TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

September 8, 2023

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

Re: 2024 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule (CMS-1784-P)

Submitted via Federal eRulemaking Portal at www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of our more than 57,000 Texas physician and medical student members, the Texas Medical Association (TMA) writes in response to the 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies as published by the Centers for Medicare & Medicaid Services (CMS) in the Aug. 7, 2023, *Federal Register*.

TMA is the largest state medical society in the nation and is committed to improving the health of all Texans. TMA's mission is empowering Texas physicians in the practice of medicine.

The proposed rule is estimated to lower the 2024 Medicare physician fee schedule conversion factor to 32.7476, or a 3.36% decrease compared with the 2023 conversion factor. The proposed conversion factor will go into effect on Jan. 1, 2024 unless Congress acts to prevent the cut. This is concerning for Texas physicians as the new 2024 cut is on top of the 2.5% cuts that took effect in 2023. These cuts harm practices trying to stay viable and care for the most vulnerable patients – older adults and people with disabilities.

The Medicare physician fee schedule continues to be highly flawed because it fails to keep up with inflation. Between 2001 and 2023, Medicare physician payments decreased by 26% when adjusted for inflation, while Medicare payments to hospitals and other health care facilities generally have kept pace with inflation, according to the American Medical Association (AMA). Over the same period, the consumer price index for physician services in U.S. cities increased by 65%.

Compounded by previous cuts, supply shortages, the rising costs and debts associated with medical education, and inflation, the result of these pay cuts for physician practices is devastating. **TMA wholeheartedly endorses a bill in Congress, the Strengthening Medicare for Patients and Providers Act (House Resolution 2474). We encourage CMS to work with Congress as they consider this bipartisan bill to reform this broken system and help ensure physicians are receiving inflationary updates, just like other Medicare providers receive.**

In addition, TMA supports Medicare payment policy principles developed by AMA and other medical societies that urge Congress to ensure financial stability and predictability for physician practices. **Financial stability is afforded through a baseline positive annual update that reflects inflation in practice costs. Further, budget neutrality requirements should be eliminated, replaced, or revised to allow for appropriate changes in spending growth.**

Specific to the Merit-Based Incentive Payment System (MIPS), TMA remains concerned that annual and incessant proposed changes significantly contribute to physician administrative burdens and regulatory

compliance challenges that result in physician burnout. **TMA pleads with the agency to alter MIPS requirements only as needed or when doing so significantly reduces the burdens physicians bear while navigating the MIPS program.**

While not addressed in the proposed rule, TMA urges CMS to address the growing and excessive electronic funds transfer, or EFT, fees charged by payers when paying physicians what they have earned. We implore the agency to address this policy within the 2024 final Medicare physician fee schedule. In August 2017, CMS posted a notice informing insurance companies that they weren't allowed to charge physicians a fee when they paid the doctors for their work. That notice later disappeared without explanation.

The shift to electronic processing began in the early 2000s when the Affordable Care Act (ACA) went into effect with the intention of increasing efficiency and saving money. However, insurers now routinely require physicians to pay out as much as 5% if they want to be paid electronically. That is another blow on top of declining reimbursements. Almost 60% of medical practices said they were compelled to pay fees for electronic payments at least some of the time, according to a 2021 MGMA survey.

ACA regulations addressed the standards for paying physicians via EFTs. The Act required all insurers to offer EFTs and encouraged doctors to accept them, which made electronic payments the go-to method for handling medical claims. A CMS analysis predicted that eliminating paper checks would lead to savings of $3 billion to $4.5 billion over 10 years.

TMA urges CMS to address via regulation the excessive electronic payment fees charged by payers when paying physicians what they have earned. AMA and more than 90 other physician groups urged the Biden administration to reinstate guidance protecting doctors' right to receive basic EFTs without additional fees.

Attached to this cover letter, TMA offers our detailed comments, recommendations, and suggestions to improve the Medicare program.

In summary, regarding Medicare physician payments, TMA:

- Fully supports CMS' proposal to delay implementation of the flawed Medicare Economic Index (MEI) cost weights.
- Continues to fully support AMA efforts to conduct a national study about practice expenses.
- Encourages CMS to work with AMA and Congress to enact legislative changes that provide financial stability and predictability through a baseline, positive annual update that reflects inflation in practice costs and addresses budget neutrality requirements to allow for appropriate changes in spending growth.
- Encourages CMS to work with AMA and the RVS Update Committee, or RUC, to remove any distortions from the resource-based relative value scale (RBRVS) currently in use by Medicare.
- Appreciates CMS' efforts to pay properly for evaluation and management (E/M) services but remains concerned that, due to the confines of the budget neutrality legislative requirements, payment for the office outpatient(O/O) E/M visit complexity add-on negatively impacts certain physician specialties that do not predominately utilize E/M codes.
- Encourages CMS to work with Congress and AMA to ensure physicians are paid appropriately for time spent caring for patients regardless of delivery type.

Regarding Medicare telehealth, TMA:

- Supports CMS' proposal to allow health and well-being coaching visits to be conducted via face-to-face telehealth, as long as the service is conducted synchronously via audio and video.
- Supports CMS' proposal to extend the in-person visit requirements until Dec. 31, 2024.

- Recognizes that CMS does not have the authority to permanently allow the patient's home to serve as an originating site for Medicare telehealth visits. TMA will continue to encourage Congress to remove the originating site geographic restrictions.
- Urges CMS to continue to permanently reimburse telehealth services at least at parity with in-person services. Reimbursement should remain informed by service type, as opposed to care setting.
- Implores CMS to allow physicians to conduct visits as needed from locations other than their primary practice setting without having to add their home address to their Medicare enrollment form.
- Supports CMS' proposal to allow direct supervision to be provided through a virtual presence and encourages CMS to permanently extend this flexibility.

Regarding other policies, TMA:

- Appreciates and concurs with CMS' proposal to further delay implementation of changes to split/shared billing arrangements.
- Supports the agency's proposal to include Medicare coverage and payment for the services of health care professionals who meet the qualifications for marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals, provided state scope-of-practice/licensure requirements are satisfied.
- Reminds CMS that it is imperative the agency ensure that any future Medicare coverage policies do not expand the scope of practice for nonphysician health care professionals.
- Remains concerned with the phased-in reductions in payment for laboratory tests ordered by qualified physicians and, as such, would support a change in federal law to eliminate the reporting requirement or to prohibit the use of lab reporting information for rate-setting.
- Encourages CMS to maintain the requirement that physicians must supervise pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation.
- Appreciates that CMS increased the bundled-episode payments for office-based opioid-use disorder (OUD) treatment, and that CMS clarified that audio-only interactions can meet Medicare requirements for reporting these services.
- Supports CMS' proposals to continue in-home administration for COVID-19, pneumococcal, influenza, and hepatitis B vaccines.
- Strongly supports the agency's proposal to pause and rescind appropriate use criteria (AUC) requirements and concurs with CMS that the goals of the AUC program have largely been met by the Quality Payment Program and other agency efforts.
- Does not support the proposal to shorten the current 30-day revocation reversal window for Medicare enrollment.
- Strongly supports coverage of the hemoglobin A1C test and applauds the agency for making proposals that adhere to United States Preventive Services Task Force (USPSTF) recommendations.
- Appreciates CMS adding the social determinants of health (SDOH) risk assessment without beneficiary cost-sharing, and that it is an optional element of the annual wellness visit.
- Steadfastly supports CMS including SDOH quality measures and recognizes that SDOH have a profound impact on patients and the physicians who care for them.

Regarding the Quality Payment Program (QPP), TMA:

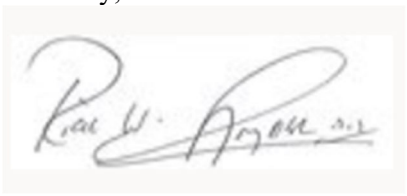
- Encourages CMS to consider advanced investment dollars and/or other incentives rather than penalties to assist accountable care organizations (ACOs) in complying with all-payer/all-patient reporting goals.
- Encourages the agency to consider implementing a pay-for-reporting period as physicians begin collecting and standardizing data on underserved Medicare beneficiaries.
- Appreciates that CMS plans to continue sending non-compliance notices to prescribers not using electronic prescribing for controlled substance prescriptions and helping them understand how they

can come into compliance. TMA urges CMS to maintain this practice and not penalize non-compliant prescribers.

