promoting access to COVID-19 vaccines, including the following episodes of the AAMC’s Beyond the White Coat Podcast series (1) [VaccineVoices: Talking to Health Care Personnel About Getting Vaccinated](#) (April 2021) and (2) [“VaccineVoices: Promoting Equity in Vaccine Access,”](#) (May 2021).

workflows. Currently, most CEHRT does not have widespread integration of the PDMP tools. Providers often need to manually document a query of the PDMP, adding considerable burden. Federal and private sectors initiatives are underway to improve approaches to integration of PDMPs in EHRs and to implement provisions of the SUPPORT for Patients and Communities Act. **The AAMC recommends additional time for work on these initiatives and continued evaluation of the status of PDMPs in the states before making this measure mandatory.**

Additionally, the AAMC recommends that CMS explore reports about the potential for PDMPs to stigmatize patients with pain, causing physicians to discharge patients receiving opioid therapy, and leading to increased fear of treating patients with opioid therapy. The focus on checking PDMPs could potentially harm patients with sickle cell disease, cancer, terminal conditions, and those on long-term opioid therapy. CMS should also recognize that ending the drug overdose epidemic requires removing barriers to effective care. This could include removing prior authorization for medications to treat OUD, ending the federal “x-waiver” to treat patients with buprenorphine for OUD, and increasing access to care for patients with pain.

CMS Should Add the Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) Measure as an Alternative for Reporting under the Health Information Exchange (HIE) Objective

CMS proposes beginning with performance year 2023 to add an additional measure through which a MIPS eligible clinician could earn credit for the HIE Objective: Enabling Exchange Under TEFCA measure. The measure would be satisfied by connecting to an entity that connects to a QHIN or connecting directly to a QHIN. This measure would be worth the total amount of points available or the HIE Objective, which CMS proposes to be 30 points. CMS proposes the measure would be reported by attestation with a yes/no response. CMS invites public comment on these proposals and other ways that TEFCA can advance CMS policy and program objectives.

The AAMC supports CMS’s proposal to add an alternative measure to the Health Information Exchange (HIE) objective for enabling exchange under the TEFCA. Including this measure as an alternative option will be helpful in enabling bidirectional information exchange. In addition, the AAMC supports using an attestation-based approach rather than requiring numerator/denominator measurement for reporting this measure. We recommend that CMS explore the utility of TEFCA participation, and monitor privacy and security issues, functional interoperability, costs and fees, and end-user satisfaction.

CMS Should Give Clinicians More Time to Progress Towards “Active Engagement” Under the Public Health and Clinical Data Exchange Objective

Currently, the Public Health and Clinical Data Exchange Objective consists of five measures, two of which are required (Immunization Registry Reporting, and Electronic Case Reporting) and three from which one measure must be selected (Syndromic Surveillance Reporting, Public Health Registry Reporting, and Clinical Data Registry Reporting). CMS currently has established three options to demonstrate active engagement for each measure under the Public

Health and Clinical Data Exchange Objective: (1) Complete registration to submit data. (2) Test and validate electronic submission of data and (3) Complete testing and validation of the electronic submission and electronically submit production data to the public health agency (PHA) or clinical data registry (CDR). CMS proposes to consolidate current options 1 and 2 into one option beginning with the EHR reporting period in CY 2023. The two options would be as follows:

- Proposed Option 1. Pre-production and Validation (a combination of current option 1 and option 2)
- Proposed Option 2. Validated Data Production (current option 3, production).

Currently, there is no requirement for eligible clinicians to report their level of active engagement for any of the measures associated with the Public Health and Clinical Data Exchange Objective. Beginning with the CY 2023 EHR reporting period in addition to submitting responses for the required measures and any optional measures, CMS proposes to require eligible clinicians to submit their level of active engagement using the two options proposed for each measure they report. CMS also proposes that beginning with CY 2023 reporting eligible clinicians may spend only one EHR reporting period at the Pre-production and Validation level of active engagement per measure, and then must progress to the validated Data Production level for the next calendar year.

While we support reporting to PHAs, we have concerns with CMS's proposal to require progression to option 2 (validated data production) active reporting after only one EHR reporting period. The ongoing public health emergency demonstrates the importance of collecting, analyzing, and exchanging public health data. Hospitals and physicians have increasingly engaged with PHAs to share data. Yet, PHA information technology systems are often unable to receive data or incorporate data electronically, and these PHA systems vary widely by state. Technology needs to facilitate these reporting options and should be more consistently applicable across states and localities.

CMS does not currently require reporting on active engagement so is unaware of the current readiness or active engagement level of eligible clinicians. As CMS acknowledges in the rule, it would like to identify registries and PHAs that may be having difficulty onboarding MIPS eligible clinicians and moving them to the Validated Production phase. CMS believes that if it collects this information, it will be able to identify barriers that prevent eligible clinicians from moving to the Validated Data Production stage and work to make changes that could overcome those barriers.

While the AAMC supports CMS's proposal for eligible clinicians to submit their level of active engagement, we urge CMS not to finalize its proposal to require that the eligible clinicians progress to option 2 (validated data production) after one year. CMS should refrain from requiring this progression until CMS has more information regarding the PHA landscape, needs of eligible clinicians, and the barriers that need to be addressed.

After collecting active engagement information in 2023, CMS should have a better understanding of the landscape and any barriers.

Also, demonstrating active engagement should be accomplished by using communications and information provided from either the eligible clinician or the PHA. It is possible that the eligible clinician does not receive a response from the PHA in a timely fashion and therefore should be able to rely on initial communication.

CMS Should Delay Changes to the Performance-Based Scoring Methodology for the EHR Reporting Period Until Clinicians are Able to Re-Establish Normal Health IT Activities Post-Pandemic

CMS proposes to shift the points available per category to put greater emphasis on the Public Health and Clinical Data Exchange Objective by increasing the points allocated to this objective to 25 points, from 10. To balance the increase in the points associated with the Public Health and Clinical Exchange Objective, CMS is proposing to reduce the points associated with the Provide Patients Electronic Access to Their Health Information measure from the current 40 points to 25 points. **While the AAMC agrees that public health related EHR reporting is critically important, we urge CMS to balance increasing emphasis on public health reporting through scoring with the need for greater investments in public health departments to support improvements to reporting and data exchange. Furthermore, CMS must recognize that the COVID-19 pandemic caused eligible clinicians to divert EHR reporting resources.** Eligible clinicians need more time to re-establish normal, post-pandemic health IT activities and to adjust to broader changes to EHR reporting as proposed, while public health departments need investment to build robust capabilities to receive and use data exchanged from eligible clinicians.

Request for Feedback – Patient Access to Health Information Measure

CMS notes that the patient use of portals to access their health information has been tied to benefits such as improvements in access, quality of care, and health outcomes. In the past, CMS added, modified, then removed a standalone View, Download, Transmit (VDT) measure on the number of patients who actively engaged with the electronic health record. CMS then implemented a measure to Provide Patients Electronic Access to their Health Information, which included a requirement for MIPS eligible clinicians to provide timely access for viewing, downloading or transmitting their health information for at least one unique patient discharged using any application of the patient's choice. This change emphasized timely electronic access of patient health information rather than requiring health care providers to be accountable for patient actions.

Recognizing the concerns and barriers with the previous VDT measure but acknowledging the advancements made within the health IT industry over the past few years, CMS publishes this request for information (RFI) seeking comments regarding how to further promote equitable patient access and use of their health information without adding unnecessary burden on the MIPS eligible clinician.

The AAMC supports broader patient access to their own health information as partners in care, but we caution against a future measure of patient access and use of such information. Patients' use of their own health information is well beyond the control of eligible clinicians and simply should not be used to reflect upon an eligible clinician's use of EHR technology. We do not see how generating figures for the frequency of logins, number of messages sent, or lab results viewed will inform improved patient outcomes or validly and reliably measure hospital use of EHR technology. The most a provider can do is to make options for access available and encourage patients to use them. **The Promoting Interoperability performance category should focus on elements of EHR use well within an eligible clinician's control, and not patient choices regarding how and when they access their health information.**

MIPS FINAL SCORE METHODOLOGY

Facility-based Measurement – Complex Patient Bonus

Complex Patient Bonus Eligibility

Beginning with performance year 2023/payment year 2025, CMS proposes to make facility-based clinicians eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category. We support this change as many facility-based clinicians treat patients with complex medical and/or social needs, and therefore should be eligible for the bonus.