- Understands that CMS is encouraging continued improvements in physician performance each year, but cannot understand the need to continuously change the program before participants have a chance to master the changes implemented the previous year.
- Implores CMS to take a step back and consider ways to improve the QPP without continuously adding resource-intensive administrative work to the practice.
- Is concerned about discussions that MIPS Value Pathways (MVPs) could become mandatory as CMS has suggested that it will eventually sunset MIPS and move participants to MVPs. Rather than force physicians into MVPs, TMA again asks CMS to focus on moving physicians to risk-based systems in voluntary, physician-led alternative payment models (APMs).
- Generally supports CMS' push for data completeness, but remains concerned about annual changes to the program that add to physician burden.
- Recommends that CMS encourage use of the High Priority Practices Guide in the SAFER Guides by making such use an optional bonus measure. Physicians should not be penalized to the point of having all of their Promoting Interoperability efforts reduced to zero for not completing one measure.
- Urges CMS to work with Congress to re-implement the advanced APM incentive payment.

Thank you for the opportunity to comment. TMA stands ready to provide you and others within the agency with our policy insight and any additional assistance you may find useful. If you have any questions, please do not hesitate to contact Robert Bennett, TMA vice president of medical economics, at Robert.Bennett@texmed.org.

Sincerely,



Rick W. Snyder II, MD
President
Texas Medical Association

COMMENTS OF THE TEXAS MEDICAL ASSOCIATION

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

Determination of PE RVUs (section II.B.)

Summary

CMS' current methodology for determining direct practice expense (PE) relative value units (RVUs) relies on data from the AMA Physician Practice Information Survey (PPIS); legislatively mandated supplemental sources such as survey data for oncology and hematology specialties; and, in some cases, crosswalks that allocate indirect PE for certain specialties and provider types.

In its final 2023 Medicare Physician Fee Schedule (PFS), CMS acknowledged the limitations and challenges raised in using current data for PE allocations after TMA and others asked the agency to wait for AMA to refresh its PPIS data. The final regulation, however, noted the "tension that waiting creates in light of concerns raised by other interested parties." CMS further stated that the "background and history above are mainly unchanged and possibly would not be addressed by an updated survey alone but may also require revisions to the PFS rate-setting methodology."

In the 2024 proposed rule, CMS seeks further suggestions to shape optimal PE data collection and methodological adjustments over time.

TMA Response

TMA fully supports CMS' proposal to delay implementation of the flawed Medicare Economic Index (MEI) cost weights pending completion of the AMA's Physician Practice Information Survey (PPIS) that will collect practice expense data directly from physician practices rather than using surrogate data sources.

TMA continues to fully support AMA efforts to conduct a national study about practice expenses. AMA's PPIS data will allow CMS to be more fully informed about the broad clinical, operational, and financial challenges that practices face. Since AMA is actively engaged in an extensive effort to collect updated cost data from physician practices, we again ask CMS to pause consideration of other sources of cost data for use in the Medicare Economic Index (MEI) until AMA has completed these efforts.

During 2023, nine of the largest state medical associations met with CMS to discuss the negative impact of the 2024 MEI reweighting plan on physicians in our states. The proposal would have rebased and revised the MEI practice expense geographic practice cost indices (GPCIs). It would have harmed the majority of physician practices in our higher-cost regions and made it more difficult for physicians to operate viable medical practices and maintain patient access to care.

In addition, TMA encourages CMS to work with AMA and Congress to enact legislative changes that provide financial stability and predictability through a baseline, positive annual update that reflects inflation in practice costs and addresses budget neutrality requirements to allow for appropriate changes in spending growth.

Potentially Misvalued Services Under the PFS (section II.C.)

Summary

CMS has the authority to examine potentially misvalued services in several categories. In addition, through an annual public nomination process, the agency receives public nominations for review of potentially misvalued codes by Feb. 10 of each year.

For 2024, the regulation lists CPT codes 59200, 27279 and three hospital inpatient and observation care visit CPT codes. In the 2024 proposed rule, the agency disagreed with the nominator that CPT code 59200 is potentially misvalued, expressed concern and asked for public input on whether 27279 as a 090 day surgical service can be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite).

Regarding the hospital inpatient and observation care visit codes, CMS proposes to maintain the values in the 2023 Medicare physician fee schedule final rule and seek further comments on these three codes as potentially misvalued.

TMA Response
It is TMA's policy to strongly support the AMA's development of a Medicare resource-based relative value scale (RBRVS) that is free of the distortions imposed by the federal government. Rather than modify code values through the fee schedule, we instead ask CMS to work with the RVS Update Committee (RUC) to value these and other services. **CMS should work with AMA and the RUC to remove any distortions from the RBRVS currently in use by Medicare.**

Payment for Medicare Telehealth Services (section II.D.)
Health and Well-Being Coaching
Summary
CMS proposes to add three health and well-being coaching services to the Medicare Telehealth Services List on a temporary basis for 2024:

1. CPT code 0591T (*Health and well-being coaching face-to-face; individual initial assessment);*
2. CPT code 0592T *(Health and well-being coaching face-to-face; individual follow-up session, at least 30 minutes)*; and
3. CPT code 0593T (*Health and well-being coaching face-to-face; group of 2 or more individuals for at least 30 minutes.)*

TMA Response
TMA supports CMS' proposal to allow health and well-being coaching visits to be conducted via face-to-face telehealth, as long as the service is conducted synchronously via audio and video. TMA agrees with CMS that these services should be delivered by clinicians acting within the scope of their respective state license and under physician supervision.

TMA recommends the addition of codes for sessions that are less than 30 minutes so clinicians may appropriately bill for sessions that necessitate less time than the 30-minute interval specified in the proposal.

Implementation of Provisions of the CAA, 2023; In-Person Requirements for Mental Health Telehealth
Summary
The Consolidation Appropriations Act (CAA) of 2023 delayed the requirements for an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, and again at subsequent intervals as CMS determines appropriate. Considering this legislative change, the in-person requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder will be effective on Jan. 1, 2025. Congress similarly delays the in-person visit requirements for mental health visits furnished by rural health clinics and federally qualified health centers via telecommunications technology.

TMA Response
TMA supports CMS' proposal to extend the in-person visit requirements until Dec. 31, 2025. TMA recognizes that since the early days of the COVID-19 public health emergency (PHE), patients may have established patient-physician relationships with psychiatrists far enough away that could create geographic challenges for the in-person visit. Texas is a big state with many rural areas, and as a result, requiring in-

person visit at specified intervals would be burdensome for patients, especially for geographically and socioeconomically vulnerable populations. Loss in access to psychiatric medications will have profound adverse effects, including increased inpatient hospitalizations.

We further support CMS' proposal to extend the in-person visit requirements considering the limited supply of psychiatrists to care for all mental health care needs.

Implementation of Provisions of the CAA, 2023; Originating Site Requirements

Summary

The CAA of 2023 temporarily expands the telehealth originating sites for any service on the Medicare Telehealth Services List to include any site in the U.S. where the beneficiary is located at the time of the telehealth service, including an individual's home, beginning on the first day after the end of the COVID-19 public health emergency (PHE) through Dec. 31, 2024.

TMA Response

TMA recognizes that CMS does not have the authority to permanently allow the patient's home to serve as an originating site for Medicare telehealth visits. Many patients suffer from comorbidities and chronic conditions that create mobility and transportation challenges. **Therefore, TMA will continue to encourage Congress to remove the originating site geographic restrictions.**

Place of Service for Medicare Telehealth Services

Summary

CMS proposes that, beginning in 2024, claims billed with place of service (POS) code 10 (Telehealth Provided in Patient's Home) be paid at the non-facility physician-fee-schedule rate. When considering certain practice situations (such as in behavioral health settings, where physicians and other practitioners have been seeing greater numbers of patients via telehealth), CMS asserts that physicians and practitioners will typically need to maintain both an in-person practice setting and a robust telehealth setting.

CMS notes there was an increase in utilization of these mental health services during the COVID-19 PHE that has persisted throughout and after its expiration. As a result, these physicians and practitioners continue to maintain their office presence even as a significant proportion of their practice's utilization may be comprised of telehealth visits. As such, CMS believes practice expenses are more accurately reflected by the non-facility rate.

TMA Response

TMA urges CMS to continue to permanently reimburse telehealth services at least at parity with in-person services. Reimbursement should remain informed by service type, as opposed to care setting. Physicians should have the flexibility to make clinically informed decisions about whether a telehealth or in-person visit would be most beneficial for the patient (consistent with the standard of care), without disconnected pricing incentives. TMA agrees that certain resource-based adjustments should be made when applicable.