RFI Complex Patient Bonus Risk Indicators and Health Equity

CMS believes that the intent of the complex patient bonus, which is to recognize clinicians who serve disproportionate numbers of patients with complex medical and/or social needs aligns with the agency's overarching initiative to advance health equity and reduce care disparities through quality programs. This methodology currently incorporates dual eligibility status and HCC score as indicators of increased medical risk and health-related social needs. CMS asks whether there are other risk indicators that should be considered in the formula.

We are pleased that CMS is interested in identifying approaches other than HCC scores and dual eligible patient status to better represent the clinical and social complexity of patients. **We request the CMS share more information on the proposed methodologies and provide testing and modeling of the proposals to enable providers to determine the impact of the approaches.**

It would be ideal for CMS to use a more comprehensive set of data on income and other social risk factors to identify complex patients rather than dual eligible status. In last year's rule, CMS references a publication (Johnston, 2020, UNC Rural Health Research Program, 2020) and an ASPE report that illustrate that there are many questions on what variables are useful indicators to understand patient complexity and how they may or may not contribute to a clinician's or practice's ability to provide high quality care with resources available.

If dual eligible status is to be used, the dual eligible ratio needs to be adjusted to eliminate the current bias against clinicians practicing in non-expansion states. This could be done by standardizing the dual eligible ratio for a clinician using the median value in the clinician's state rather than using the national mean or median. The Part D low-income subsidy could be a potential income indicator for patients. Unlike dual eligibility, the low-income subsidy qualification is set nationally and is not subject to state-by-state variability.

PUBLIC REPORTING ON THE COMPARE TOOLS HOSTED BY HHS

Telehealth Indicator

Noting the increase in telehealth services that were covered and furnished during the COVID-19 PHE, CMS proposes to add a telehealth indicator to the clinician and group profile pages on the Compare tool. We support the addition of this information, as knowing whether a clinician offers telehealth services will be helpful to Medicare beneficiaries and could help to further health equity goals.

Publicly Reporting Utilization Data on Profile Pages

CMS would like to report utilization data on patient-facing clinician profile pages to allow for more granular clinician searches to identify specific types of clinicians and specific procedures that they perform. To do so, CMS proposes to collapse HCPCS cods using the Restructured Berenson-Eggers Type of Service (BETOS) Codes Classification System into procedural categories. While the AAMC supports the provision of useful information to patients, we are concerned that the utilization data would provide an incomplete picture of the services each physician performs and be misleading to patients since it would be limited only to Medicare utilization data. The dataset proposed would not include any utilization data for Medicare Advantage, Medicaid, Veteran Affairs, or private payor beneficiaries. **Therefore, we do not support reporting this utilization data on the Compare website until CMS is able to include data beyond Medicare claims.**

MIPS VALUE-BASED PATHWAYS (MVPs)

In the 2020 PFS final rule, CMS established a new MIPS participation framework, referred to as MIPS Value Pathways (MVPs). For 2023, CMS plans to enable eligible clinicians to report under the MIPS Value Pathways and states its goal to move away from Traditional MIPS to MVPs in the future. CMS confirms its intention for MVPs to become the only method available to participate in MIPS in future years; however, does not make any proposals for a date to sunset Traditional MIPS. This rule includes proposals that address operational aspects of subgroup reporting, the MVP development and maintenance process, and scoring for MVPs. CMS proposes to add 5 new MVPs and revise all 7 existing MVPs so that all 12 would be available to report in performance year 2023.

As CMS considers how MVPs and subgroups would be operationalized, it is important to understand the unique challenges posed by the QPP for large multi-specialty practices such as those typically found in academic medical centers. Physicians at AAMC member institutions are organized into large multi-specialty groups known as faculty practice plans which often have a single TIN. Recent data shows that the practice plans range in size from a low of 115 individual NPIs to a high of 3,694 with a mean of 1,258 and a median of 1,088. On average these practices have over 70 adult and pediatric specialties and numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. In some cases, faculty practice plans are highly integrated and make decisions about quality and care coordination as a single entity. In other instances, such decision-making occurs at the departmental or specialty level. With the large number of distinct specialties reporting under one TIN, it will be very challenging to identify MVPs that will be meaningful for the myriad of specialties and subspecialties in the practice. Even if multiple MVPs are selected for reporting, it will still be challenging to identify MVPs that encompass the scope of conditions treated and the vast number of specialties included in academic medical centers. These faculty practice plans have physicians that join and leave the practice throughout the course of the year, which makes it more complicated to identify which physicians should be included in a particular subgroup.