Reporting Home Address for Telemedicine Visits

Summary

Section 1848 of the Social Security Act requires CMS to apply geographic practice cost indices to adjust physician fee schedule payments based on the relative resource costs in different fee schedule areas. For services payable under the Medicare physician fee schedule (PFS), the address where the physician or supplier furnishes a service determines the locality used to geographically adjust the PFS payment amount.

Physicians and practitioners who submit a claim to Medicare are generally instructed to report the location where the service was rendered as the "service location" (item 32 on the paper claim Form CMS-1500 or its electronic equivalent) to determine the locality used for payment. This location may differ from the physician or practitioner's billing address, which is also required on the claim (item 33).

During the COVID-19 PHE, CMS allowed physicians and practitioners to render telehealth services from their homes without reporting their home address on their Medicare enrollment, while continuing to bill from their currently enrolled location. Under the agency's current policies, this flexibility was extended from the conclusion of the COVID-19 PHE on May 11, 2023 through Dec. 31, 2023. The agency indicated updates to this policy would be considered as part of the PFS rulemaking process for calendar year 2024 and beyond.

A CMS representative via email advised TMA that physicians who have concerns about their home address appearing publicly through Care Compare can contact Care Compare through https://qpp.cms.gov/ to provide an alternate address or have their home address suppressed.

In the 2024 Medicare PFS, CMS is surprisingly silent on the issue of reporting the physician's home address for telemedicine visits performed in their home after Dec. 31, 2023.

TMA Response
TMA implores CMS to reconsider this requirement and allow physicians to conduct visits as needed from locations other than their primary practice setting without having to add their home address to their Medicare enrollment form. This allows physicians to extend the hours they are available to patients without concern that their address will be made public or their Medicare enrollment form is updated.

Physicians who provide behavioral health services may only conduct telemedicine visits from their home. Physicians should have the option of not including their home address in the directory. The nature of this population of patients introduces a heightened level of safety concerns. CMS also requires physical locations to be subject to onsite visits to ensure they are suitable to provide care. The requirements include proper equipment, sanitation, privacy, and compliance with relevant laws and regulations. TMA believes the physical attributes of the inspection are not needed at the distant site when delivering telehealth services.

Direct Supervision via Use of Two-Way Audio/Video Communications Technology
Summary
CMS proposes to continue to define direct supervision to permit the presence and "immediate availability" of the supervising physician or practitioner through real-time audio and visual interactive telecommunications through Dec. 31, 2024.

TMA Response
TMA is supportive of CMS' proposal to allow direct supervisions to be provided through a virtual presence and encourages CMS to permanently extend this flexibility. It is important for rural or distant training centers with residency and fellowship programs, especially those with satellite facilities, to have the option of virtual supervision.

Valuation of Specific Codes (section II.E.)
Summary
CMS is required to modify the technical component (TC) of certain imaging services (established for a year under the fee schedule) if the TC exceeds the Medicare hospital outpatient payment department (HOPD) fee schedule established under the Outpatient Prospective Payment System (OPPS). For such services and codes, CMS substitutes the fee schedule amount for the TC for the year. For imaging services furnished after 2007, CMS caps the TC of the PFS payment amount for the year by the HOPD payment amount for the service. CMS then applies the PFS geographic adjustment to the capped payment amount.

In the proposed rule starting on page 52311, CMS proposes ten codes meet the definition of imaging services, subjecting them to the OPPS cap, for 2024.

TMA Response
It is TMA's policy to strongly support AMA development of a Medicare resource-based relative value scale (RBRVS) that is free of the distortions imposed by the federal government. Rather than modify codes through the fee schedule, we instead ask CMS to work with the RUC to value these and other services. **CMS should work with the AMA and the** RVS Update Committee (**RUC) to remove any distortions from the RBRVS currently in use by Medicare.**

Evaluation and Management (E/M) Visits (section II.F.)
Summary
Over the past several years, CMS has engaged with the AMA and other interested parties to update coding and payment policies for evaluation and management (E/M) services that better reflect the current practice of medicine, reduce administrative complexity, and facilitate more accurate payment.

For 2023, the CPT Editorial Panel revised other E/M code families (except critical care services) to match the general framework of the office/outpatient (O/O) E/M codes, including inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. CMS incorporated these changes in the final 2023 Medicare physician fee schedule (PFS).

While CMS adopted RUC-recommended values for most other E/M codes which increased their relative valuation in aggregate, the agency stated that certain types of O/O E/M services remain undervalued. More specifically, CMS expressed concern over assumptions, direct comparisons, and survey times made in the RUC recommendations. These concerns discuss that patient needs were inherently more complex, or work was more intense for E/M services furnished in non-office settings such as inpatient, ED, and home visits when compared with office settings.

In 2021, Congress imposed a moratorium on Medicare payment under the PFS for Healthcare Common Procedure Coding System (HCPCS) code G2211 until the end of 2023. CMS acknowledged this delay and cited concerns about the expected budget neutrality adjustment necessitated by implementation of the G2211 add-on and the legislatively required redistributive impact on PFS payment.

Separately within this section, CMS includes proposals regarding split (or shared) visit coding and documentation policies. A split visit refers to an E/M service performed by both a physician and a nonphysician practitioner (NPP) in the same group practice. In an office setting, the billing rules for "incident to" apply under this circumstance. This is not the case for split services furnished in a facility. Longstanding CMS policy asserts that physicians can bill for E/M services if they perform a "substantive portion" of the encounter. Otherwise, the NPP would bill for the service.

In 2022, CMS finalized a new policy for E/M visits furnished in a facility setting, allowing payment to a physician for a split visit (including prolonged visits) when a physician and NPP provide the service together (not necessarily concurrently), and the billing physician personally performs a substantive portion of the visit. At the time, CMS defined "substantive portion" of the visit as more than half of the total practitioner time. As such, physicians are required to see the patient for more than half of the total time of a split/shared E/M visit to bill for that service. In 2023, after considering comments received, CMS delayed implementing this policy until Jan. 1, 2024.

In this proposed rule, CMS again recommends delaying implementation of the agency's 2022 definition of "substantive portion", this time through at least Dec. 31, 2024. The agency also proposes to maintain the current definition of substantive portion for 2024 that allows for use of either one of the three key components (history, exam, or medical decision-making) or more than half of the total time spent to determine who bills the visit.

TMA Response
We appreciate the agency's revised utilization assumptions for the G2211 E/M add-on code from 90% to 38%, yet echo concerns raised regarding the utilization assumptions for G2211, which causes the majority of the 2024 budget neutrality reduction proposed in this regulation. **TMA appreciates CMS' efforts to pay properly for E/M services but remains concerned that, due to the confines of the budget neutrality legislative requirements, payment for the O/O E/M visit complexity add-on negatively impacts certain physician specialties that do not predominately utilize E/M codes.** TMA advocates for payment policies to be fair for all physician specialties. Budget neutrality requirements unfairly pit certain physician specialties against others by encouraging division among specialists and primary care physicians.

While TMA acknowledges and supports CMS' work regarding complex patients, we are concerned about this add-on code since:

1. The code drives a significant payment reduction to the overall MPFS for 2024. Specifically, CMS notes that approximately 90% of the negative 2.17% budget neutrality adjustment to the conversion factor for CY 2024 is attributable to G2211, with all other proposed valuation changes making up the other 10%.
2. It is complicated, as proposed, on when to use the add-on code and how to document it.
3. The comparison to existing CPT codes is problematic and could create confusion for physicians.
4. It is of limited use as it only applies to O/O E/M codes, which may not be the most effective. Billing this HCPCS code with other E/M codes (e.g., home visits) would be more effective in ensuring physicians with the sickest patients are able to bill properly.

TMA encourages CMS to provide more clarification and examples on when physicians can use this code.

Furthermore, TMA encourages CMS to work with Congress and AMA to ensure physicians are paid appropriately for time spent caring for patients regardless of delivery type. TMA recommends that CMS apply the office visit E/M increases uniformly across all services and specialties and not hold specific specialties to a different standard from others.

Finally, we appreciate and concur with CMS' proposal to further delay implementation of changes to split/shared billing arrangements. TMA encourages CMS to monitor how this policy impacts physician and provider practice. We ask CMS to clarify how the agency will process claims using one of the three key components (history, exam, or medical decision-making). Specifically, CMS should specify whether it will require history or exam to be documented as it would have been prior to 2021, or if a physician deems looking at one element on the exam as medically appropriate supporting enough to meet the "more than half time."