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

Subgroup Reporting

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

CMS proposes revisions to the definitions of single and multispecialty groups for purposes of subgroup reporting to MIPS through MVPs. Specifically, they state a group member specialty type would be determined by CMS using the specialty codes assigned to clinicians by the

agency's Medicare Administrative Contractors (MACs) and that are derived based on Part B claims submitted by clinicians. Multispecialty groups would have members from two or more specialty types. CMS also proposes to limit each clinician to membership in a single subgroup within each TIN to which the clinician belongs. CMS also notes that is not imposing limits on specialty number and types nor on the number of clinicians included in a subgroup.

Rather than finalizing its proposal to use Medicare Part B claims data to determine specialty information, we urge CMS to allow subgroups to attest to their specialties during the registration process. We are concerned that using Medicare Part B claims to make determinations on specialty types may not result in information that is accurate regarding specialties that are providing care in a multispecialty group. The 2020 QPP Experience Report demonstrates why the Medicare Part B claims data would not result in accurate determinations of specialties. This report shows that over 15 percent of MIPS eligible clinicians were classified as having more than one specialty.

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

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

Subgroup Scoring

CMS proposes to assess subgroups based on their affiliated (parent) group performances for measures in the cost performance category as well as population health measures and outcomes-

based administrative claims measures in the quality performance category. CMS makes these proposals out of concerns that subgroups will be unable to meet case minimums for administrative claims measures and to make sure that all population health measures are scored for all subgroups. In addition, these measures have not been tested for reliability and validity at the subgroup level and there are concerns with attribution and risk adjustment for subgroup scoring.

We believe that CMS is raising valid concerns. We recommend that CMS explore solutions to address these concerns to enable subgroup reporting across all measures and performance categories in the future. Information on the subgroup levels performance that is more granular would be more meaningful to clinicians and consumers. One option could be to score the eligible clinicians at the subgroup level and the group level and give them the highest score of the two options.

CMS states that gaming could be facilitated by the MVP subgroup framework as multispecialty groups could split into subgroups in a manner that avoided being scored on costs and intends to monitor for this behavior in the future. Instead of focusing on unfounded gaming concerns, we recommend that CMS work with physician organizations and MVP developers to test new and innovative cost measures that are clinically appropriate for the MVP. There is a limited inventory or episode-based cost measures to apply to clinicians that may choose to participate in an MVP. Expansion of cost measures could enable more meaningful information on the performance of subgroups and incentivize participation in the MVPs.

We support CMS's proposal that a final score will not be assigned to a registered subgroup that does not submit data as a subgroup. Eligible clinicians will be more likely to make an effort to form and participate as subgroups that report to MVPs if they can be assured that they are able to subsequently change their participation status. We also support CMS's proposal that the final score to be used for payment adjustments will be the highest of the available final scores of the APM entity final score, subgroup final score, individual final score from MVPs, Traditional MIPS, and/or the APP.

Request for Information: MVP and APM Reporting

CMS seeks feedback on ways to better align clinician experience between MVPs and APMs. The AAMC recommends that CMS move away from contorting traditional MIPS into MVPs and instead work with physician specialties to develop MVPs that are similar to an APM in that they center on quality improvement, efficient resource use, patient outcomes, and technology to improve care for specific patient populations or conditions.