<u>Advancing Access to Behavioral Health (section II.J.)</u>
Summary
Congress passed the Consolidated Appropriations Act of 2023, which provides for Medicare coverage and payment for the services of health care professionals who meet the qualifications for marriage and family therapists (MFTs) and mental health counselors (MHCs).

The law defines "marriage and family therapist services" as services furnished by an MFT for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT is legally authorized to perform under state law of the state in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service. It also defines the term MFT to mean an individual who:

- Possesses a master's or doctoral degree that qualifies for licensure or certification as a MFT pursuant to state law of the state in which such individual furnishes marriage and family therapist services;
- Is licensed or certified as an MFT by the state in which such individual furnishes such services;

- After obtaining such degree, has performed at least two years of clinical supervised experience in marriage and family therapy; and
- Meets such other requirements as specified by CMS.

CMS also proposes to create two new HCPCS codes (GPFC1 and GPFC2) describing psychotherapy for crisis services furnished in any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting. In the 2022 physician fee schedule final rule, CMS defined the term "home" broadly to include temporary lodging, such as hotels and homeless shelters.

The proposed new G-codes and their descriptors are:

- GPFC1 (*Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes*); and
- GPFC2 (*Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (List separately in addition to code for primary service)*).

The agency proposes to calculate the work, practice expense (PE), and relative value units (RVUs) for GPFC1 and GPFC2 by multiplying the work, PE, and RVUs for CPT codes 90839 and 90840, respectively, by 1.5.

TMA Response
TMA affirms both mental and physical health are critical to a patient's overall well-being. As such, we support equitable treatment, service, and payment parity for mental health, including substance misuse and dependence, equal to that for other medical conditions. TMA continues to educate members, patients, the media, legislators, and policymakers about the efficacy and cost-effectiveness of support, services, and interventions for mental health. In that spirit, **we support the agency's proposal to include Medicare coverage and payment for the services of health care professionals who meet the qualifications for MFTs and mental health counselors (MHC) when billed by these professionals (provided that state scope-of-practice/licensure requirements are satisfied as discussed more fully below).**

For purposes of such MFT and MHC services, TMA appreciates that CMS does not disrupt long-standing "incident-to" billing arrangements among physicians and nonphysician practitioners.

Because scope of practice laws are generally governed by states (as a critical component of regulating health and welfare), TMA concurs with the proposal since CMS defers to state laws and rules that govern a health professional's scope of practice/licensure, including any delegation and supervision requirements applicable under state laws. This is important to maintain consistent quality in patient care and prevent confusion. Scope of licensure/practice, including any delegation and supervision requirements, has been carefully tailored at the state level to account for each state's licensure requirements. **It is imperative that CMS ensure that any future Medicare coverage policies do not expand the scope of practice for nonphysician health care professionals.**

Regarding psychotherapy for crisis services furnished in any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, TMA wholeheartedly supports the agency's proposals.

<u>Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Medical Services (section II.K.)</u>
Summary
Generally, Medicare precludes payment under Medicare Parts A or B for any expenses incurred for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.

In 2023, CMS identified certain clinical scenarios where payment is permitted under both Medicare Parts A and B for certain dental services, and the agency established a process for the public to submit additional dental services that may be inextricably linked to other covered services for consideration and review.

For 2024, CMS proposes to cover additional dental services it considers integral to the successful outcome of a Medicare covered clinical service, specifically those used to identify, diagnose, and treat:

- Oral or dental infections in connection with certain cancer treatments, including chemotherapy;
- Chimeric antigen receptor (CAR) T-Cell therapy; and
- High-dose bone modifying agents.

The regulation also proposes to clarify that eligible dental services related to treatments for head and neck cancer may occur in an inpatient or outpatient setting, and may occur prior to the initiation of or during treatment for head and neck cancer, whether primary or metastatic, regardless of site of origin and/or initial modality of treatment.

The agency requests input on whether additional dental services should be added, specifically those considered inextricably linked to cardiac intervention services and treatment for sickle cell disease, hemophilia, auto-immune conditions, diabetes, and other chronic conditions.

In addition, the agency clarifies that Medicare will not pay for dental services that are not immediately necessary to eliminate or eradicate infections prior to chemotherapy or administration of CAR T-cell therapy or necessary to the success of antiresorptive therapy would not be covered by Medicare, including dental implants, crowns, or dentures. CMS seeks comment on possible overlap of dental coverage plans/third-party payers.

TMA Response
Generally, TMA supports the proposed additional dental services. We encourage CMS to also cover other conditions (such as sickle cell, aplastic anemia who need transplant, etc.) that may be treated with the same regimens that are used for people with cancer. Their risks are the same even though they have a different diagnosis. Furthermore, for Medicare beneficiaries requiring their teeth to be removed because of their cancer treatment, restoration (e.g. dentures, implants) should be covered.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section II.B.)
Summary
Congress extended payment for telehealth services furnished by FQHCs and RHCs for the period beginning on the first day after the end of the COVID–19 public health emergency (PHE) and ending Dec. 31, 2024, if the PHE ends prior to that date. CMS continues to make payments under this methodology.

TMA Response
TMA fully supports payment to RHC and FQHCs for telehealth services.

Clinical Laboratory Fee Schedule (CLFS): Revised Data Reporting Period and Phase-in of Payment Reductions (section III.D.)
Summary
In 2014, Congress passed the Protecting Access to Medicare Act, which requires significant changes to how Medicare pays for clinical diagnostic laboratory tests (CDLTs) under the Clinical Laboratory Fee Schedule (CLFS). CMS now proposes that for the data reporting period Jan. 1- March 31, 2024, the corresponding data collection period will be Jan. 1- June 30, 2019. Afterward, CMS will continue data reporting every three years.

The agency also proposes phased-in laboratory payment reductions. Specifically, payment for CLDTs in 2023 will not be reduced below the 2022 payment. For 2024-2026, laboratory payments will not be reduced by more than 15% below the proceeding calendar year rate.

TMA Response
TMA remains concerned with the phased-in reductions in payment for laboratory tests ordered by qualified physicians. Clinical diagnostic tests are foundational to clinical decision-making, informing 70% of medical decisions that guide patient care. Between 2017 and 2022, payment for common tests for diseases like diabetes, cancer, and heart disease were cut by 27%. The next round of Medicare cuts would drop reimbursement up to another 15% for about 800 laboratory tests widely used to screen, and TMA opposes federal mandates that require private-sector reporting of CDLT data. **As such, we would support a change in federal law to eliminate the reporting requirement or prohibit the use of lab reporting information for rate-setting.**

Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Expansion of Supervising Practitioners (section III.E.)
Summary
To fulfill a statutory requirement effective Jan. 1, 2024, CMS proposes to expand the types of practitioners who may supervise pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation programs to include a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).

TMA Response
While TMA understands the agency's implementation of the statutory requirement regarding the programs, we strongly oppose removing the requirement that physicians supervise all pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation and expanding supervision privileges to PAs, NPs, and CNSs. TMA encourages CMS to maintain the requirement that physicians must supervise pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (section III.F.)
Summary
During 2023 rulemaking, CMS finalized rates for bundled episodes of care for OUD services provided through OTPs to reflect more resources devoted to psychotherapy.

CMS now proposes to similarly increase bundled-episode payments for office-based OUD services that are also included on the Medicare Telehealth List. Consequently, audio-only interactions would meet Medicare requirements for reporting OUD services. For services provided through OTPs, CMS proposes to continue allowing periodic assessments to be provided via audio-only communications in 2024.

TMA Response
We appreciate that CMS increased the bundled-episode payments for office-based OUD treatment and that CMS clarified that audio-only interactions can meet Medicare requirements for reporting these services.

Medicare Shared Savings Program (section III.G.)
Quality Performance Standard and Other Reporting Requirements (section III.G.2)
Summary
To further move Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) toward digital measurement and promote alignment with the Quality Payment Program (QPP), CMS proposes several changes to the alternative payment model (APM) performance pathway (APP) quality performance standards and reporting requirements.

CMS set a goal of transitioning ACOs from MSSP-specific web interface measures to electronic clinical quality measures that align with QPP reporting requirements. This means that MSSP ACOs would have to report quality measures on all patients and all payers, not just Medicare beneficiaries or those with a primary care relationship with ACO clinicians.

In response to feedback from numerous stakeholders and recognizing the cost, administrative burden, and potential negative impact on ACO performance, CMS proposes the establishment of Medicare clinical quality measures (CQMs) to ease ACO transition to the previously proposed all-payer/all-patient reporting requirements. For performance year (PY) 2024, ACOs may still report quality data via the CMS Web Interface (10 measures); or they have the option of reporting three measures under the eCQM (electronic health record), MIPS CQM (registry) and/or Medicare CQM (ACO) data types, along with two claims-based measures. All reporting options require administration of the Consumer Assessment of Healthcare Providers and System (CAHPS) for Merit-Based Incentive Payment System (MIPS) Survey. Beginning in PY 2025 and subsequent years, the CMS Web Interface will no longer be available, and ACOs must report via the remaining collection types. CMS will determine the timeframe to sunset Medicare CQMs in future rulemaking. The data completeness threshold for MSSP ACOs is proposed at 75% for the PY 2024-26 and 80% for PY 2027.

TMA Response
TMA appreciates the introduction of Medicare CQMs as a transition to the all-patient/all-payer requirements initially proposed by CMS. As noted by the agency, however, challenges still prevail. ACO capabilities to collect, normalize, and report data vary widely. Well-funded organizations sponsored by integrated health systems, payers, private equity-backed organizations, and for-profit aggregators are able to comply with all-payer/all-patient reporting mechanisms at a much faster rate than others. As CMS moves forward with its venerable goal of consolidating quality measures across all programs, the agency is urged to consider financial and administrative burdens that many low-revenue ACOs must face to sustain MSSP participation. As described in the proposed rule, this will include ongoing monitoring and revision of Medicare CQM reporting policies – hopefully well into the future.

TMA encourages CMS to consider advanced investment dollars and/or other incentives, rather than penalties, to assist ACOs in complying with all-payer/all-patient reporting goals.

Expanding the Health Equity Adjustment to Medicare CQMs (section III.G.2b4)
Summary
Beginning with performance year (PY) 2023, CMS finalized a positive health equity adjustment on Merit-Based Incentive Payment System (MIPS) quality performance scores for ACOs that successfully report e-clinical quality measures (CQMs) and/or MIPS CQMs; meet quality benchmarks; and serve a higher portion of underserved beneficiaries. CMS proposes that for PY 2024 and beyond, ACOs reporting Medicare CQMs also would be eligible for the health equity adjustment to their quality performance category score when calculating shared-savings payments.

TMA Response
TMA supports this proposal and recognizes the importance of a health equity adjustment in recognition of ACOs serving a high proportion of underserved beneficiaries who have traditionally lacked access to care or non-clinical resources that significantly impact their health. **CMS has recognized, significant gaps in model design and data collection to support health equity goals, and the agency may wish to consider implementing a pay-for-reporting period as physicians begin collecting and standardizing data on underserved Medicare beneficiaries.**

Proposals to Align CEHRT Requirements for Shared Savings Program ACOs with MIPS (section III.G.2h)
Summary
Under current policy, a Medicare Shared Savings Program (MSSP) accountable care organization (ACO) that does not meet the standards to be an advanced alternative payment model (APM) must certify annually

that at least 50% of eligible clinicians use certified electronic health record technology (CEHRT) to document and communicate clinical care to their patients or other health care providers. Advanced APM ACOs must certify annually that at least 75% of their clinicians use CEHRT. To streamline CEHRT threshold requirements for ACOs and better align reporting with the Merit-Based Incentive Payment System (MIPS), CMS proposes to eliminate CEHRT threshold requirements in 2024, and all ACO clinicians must utilize CEHRT unless they meet MIPS exclusion or hardship exemptions.

In the final 2023 PFS, CMS introduced a voluntary reporting option for APM entities to report the MIPS Promoting Interoperability (PI) performance category at the APM entity level while their clinicians maintain the option to report at the individual or group level. Effective Jan. 1, 2024, CMS will require all MIPS-eligible clinicians, qualifying participants (QPs), and partial QPs participating in an ACO to report the PI performance category measures and requirements to MIPS. This can be done as an individual, group, virtual group, or via the ACO as an APM entity. Further, the ACO must publicly report the number of ACO clinicians who earn a MIPS PI category score. Specialists in an ACO have the option to report under a MIPS Value Pathway (MVP) as of the beginning of the 2023 calendar year.

TMA Response
TMA applauds CMS' efforts to address administrative burdens associated with MSSP participation and to better align compliance requirements among many disparate quality and value-based care programs. However, it must be said again that ongoing changes to QPP/MIPS participation and reporting requirements have significant downstream impacts on individual physician practices and their ability to participate in CMS/ Center for Medicare & Medicaid Innovation alternative practice models. The same holds true for ACO entities as CMS attempts to link truly innovative and successful APMs with the complex and challenging QPP, which brings heightened stress, administrative hassles, and financial risk to struggling practices with little or no reward.

<u>Determining Beneficiary Assignment Under the Shared Savings Program (section III.G.3)</u>
Summary
CMS proposes modifications to accountable care (ACO) attribution methodologies that would add an estimated 1 million beneficiaries to the Medicare Shared Savings Program (MSSP). Currently, ACO beneficiary assignment is based on voluntary selection by the beneficiary or by their utilization of primary care services provided by physicians in the ACO. Effective Jan. 1, 2025, CMS proposes a third step to the attribution process that will extend the current 12-month assignment window to 24 months. This would allow attribution for beneficiaries who receive primary care services from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month assignment window with at least one physician visit in the preceding 12 months. This will make it easier to attribute beneficiaries who do not need to or simply refuse to see a physician every year.

TMA Response
In addition to driving CMS towards its 2030 MSSP participation goals, the agency projects that this proposal will promote health equity goals to reach a larger share of beneficiaries enrolled in Medicare's disabled category, those receiving the Medicare Part D low-income subsidy (LIS), and those residing in areas with higher area deprivation index (ADI) scores. TMA strongly supports this proposal that will expand MSSP access to traditionally underserved beneficiaries, resulting in a number of downstream benefits relating to assigned populations, including size requirements for MSSP participation, setting benchmarks, calculating risk scores, and issuing health equity adjustments. While this will likely have the biggest impact on ACOs with populations receiving care from nurse practitioners, physician assistants, and clinical nurse specialists, CMS has ensured that physician visits continue as the key driver of attribution.

In visiting with physician leaders in the ACO community, however, it was noted that several low-revenue ACOs providing care to beneficiaries in rural communities and cities and towns along the Texas-Mexico border are currently struggling to meet the 5,000-beneficiary threshold required for MSSP participation. Loss of just one participating physician due to retirement, practice closure or consolidation, or recruitment

by a larger regional ACO can have a devastating impact on an ACO's attribution. CMS could consider lowering attribution requirement for ACOs in these areas that will be crucial in helping the agency to achieve its health equity goals.

Proposal To Cap Regional Service Area Risk Score Growth for Symmetry With ACO Risk Score Cap (section III.G.4b)

Summary

Building off the 2023 final physician fee schedule, CMS proposes to modify the three-way blended benchmark update methodology used by the Medicare Shared Savings Programs (MSSP). This methodology couples national and regional growth rates determined after the end of each performance year with a fixed projected growth rate (the accountable care prospective trend) established at the beginning of the accountable care organization's (ACO's) agreement period. In establishing historical benchmarks CMS adjusts expenditures for changes in condition severity and case mix over time using the CMS prospective hierarchical condition category (HCC) risk score. HCCs are adjusted between benchmark year three and the performance year, and are capped at 3% for the five-year agreement period. (Note that separate adjustments are made for each beneficiary enrollment type – end-stage renal disease, disabled, aged/dual eligible, and aged/non-dual eligible.)

Critics have raised concerns that current policies place a cap on an ACO's risk score growth, but not on the regional score, which is reflected in calculations to update the regional growth rate. Beginning Jan. 1, 2024, CMS proposes that the risk-adjustment process recognize the regional component of the update by capping the regional risk score growth at 3% with an additional market-share adjustment that increases the cap for ACOs with larger market share.

TMA Response

TMA is cautiously optimistic about this proposal and appreciates that CMS is open to recommendations from the ACO community. When an ACO has a large market share, its success can significantly impact the regional benchmark, lowering the market trend to unattainable levels. Application of the risk cap to both the ACO and region offers a more equitable marketplace for all and incentivizes ACO growth in rural and underserved markets. TMA encourages CMS to carefully monitor the impact of Medicare Advantage (MA) on historical benchmarks given that its growth continues to outpace traditional fee for service, along with its ability to risk-adjust annually and cherry-pick plan offerings by county.