CMS asks how it can best limit burden and develop scoring policies for APM participants in multispecialty groups who choose to participate in MVPs and report specialty care performance data. To limit burden, we recommend that CMS create MVPs that align with the focus of the APM. CMS also asks whether the agency should require APM participants to focus on those clinicians who work in the associated quality measurement clinical area and require subgroup reporting of relevant MVPs for others. We recommend that CMS **not** mandate subgroup

reporting of relevant MVPs for clinicians that are in the APP but rather make MVP reporting for those clinicians optional. We recognize that the APP measure set has a population health and primary care focus and that there may be other specialist focused measures that are more relevant to specialists that are part of an APM entity, such as an ACO, reporting through the APP. Allowing MVP reporting for subgroups within the ACO on specialist specific measures could result in more meaningful measurement of specialist performance within an ACO. **However, the AAMC urges CMS to allow reporting MVPs and scoring for certain specialists on a set of optional specialist focused measures, as increasing measurement burden on ACOs in an effort to assess the role of specialists could chill participation in ACOs.** Currently, specialists serve an important role in ACOs by providing high quality care to their patients and ensuring that their patients are referred to the primary care physicians to receive appropriate preventive health care to improve population health.

ALTERNATIVE PAYMENT MODEL (APM) PERFORMANCE PATHWAY (APP)

APM Entity Level Participation for MIPS Eligible Clinicians Participating in MIPS APMs

APM Entities may report Traditional MIPS using any available MIPS reporting pathway, including the APM Performance Pathway (APP), Traditional MIPS, and MVPs. APM entities that do not report through the APP will continue to have the cost performance category weighted at zero percent of their MIPS score, but will be required to report on quality, improvement activities and promoting interoperability. The Promoting Interoperability (PI) category would be scored for multi-TIN APM Entities using the promoting interoperability roll-up calculation. In this rule, CMS proposes to introduce a voluntary reporting option for APM Entities to report the PI category at the APM Entity level beginning with the 2023 performance period or continue to be scored using the roll-up calculation. AAMC supports this proposed approach as there may be data aggregation and integration tools available that multi-TIN APM entities could use that would enable them to calculate performance at the APM Entity level. This would be beneficial in cases where the APM entity represents a single practice site or specialty within a larger multispecialty TIN and the APM Entity itself performed above average relative to the rest of the larger TIN.

ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMS)

Medical Home 50-Clinician Limit

Beginning with performance year 2023, CMS proposes to apply the 50-clinician limit on the number of clinicians in an organization that participates in a Medicare-sponsored Advanced APM under a Medical Home model at the level of the medical home's APM Entity rather than its parent organization as is currently done. AAMC supports applying the limit at the APM Entity level. This change will more accurately capture the participants in the Medical Home Model.

Request for Information on the Elimination of 5% AAPM Incentive Payments

CMS discusses that beginning in performance year 2023, which correlates with payment year 2025, there is no further statutory authority for a 5% APM Incentive Payment for eligible clinicians who become qualified participants in advanced alternative payment models. However, beginning with performance year 2024, which correlates with payment year 2026, there will be two different PFS conversion factors depending on whether the services are furnished by an eligible clinician who is a QP for the year. CMS notes that the updates are not expected to equate to the anticipated maximum available positive payment adjustment potentially available under MIPS until after CY 2038.

CMS seeks input on what, if any, administrative actions eligible clinicians and APM entities would potentially find helpful to better balance the payment incentives within the Quality Payment Program (QPP) program going forward while encouraging eligible clinicians and APM entities to participate in APMs. CMS includes a list of specific questions: including: (1) the most important questions clinicians considered when deciding to participate in AAPM; 2) how effective the 5% is in getting participation; 3) how the end of 5% bonus payment will affect organizations; and 4) whether there are perceived advantages of participating in MIPS versus an APM.

We appreciate CMS's solicitation of feedback on any actions that CMS could take to promote continued participation in AAPMs, particularly in light of the end of the 5 percent bonus payment. Value-based care is improving patient care and successfully reducing costs in the healthcare system. For example, ACOs have saved Medicare \$13.3 billion in gross savings since 2012 and, according to an HHS Inspector General Study, ACO clinicians have outperformed fee-for-services (FFS) providers on 81% of quality measures.³³ APMs give providers tools to innovate and coordinate care, resulting in improved outcomes for beneficiaries.

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

The AAMC is concerned that the lack of the 5 percent financial incentive under the Quality Payment Program for APMs for the 2025 payment year will discourage participation in Advanced APMs in performance year 2023. For payment year 2025, clinicians in MIPS have the opportunity for a payment adjustment of +/-9% while those in AAPMs have no incentives. For

³³ US Department of Health and Human Services Office of the Inspector General, "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality," [Report \(OEI-02-15-00450\)](#) (August 2017)

payment year 2026 and beyond, clinicians in AAPMs have the opportunity for a .75% update to the CF while those not in AAPMs would receive a .25% update. While there will be a higher update to the conversion factor beginning in 2026 payment year for QPs in an AAPM as compared to non-QPs we do not believe that this higher update would be sufficient to incentivize participation. As CMS shows in the rule, the QP conversion factor is not expected to equate to the anticipated maximum positive payment adjustment under MIPS until after CY 2038. We urge CMS to include in its legislative agenda support for the continuation of the AAPM 5 percent bonus (e.g., support for legislation, such as the Value in Health Care Act (H.R. 4587)). If Congress does not act to extend the bonus, we urge CMS to take administrative actions within its authority that would mitigate the effects of the 5 percent bonus loss. This could include changes to benchmarking, increasing shared savings opportunities, reducing administrative burden, allowing more flexibility, and allowing longer transitions for APMs to downside risk.

In the rule, CMS asks about other factors that could influence the decision of clinicians to participate in AAPMs. While the 5 percent bonus payment is very important, there are other factors that affect an eligible clinician's decision about whether to participate in an Advanced APM. Providers consider whether the APM model aligns with care goals for their patient populations, especially whether the APM will enable them to be reimbursed for providing more coordinated high-quality care than the current system. In addition, providers assess the overall financial opportunity of participation in the APM, including: 1) the availability of shared savings; 2) whether the benchmark methodology sets financial targets that adequately risk adjust for factors beyond clinician control; 3) whether there is sufficient volume of patients so that a small number of outliers don't impact success; 4) administrative burden associated with data submission requirements; and 5) whether there is enough time for implementation before downside risk applies. Using its administrative authority to make changes to the program that address these factors can make it more attractive for providers to participate in Advanced APMs and improve health outcomes.

Qualifying Participants (QPs) in AAPMs

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

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

levels. The thresholds for 2022 performance year, will remain at 50% of the revenue received through the APM and 35% of their Medicare patients receiving services through the APM. We supported the change to these thresholds.

We remain deeply concerned about the increase to the thresholds that will occur in the 2025 payment year. The increasing thresholds that must be met to be considered qualified participants in an advanced APM will discourage participation, thereby limiting beneficiary access to high quality and better coordinated care. It is very difficult for APMs to increase the volume of payments received through the APM or amount of Medicare FFS patients who receive services through the APM. It is especially difficult for ACOs in rural areas and those that include specialists, since primary care determines ACO assignment.

We urge CMS to encourage Congress to take action that would give CMS the authority to set thresholds in the future at a level that will incentivize participation in advanced alternative payment models.

RFI: Potential Transition to Individual QP Determinations Only

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

In this proposed rule, CMS issues a Request for Information regarding whether QP determinations should be made at the individual clinician level rather than at the APM Entity Level. **We recommend that in future years CMS explore an approach to QP determinations that would better identify and reward individual eligible clinicians with substantial engagement in Advanced APMs.** The current approach incentivizes APM Entities to exclude from their APM Participation Lists clinicians (primarily specialists) who furnish proportionally fewer services that lead to attribution of patients or payment amounts to the APM entity. Specialists that are participants in an APM may tend to provide much fewer services to the patients in the APM. Under the current design of the program, the participation of these specialists could negatively impact clinicians who furnish services to large number of patients through the APM by dragging down the entity's collective QP threshold scores. This could discourage Advanced APM participation, which is contrary to the agency's plan for transitioning Medicare to a value-based program.

REQUESTS FOR INFORMATION

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs

CMS seeks feedback to inform future rulemaking to support the Agency’s goal of transitioning to digital quality measurement in its quality reporting and performance programs, with a focus on the use of FHIR-based application programming interfaces to support such efforts.

Definition of Digital Quality Measures (dQMs)

The AAMC believes that improved electronic health record (EHR) interoperability for the exchange and use of electronic health data has great promise to not only improve quality measurement and patient outcomes, but also to reduce burden on providers. However, we encourage CMS to continue to refine its definition of dQMs and set clear and specific parameters for what it hopes to achieve and what it expects of physicians. The other key principle is that the primary purpose of a medical record is for use by the care team to assess, plan for care, and transmit data to other providers. The EHR has been criticized in the past for becoming more of a tool for billing, obfuscating its use to relay critical information to the care team. As CMS looks at the important use of the EHR for dQMs, it must keep in mind that these processes must not interfere, delay, or hinder patient care.