Proposed Modifications to Advance Investment Payments (AIP) Policies (section III.G.5b)

Summary

Finalized in 2023, the AIP program was limited to new, low-revenue accountable care organizations (ACOs) that were inexperienced with performance-based risk. As such, the regulations required that an ACO remain inexperienced with risk while receiving advance investment payments. Starting Jan. 1, 2024, CMS proposes to modify the eligibility requirements so that an AIP ACO may advance to two-sided risk under the BASIC track's glide path beginning in performance year three of its five-year agreement period. The ACOs may not use AIP to fund repayment mechanisms or repay shared losses.

TMA Response

TMA is supportive of this proposal as it allows flexibility for ACOs to advance to higher levels of risk at their own pace. We continue to urge CMS to consider offering AIP opportunities for renewing, low revenue ACOs that require additional investment to sustain participation in the MSSP. This could include those who have not met shared savings, those caring for underserved populations, and those attempting to comply with e-clinical quality measure (CQM) or Merit-Based Incentive Payment System CQM reporting. This type of up-front investment would enable them to develop and deploy technologies and care coordination resources.

Shared Savings Program Eligibility Requirements (section III.G.6)

Summary

CMS intends to remove the option for accountable care organizations (ACOs) to request an exception to the shared governance requirement that 75% control of the ACO's governing body must be ACO participants. The agency has not granted an ACO an exception to this requirement to date despite having the regulatory capacity to do so. CMS believes the 75% requirement is critical to ensure ACOs are participant-led and has implemented a similar requirement for the ACO Reach program.

TMA Response

TMA strongly supports this requirement with the belief that physicians should be leaders of the health care team, and this includes ACO governance. This becomes increasingly important as clinicians look outside the health care community for funding, technology, and other resources required to participate in CMS value-based care programs.

Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H.)

Summary

The agency proposes to continue reimbursement for in-home administration of the COVID-19 vaccine (Healthcare Common Procedure Coding System code M0201). The agency also proposes to extend in-home administration payment to pneumococcal, influenza, and hepatitis B vaccines. In-home administration payment ($36.85 in 2023) is limited to one payment per home visit even if multiple vaccines are administered during the same home visit.

The agency clarified that it would continue to update the payment amount for in-home administration annually by the percentage increase in the Medicare Economic Index (projected to be 4.5% in 2024 and geographically adjusted).

TMA Response

TMA remains dedicated to helping ensure all Texans are fully vaccinated. As such, we support CMS' proposals to continue in-home administration for COVID-19, pneumococcal, influenza, and hepatitis B vaccines.

Appropriate Use Criteria for Advanced Diagnostic Imaging (section III.J.)

Summary

In 2014, notably before passage of more comprehensive Medicare physician payment reforms via the Medicare Access and CHIP Reauthorization Act of 2015, Congress passed a law dictating that, to receive payment for advanced diagnostic imaging, a *furnishing professional* (e.g., radiology) must collect and report to CMS the *ordering professional's* (e.g., primary care specialist) appropriate use criteria (AUC) consultation information. This includes the ordering professional's national provider identifier number (NPI), the qualified clinical decision support mechanism (CDSM) that was consulted, and whether the service ordered adheres to the AUC consulted (if applicable).

After detailing extensive efforts to operationalize the AUC program, the agency now observes that, "we have exhausted all reasonable options for fully operationalizing the AUC program consistent with the statutory provisions." As such, CMS proposes to pause implementation of the AUC program indefinitely for reevaluation.

TMA Response

We greatly appreciate the agency's recognition of the burden AUC requirements impose on both ordering and furnishing professionals. **TMA strongly supports the agency's proposal to pause and rescind AUC requirements, and concurs with CMS that the goals of the AUC program have largely been met by the Quality Payment Program and other agency efforts.**

Medicare and Medicaid Provider and Supplier Enrollment (section III.K.)

Summary

While CMS has existing policy to revoke a provider or supplier's (including physicians) enrollment if they have been convicted of a federal or state felony, the agency proposes to now include the conviction of a misdemeanor under federal or state law within the previous 10 years as a reason for revocation.

CMS also proposes to require all Medicare providers and suppliers to report additions, deletions, or changes in their practice locations within 30 days.

CMS has authority to deactivate a provider's or supplier's Medicare billing privileges for several reasons. The agency discusses that:

> A deactivation differs from a revocation in that the former: (1) merely involves the stoppage, rather than the termination, of the provider's or supplier's billing privileges; and (2) does not entail any reenrollment bar under § 424.535(c). The latter is a particularly important distinction, for a deactivated provider or supplier can reactivate its billing privileges by following the procedures in § 424.540(b). It need not wait (as a revoked provider or supplier must) for the expiration of the 1-to-10-year bar period referenced in § 424.535(c) before attempting to restore its ability to bill Medicare. Indeed, we sometimes impose a deactivation instead of a revocation when we believe a more modest sanction is warranted.

As such, CMS proposes a new 60-day "stay of enrollment" designation that the agency could use to delay revocation or deactivation of billing privileges for simple paperwork mistakes or missed deadlines. The 60-day stay is discretionary and will be determined by the agency on a case-by-case basis. Providers or suppliers will not receive payments for services or items furnished to Medicare patients during the stay of enrollment.

TMA Response

TMA cannot support the agency's proposal not to pay providers or suppliers for services or items furnished to Medicare patients during the "stay of enrollment." Instead, we urge CMS to implement a process for providers or suppliers who submit the proper paperwork within the 60-day time frame to dispute Medicare non-payment decisions made during the "stay of enrollment."

Regarding the proposal to reduce the 30-day period to 15 days. TMA believes this shortened period may not be possible for providers and suppliers who are acting in good faith to sever contractual relationships with an offending party. For these reasons, **TMA does not support the proposal to shorten the current 30-day revocation reversal window.**

Expand Diabetes Screening and Diabetes Definitions (section III.L.)

Summary

CMS proposes to cover the hemoglobin A1C (HbA1c) test for diabetes and prediabetes screening purposes, as consistent with updated United States Preventive Services Task Force (USPSTF) recommendations. The agency proposes to also align screening frequency caps at twice within a rolling 12-month period and simplify the definition of diabetes by removing codified clinical test requirements, which is required for some but not all diabetes services.

TMA Response

We strongly support coverage of the hemoglobin A1C test and applaud the agency for making proposals that adhere to USPSTF recommendations. We appreciate that CMS recognized rolling 12-month periods.

Requirements for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan (section M.)

Updates to CMS EPCS Program Exceptions for Cases of Recognized Emergencies and Extraordinary Circumstances

Summary

CMS proposes to further modify the recognized emergency exception and the extraordinary circumstances waiver. The proposal allows CMS to extend electronic prescribing for controlled substances (EPCS) waivers to all prescribers in the geographic area of an emergency. CMS proposes to further allow this waiver to extend for the full measurement/calendar year. Additionally, CMS would continue to allow prescribers to apply for EPCS waivers based on circumstances beyond the prescribers' control.

TMA Response

TMA agrees with and appreciates CMS' proposal to extend EPCS waivers as it reduces physician burden when CMS can apply a blanket waiver to a geographic region impacted by a declared disaster. TMA further agrees that it reduces the burden of calculating EPCS compliance when the waiver is extended for the full measurement year.

Actions for Non-Compliance with EPCS Compliance

Summary

CMS proposes to continue through Dec. 31, 2024, the practice of sending notices of non-compliance with EPCS compliance to prescribers who prescribe more than 100 Schedule II-V controlled substances in a calendar year, or as CMS terms it, a measurement year.

TMA Response

TMA appreciates that CMS plans to continue sending non-compliance notices and helping prescribers understand how they can come into compliance. TMA urges CMS to maintain this practice and to not penalize non-compliant prescribers. TMA recognizes the importance of EPCS but implores CMS to better understand why a small minority of prescribers consciously choose to not adopt EPCS. The Surescripts 2022 National Progress Report indicates that 81.9% of prescribers are now EPCS-enabled. TMA requests that CMS reveal the number of non-compliance letters sent to prescribers each year and to continue to share data on the percentage of Medicare Part D prescribers now using EPCS based on data collected by CMS.

Hospice: Changes to the Hospice Conditions of Participation (section III.O.)

Summary

Congress passed a law that requires an interdisciplinary group in hospice care to include at least one clinical social worker, marriage and family therapist, or mental health counselor. In this proposed rule, CMS compared and contrasted these three nonphysician provider types and proposed policies implementing the statutory requirement.

TMA Response

TMA supports the agency's implementation of these policies and continues to educate our members regarding benefits of palliative care and hospice care for persons with life-limiting illnesses and their families.