The definition as revised in this Request for Information remains overly broad, and lists data sources including “administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, laboratory systems, prescription drug monitoring programs (PDMPs), instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data such as home blood pressure monitor, or patient-reported health data), health information exchanges (HIEs) or registries, and other sources.” Not all these data sources are ready for “prime time” and inclusion in quality measurement. For example, wearable devices and patient-generated health data hold great promise for the future but have not been vetted as valid and reliable interoperable data sources or as usable for clinical quality improvement and assessment. There is real concern that letting data from wearable devices or patient-generated health data flow freely into EHRs might obfuscate clinically relevant information rather than enhance it and may require redesigning clinical workflows to reduce clinician burden.^{34, 35} Beyond the validity and utility of the data generated, wearable devices such as smartwatches and fitness trackers are not universally adopted, with some research suggesting higher uptake by Americans with higher earnings or

³⁴ See Jim et al, [Innovations in Research and Clinical Care Using Patient-Generated Health Data](#), CA: A Cancer Journal for Clinicians Vol. 70: 182-199 (2020), finding challenges and solutions for the integration of PGHD into clinical care are presented. The challenges include electronic medical record integration of PROs and biometric data, analysis of large and complex biometric data sets, and potential clinic workflow redesign.

³⁵ See Lavalley et al, [mHealth and patient generated health data: stakeholder perspectives on opportunities and barriers for transforming healthcare](#), mhealth (2020), noting that significant barriers included data validity and actionability, and burden of integrating patient-generated health data into existing care processes.

levels of educational attainment.³⁶ CMS should be cautious about using data from wearable devices to ensure that such data does not invite bias or inequities. Finally, CMS should examine the regulatory frameworks for such data, as there might be issues of proprietary software, privacy laws, and cyber security when transferring the data into EHRs.

Approaches to Achieve FHIR eCQM Reporting

Last year, the AAMC recommended that CMS should also outline plans for piloting new data sources for quality measurement, identifying reasonable near-term and longer-term priorities. We are encouraged to see CMS respond in this year's RFI with an acknowledgement of an iterative process and a focus on more interoperable eCQM reporting. We believe that as CMS tests FHIR-based conversions for eCQM reporting, it should ensure that providers and their vendors are able to implement and optimize interoperable FHIR-based exchange without any unintended setbacks or consequences.

Finally, we continue to recommend that CMS engage the National Quality Forum (NQF) in this work, to ensure that digital measure specifications are appropriately evaluated for utility in improving quality of care. The AAMC and our members would welcome the opportunity to partner with CMS and to collaborate on more specific plans for digital quality measurement for the future.

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

CMS seeks feedback to inform future rulemaking to support the Agency's approaches to the adoption of the Office of the National Coordinator (ONC) for Health Information Technology (HIT)'s first version of the Trusted Exchange Framework and Common Agreement (TEFCA) as a universal policy and technical floor for interoperability. The AAMC is supportive of TEFCA and recommends that CMS create a collaborative environment for providers to engage with and implement TEFCA capabilities and use-cases. Due to the ongoing COVID-19 PHE, hospitals, health systems, and physicians have had to divert resources to manage surges and other operational constraints. Time is needed to allow hospitals and physicians to evaluate and implement TEFCA standards.

CONCLUSION

The AAMC continues to appreciate the work done by CMS during the public health emergency. We are committed to work collaboratively with the Agency to improve care delivery and study the lessons to be learned from the COVID-19 experience to enhance care, improve access and to promote equity.

³⁶ See Emily A. Vogels, [About one-in-five Americans use a smart watch or fitness tracker](#), Pew Research (Jan. 9, 2020) finding device use varies substantially by socioeconomic factors.

Administrator Brooks-LaSure
September 6, 2022
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The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org, Ki Stewart at kstewart@aamc.org or Phoebe Ramsey at pramsey@aamc.org.

Sincerely,

Rosha C. McCoy MD

Rosha Champion McCoy, MD, FAAP
Acting Chief Health Care Officer

cc: David J. Skorton, MD
CEO and President