Updates to the Definitions of Certified Electronic Health Record Technology (section III.R.)

Summary

CMS is proposing to revise the certified electronic health record technology (CEHRT) definition to align with the Office of the National Coordinator's (ONC's) definition. ONC's recent proposal to remove year-themed names has not yet been finalized. The CMS definition will point to the regulatory text rather which is updated based on ONC's regulatory process.

TMA Response
TMA agrees with CMS that it should align with the regulatory text when defining the current version of CEHRT. This reduces confusion for physicians participating in the promoting interoperability category and the Quality Payment Program by aligning with ONC's definition as it refers to various editions of CEHRT in regulation.

A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (section III.S.)
Summary
For 2024, CMS proposes to add a new social determinants of health (SDOH) risk assessment as an optional, additional element of the annual wellness visit (AWV), and proposes to provide payment for the assessment. This proposal is separate from CMS' proposal to establish a stand-alone G-code (GXXX5) for a SDOH risk assessment given at the same time as the evaluation and management (E/M) visit.

TMA Response
TMA appreciates CMS adding the SDOH risk assessment in a manner without beneficiary cost-sharing and that it is an optional element of the AWV. However, we encourage CMS to include clear guardrails on who can bill for this and to ensure that this screening tool and information gathered through the assessment can easily be collected, shared appropriately, and incorporated into the physician's electronic health record as structured data. To promote care coordination efforts and patient-centered care, the information collected from this assessment should be easily supplied to specialists.

Caregiver Training Services (CTS)
Summary
CMS proposes to allow treating physicians and practitioners to train caregivers in a group setting, simultaneously with other caregivers involved in the care for patients with similar needs to carry out a treatment plan, and the applicable CPT codes (96202, 96203, and 9X017) would be billed once per beneficiary.

TMA Response
We generally support the agency's proposal as it increases access to high quality care and supports caregivers. We appreciate that CMS followed the RVS Update Committee (RUC) recommendations for these services.

Updates to the Quality Payment Program (QPP) (section IV.)
Summary
Under the QPP, clinicians may receive payment adjustments based upon their performance under the Merit-Based Incentive Payment System (MIPS), or the advanced alternative payment model (APM) track if they participate in a program that includes more than a nominal amount of financial risk. MIPS-eligible clinicians will have payments increased, decreased, or maintained based on their performance in four categories — quality, cost, promoting interoperability, and improvement activities. Those participating in Advanced APMs are exempt from MIPS and previously qualified for a 5% bonus payment that was reduced to 3.5% for the 2023 performance year. The APM bonus has since expired and requires congressional action for reinstatement.

CMS operates more than 20 quality programs for individual clinicians, health care facilities, payers, and value-based entities such as accountable care organizations. Each program has its own set of quality measures for which entities report on and are held accountable for their performance. Consequently, several QPP proposals for 2024 coincide with the agency's broader initiatives such as the CMS National Quality Strategy (launched in 2022) and the Universal Foundation of quality measures as CMS looks to streamline and align measures that are meaningful for broad segments of the population.

The agency also proposes strategies that begin to operationalize plans spelled out in its CMS Framework for Health Equity, a 10-year approach to embed health equity across all CMS programs.

TMA Response
Although some progress has been made, lack of alignment across CMS' quality programs has contributed to challenges for clinicians, facilities, and health insurers when it comes to prioritizing outcomes that are meaningful for patients. However, it is imperative to recognize that the continuous changes to participation and reporting requirements, program terminology, and other aspects have proven to pose significant impacts on patient-physician interaction, which further hinders the ability of physicians to develop practice goals and better measure/improve their own performance. Physician burnout is also a serious consequence for physicians who operate a small business and must comply with myriad regulations. Physicians' primary mission is to help, treat, and heal their patients who are sick and suffering.

As CMS enters the seventh year of the QPP, **TMA understands that CMS is encouraging continued improvements in physician performance each year. What TMA cannot understand is the need to continuously change the program before participants have a chance to master the changes implemented each previous year.** This requires significant resources to train clinical staff supporting physicians, who are already overburdened, and to implement workflow adjustments to comply with the required changes. Each minute spent on additional work to meet program measurements is a minute taken away from patient care. The continuous changes are unsustainable. **TMA implores CMS to take a step back and consider ways to improve the QPP without continuously adding resource-intensive administrative work to the practice.**

Development of New MIPS Value Pathways (MVPs) (section IV.4a)
Summary
MPVs were launched in 2023 as an alternative to MIPS reporting with a goal of offering performance measures that were more relevant to a clinician's scope of practice – namely for specialists. With 12 pathways reflecting various specialties and care settings currently available, CMS proposes five new MVPs around the topics of women's health, infectious disease, quality care for ear, nose, and throat, and rehabilitative support for musculoskeletal care. The agency also proposes to consolidate the promoting wellness and managing chronic conditions MVPs into a single primary care MVP. Modifications are also proposed to the other previously finalized MVPs so MVP participants would have a total of 15 MVPs available for the 2024 performance period/2026 payment year.

TMA Response
TMA is concerned about discussions that MIPS MVPs could become mandatory as CMS has suggested that it will eventually sunset MIPS and move participants to MVPs. This is especially concerning as the Medicare Access and CHIP Reauthorization Act of 2015 authorized CMS to create two pathways in the Quality Payment Program – the agency must not require physicians to participate in a third pathway that was not envisioned by Congress. **Rather than force physicians into MVPs, TMA again asks CMS to focus on moving physicians to risk-based systems in voluntary, physician-led alternative payment models (APMs).** Further, CMS estimates that only 14% of eligible clinicians will participate in MVP reporting in performance year 2024. Many more MVPs for specialists and subspecialists are needed to encourage physician participation in the new reporting program, including a viable and efficient means of reporting for multi-specialty groups.

MIPS Performance Category Measures/Activities – Quality (section IV.4f.1)
Summary
The quality performance category represents 30% of the total Merit-Based Incentive Payment System (MIPS) score. CMS proposes changes that would result in a total of 200 quality measures in its inventory. This includes the addition of 14 measures, removal of 12 measures, partial removal of three measures that are retained for MVP use only, and substantive changes to 59 existing measures. The agency also proposes to expand the definition of the term high-priority measure to include health equity measures.

TMA Response

While TMA is generally supportive of CMS' push for data completeness, we remain concerned about annual changes to the program that add to physician burden. The data collection for the quality category is a full year, which leaves physicians little time to prepare for any changes expected to be implemented by Jan. 1. CMS should consider a phased-in approach that gives physicians time to prepare. Additionally, CMS should provide practice support as physicians acclimate to the required changes.

Data Completeness Criteria (section IV.4f.1d)

Summary

CMS implemented data completeness criteria as part of the 2017 Quality Payment Program (QPP) proposed rule to ensure that data submitted on quality measures are complete enough to accurately assess a Merit-Based Incentive Payment System (MIPS) eligible clinician's quality performance. The threshold was initially set at 50% with an increase to 60% in performance years (PYs_ 2018-19, and another increase to 70% for PYs 2020-2023. CMS proposes again to increase data completeness thresholds for subsequent performance periods for e-clinical quality measures (CQMs), MIPS CQMs, Medicare Part B claims measures, and qualified clinical data registry measures to 75% for PY 2026 and 80% for PY 2027. The agency also proposes criteria thresholds for the new Medicare CQM reporting method at 75% for PY 2024-26 and 80% for PY 2027.

TMA Response

While TMA supports CMS' efforts to encourage data completeness, we are concerned about the constantly changing and moving target under the QPP. It is difficult, time-consuming, and administratively burdensome for physicians and practices to keep up with the drastic changes and restructured framework for QPP participation. If the bar is continuously changed, it is difficult to evaluate the success as the comparison metric keeps shifting. We urge CMS to continue to reward those who reach 75% but provide more to those who reach 80% as a stepwise approach.

MIPS Performance Category Measures/Activities – Cost (section IV.4f.2)

Summary

The cost category represents 30% of the total Merit-Based Incentive Payment System (MIPS) score. CMS proposes to calculate the cost improvement score at the category rather than the measure level without using statistical significance starting with performance year (PY) 2023. The agency also proposes to add five new episode-based cost measures beginning with PY 2024, each with a 20-episode case minimum. The measures are: an acute inpatient medical condition measure (psychoses and related conditions), three chronic condition measures (depression, heart failure, and low back pain), and a measure focusing on care provided in the emergency department setting (emergency medicine). CMS is also proposing to remove the acute inpatient medical condition measure, simple pneumonia with hospitalization, beginning with the 2024 performance period/2026 MIPS payment year.

In previous rulemaking, CMS established that the MIPS cost category would include improvement scoring to reward participants that showed progress. While the maximum cost improvement score was zero percentage points for MIPS 2020-2024 payment years, CMS proposes to start with a 1% point improvement score beginning with the 2025 MIPS payment year.

TMA Response

TMA generally supports proposed changes to cost measures that improve meaningful and accurate measurement and begin to align with the agency's value-based care initiatives. TMA cautions, however, against building further complexities into the Quality Payment Program, which is already administratively burdensome. It may be helpful to not have this be specifically part of a cost or improvement measure the first year it is presented as there are always issues to be worked out. Sharing the data and allowing physicians to provide initial comments on its accuracy can be useful before including it in any measure or evaluation.

MIPS Performance Category Measures/Activities – Improvement Activities (section IV.4f.3)
Summary
The Improvement Activities Category represents 15% of the total Merit-Based Incentive Payment System (MIPS) score. CMS proposes adding five new activities, modifying one, and removing three improvement activities from the inventory. CMS believes the new and modified categories help fill identified gaps and seek to ensure that activities reflect current clinical practice. These proposals include a MIPS Value Pathways-specific activity – practice-wide quality improvement – that would allow clinicians to receive full credit in these performance categories. It also includes activities related to the CMS Framework for Health Equity 2022-2032 which are responsive to the administration's goal of advancing health equity for all.

TMA Response
TMA appreciates CMS' efforts to address health equity and identify social determinants of health as these efforts mirror some of TMA's work. However, we remain concerned with physician burden as the MIPS program continuously changes requiring physicians to review any previously used activities to determine continued existence and updated requirements.

MIPS Performance Category Measures/Activities – Promoting Interoperability (section IV.4f.4b)
Summary
The promoting interoperability category represents 25% of the total Merit-Based Incentive Payment System (MIPS) score. CMS proposes to increase the Promoting Interoperability reporting period from 90 to 180 continuous days within the calendar year beginning in performance year 2024.

TMA Response
TMA is concerned that this change will unnecessarily increase physician reporting burden due to a misplaced concern that participants may focus only on improving their scores for 90 days rather than improving overall performance throughout the year. Physicians, for example, don't invest time and financial resources to develop and implement e-prescribing workflow procedures for 90-day use. This is also true of providing patients with timely access to their electronic health information which is also a 21st Century Cures Act regulatory requirement. TMA urges CMS to maintain the 90-day promoting interoperability reporting requirement to avoid additional administrative burden and drain on practice resources that takes away from patient care.

Changes to the Query of Prescription Drug Monitoring Program (PDMP) (section IV.4di)
Summary
CMS proposes to modify the second PDMP measure exclusion from "Any MIPS (Merit-Based Incentive Payment System) eligible clinician who writes fewer than 100 permissible prescriptions during the performance period" to "Any MIPS-eligible clinician who does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period."

TMA Response
TMA agrees that the verbiage change does address slight confusion for those who may not be able to electronically prescribe controlled substances. TMA supports CMS' proposed edit and should retain the words "fewer than 100."

Changes to the Safety Assurance Factors for EHR Resilience Guides Measure (section IV.4diii)
Summary
CMS proposes to require eligible clinicians to attest "yes" to conducting an annual assessment of the High Priority Practices Guide in the SAFER Guides. Previously practices could attest "yes" or "no". In 2024, a "no" response will result in a score of zero for the whole promoting interoperability performance category.

TMA Response
TMA believes the SAFER Guides are a useful tool for physician practices and has encouraged usage since they were published in 2016. **TMA recommends that CMS encourage use of the High Priority Practices**

Guide in the SAFER Guides by making it an optional bonus measure. Physicians should not be penalized to the point of having all of their promoting interoperability efforts reduced to zero by not completing one measure. If CMS continues to require the use of the SAFER Guides, then at the very least it should be assigned a minimal number of points that slightly reduces the promoting interoperability score if the assessment is not completed.

MIPS Final Score Methodology – MIPS Payment Adjustments (section IV.4g.1f)

Summary

To avoid a negative adjustment under the Merit-Based Incentive Payment System (MIPS), clinicians must reach a performance threshold currently set at 75 points. CMS proposes increasing this to 82 points for MIPS performance year (PY) 2024/payment year 2026. Of note, CMS maintained a 75-point threshold for two consecutive years during the COVID-19 public health emergency. When setting the threshold, CMS previously looked at the mean score from a single performance period. In this proposed rule, CMS would review a "prior period" defined as three performance periods. For PY 2024, CMS is proposing to use PYs 2017-19 and estimates that approximately 54% of MIPS-eligible clinicians would receive a negative payment adjustment of up to 9% if finalized.

TMA Response

TMA is concerned about the increased performance threshold. This change is estimated to increase the number of MIPS-eligible clinicians receiving penalties of up to 9%. CMS continually moves the mark with its reporting regulations, which creates difficulties for physicians as they adapt to changing policies. Physicians should be able to focus their time and energy on direct patient care, and not face increased administrative burden. TMA urges CMS to delay the performance threshold increase as physicians continue COVID-19 recovery efforts which include an increasing patient load, significant practice cost inflation rates, and staffing issues.

Overview of QP Determinations and the APM Incentive (section IV.4g.1n)

Summary

Under current statute, qualified participant (QP) threshold percentages will increase beginning with the 2024 performance year (PY)/2026 payment year as follows: 1) Medicare payments: QP threshold increasing from 50% to 75% and the partial QP threshold increasing from 40% to 50%; and 2) Medicare patients: QP threshold increasing from 35% to 50% and the partial QP threshold increasing from 25% to 35%.

TMA Response

TMA is deeply concerned with the increasing thresholds as traditional Medicare fee-for-service enrollment stagnates and Medicare Advantage grows (reaching almost 50% nationally). Some physicians may opt out of CMS-sponsored advanced alternative payment models, opting for Medicare Advantage contracts that offer additional patient coverages, physician payment incentives, and care coordination resources. While we understand this is included in statute, these are significant increases, which may be difficult for small and rural practices.

APM Incentive Payment (section IV.5)

Summary

The Medicare Access and CHIP Reauthorization Act of 2015 included a 5% incentive payment for clinicians participating in advanced alternative payment models (APMs) through the 2022 performance year (PY)/2024 payment year. Congress extended availability of the advanced APM incentive for one year but reduced the amount to 3.5% for PY 2023/payment year 2025. This extension avoided a one-year gap for which there would have been no statutory payment incentive for advanced APM participation. The incentive has now expired and would require congressional action for reinstatement. Also, beginning for PY 2024/payment year 2026, qualifying APM participants (QPs) will receive a higher physician fee schedule (PFS) update, a 0.75% "qualifying APM conversion factor." This is compared with a 0.25% PFS update for non-QPs. Eligible QP clinicians will continue to be excluded from Merit-Based Incentive Payment System reporting and payment adjustments.

TMA Response
TMA urges CMS to work with Congress to re-implement the advanced APM incentive payment. This type of incentive payment offers a safeguard against the added administrative and care coordination burdens that QPs must encounter should the APM fail to earn shared savings. If CMS aims to have all traditional Medicare beneficiaries in an accountable care relationship by 2030, increased financial incentives and direct technical assistance are needed to ensure small and rural practices are able to successfully engage in value-based models.

Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development – Request for Information (RFI)
Summary
Within the Medicare Shared Savings Program (MSSP) and Merit-Based Incentive Payment System (MIPS) sections, CMS discusses the use and adoption of social determinants of health (SDOH) quality measures.

TMA Response
TMA steadfastly supports CMS including these measures, and the association called for their use in a letter to CMS sent last year. At TMA, we recognize that SDOH have a profound impact on patients and the physicians who care for them, especially in the wake of COVID-19. The two measures, MUC2021-134 and MUC2021-136, signal that CMS has begun to recognize and address the significant impact that social determinants of health have on health disparities, outcomes, and costs. Additionally, social drivers impact both physician well-being and the economics of clinical practice.

It is crucial to note that, in the absence of any standard SDOH measures, physicians are functionally held clinically and financially responsible because patients with greater social risk – which is not currently measured or included in risk-adjusted cost benchmarks for alternative payment models – are associated with higher health care costs. Obscuring the results of the social needs screening – by rejecting MUC21-136 – would make invisible crucial drivers of health outcomes, costs, and disparities, and impede appropriate investments in the community resources necessary to improve our patients' health.