AMERICAN OSTEOPATHIC ASSOCIATION

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September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1807-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; CY2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P)

Dear Administrator Brooks-LaSure:

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and medical students we represent, appreciates this opportunity to comment on the CY2025 Medicare Physician Fee Schedule Proposed Rule. The AOA is encouraged by many proposals in the rule, particularly proposals that seek to promote access to vital telehealth services; improve payment and access for behavioral health services; and address challenges physicians face with Merit-based Incentive Payment System (MIPS) scoring. The AOA also appreciates CMS' strong interest in exploring ways to improve payment and access to comprehensive, whole-person focused primary care. However, we believe that numerous changes must be made before this rule is finalized to ensure that it supports appropriate payment for services, alleviates administrative burdens, and results in appropriate quality measurement.

As osteopathic physicians, we are trained in a patient-centered, whole-person approach to care, which entails partnering with our patients to understand their backgrounds and health care needs. Osteopathic physicians also practice across all medical specialties. It is with this perspective that we offer comments on the rule's provisions.

CY2025 Physician Fee Schedule Provisions

Calendar Year 2025 Conversion Factor

While the AOA appreciates CMS' goals of supporting comprehensive, coordinated care by strengthening payment for primary care, behavioral health, and other vital services, we are deeply concerned about the proposed reduction to the CY2025 conversion factor. CMS proposes a conversion factor of $32.3562, which reflects a 2.77% reduction in payment from CY2024. This reduction reflects the expiration of the 2.93% upward adjustment averting prior cuts enacted by Congress under the Consolidated Appropriations Act of 2024 and a 0.05% positive budget

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neutrality adjustment. This change will have a detrimental impact on payment across medical specialties, and will particularly hurt small and independent practices that are struggling to keep pace with rising costs of operating a practice. CMS is making a corresponding reduction to the anesthesia conversion factor which would be set at $20.3340.

Since 2000, the cost of practicing medicine, as measured by the Medicare Economic Index (MEI), has increased 48%, while fee schedule updates have only resulted in a 12% increase in payment.[1] This means that when accounting for inflation, physician practices are delivering care with reduced payment. While we recognize that the proposed payment reductions are the result of statute, which limits CMS' authority to mitigate them, the AOA wishes to highlight the context in which these cuts are occurring. In light of the increasingly challenging practice environment physicians face, the impact of any new policies on practices' operational costs, total payment, and the ability to continue serving their communities should be CMS' primary consideration as it weighs (1) which policies to finalize, and (2) how to advance policies envisioned in the rule's various requests for information (RFIs).

Determination of Practice Expense RVUs

In 2023, CMS updated MEI weights for the different cost-components of the MEI for CY2024 using a new methodology based primarily on a subset of data from the 2017 US Census Bureau's Service Annual Survey. However, CMS deferred moving forward with changes to MEI weights as the American Medical Association (AMA) is still conducting a physician practice expense survey to generate more current data. For CY25, CMS proposes to continue delaying implementation until AMA completes the survey. **The AOA strongly supports CMS' decision to delay.** This will ensure that updates to MEI weights that redistribute components of payment reflect national, representative data on current physician practice costs.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act

The AOA applauds CMS' efforts to maintain broad access to telehealth services through the payment policies proposed in this rule. Healthcare access challenges across the U.S. are reflected in the fact that 74 million Americans reside in a primary care health professional shortage area, and workforce shortages for other specialties, such as psychiatry are even more profound.[2] Access to telehealth plays a critical role when patients need to travel long distances to see a physician, live in rural and underserved settings, face transportation challenges, experience mobility issues, are unable to take off work, or face a range of social determinants that limit their ability to receive in-person care. CMS' decision to continue payment for telehealth evaluation and management (E/M) services at parity with corresponding in-person services, to add vital services to the telehealth

[1] Medicare Payment Advisory Commission (MedPAC). June 2024 Report to Congress. Available here.
[2] Health Resources & Services Administration. "Health Workforce Shortage Areas." January 18, 2024. Available here.

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service list, and to continue payment for audio-only services, among other changes, will make virtual care available to those who need it.

Medicare Telehealth Services List

The AOA supports CMS' decision to add individual counseling for preexposure prophylaxis (PrEP), on a permanent basis, to the Medicare Telehealth Services List. The AOA agrees with CMS that it is clinically appropriate to provide this service via telehealth, and adding PrEP counseling to the telehealth service list will not only improve access but will also have the public health benefit of promoting appropriate adherence to PrEP.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

We applaud CMS for continuing to support access to audio-only telehealth services. In this rule, CMS is proposing revisions to include audio-only technology as an interactive telecommunications system for patients who are not capable of, or do not consent to, the use of video technology. In other words, CMS will pay for audio-only services as long as a practice is capable of providing telehealth via audiovisual (AV) technology.

Audio-only services have been vital to many underserved communities. Racial and ethnic minorities, and individuals who are low-income, have been found to be more likely to use audio only services.[3][4] Audio-only services can allow some patients to access care in instances when they may otherwise forgo care. **Continued payment for audio-only will enable practices to continue offering services to populations that often face substantial barriers to care, and we strongly support this proposal.**

Distant Site Requirements

CMS proposes to continue to permit distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. The agency notes that it proposes the extension with worker safety and privacy in mind. Workplace safety is a growing issue broadly impacting the physician workforce, with violence against healthcare workers becoming more commonplace since the COVID-19 Public Health Emergency (PHE). The Bureau of Labor Statistics reports that healthcare workers are five times as likely to experience workplace violence than employees across all other industries.[5] **The AOA strongly supports this extension and believes the flexibility will strengthen physician safety and privacy protection.**

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS proposes to continue to define direct supervision in a manner that allows the requirement to be satisfied via the "virtual presence" and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications. CMS proposes to extend the

[3] Chen J, Li KY, Andino J, Hill CE, Ng S, Steppe E, Ellimoottil C. Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic. J Gen Intern Med. 2022.
[4] HHS Assistant Secretary for Planning and Evaluation. "Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)." April 2023.
[5] United States Bureau of Labor Statistics. "Workplace Violence in Healthcare, 2018". April 2020. Available here.

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use of this definition established during the PHE through December 31, 2025. CMS also proposes to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) for services provided by auxiliary personnel working under direct supervision provided "incident to" a physician service and services described by Current Procedural Terminology (CPT) code 99211.

AOA urges CMS to reconsider these proposals and cautions the agency that long-term extension of this flexibility, and the proposed permanent definition change, raise patient safety concerns for services provided by non-physician clinicians incident to a physician service, as well as for services provided by non-physician clinicians being supervised by non-physician practitioners. We disagree with CMS' perspective that these policies strike an effective balance between promoting access to care and ensuring care quality. Instead, such policies enable non-physician clinicians to care for patients with less direct oversight, which reduces care quality and increases risk for adverse events. The physician-led team-based model of care is essential to ensuring the best outcomes for patients. We believe that direct supervision with physical presence is important to patient safety. This not only ensures patients receive appropriate care, but also can prevent avoidable deteriorations in patients' conditions, hospitalizations, or other adverse outcomes.

Supervision of Residents in Teaching Settings

CMS proposes to extend the current policy allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is furnished virtually (i.e., a 3-way telehealth visit, with all parties in separate locations). The extension would continue through December 31, 2025. **The AOA continues to support this policy, which will provide greater flexibility for residents to render telehealth services while ensuring an appropriate level of supervision; and AOA encourages the agency to make this policy permanent.**

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS proposes to continue to waive frequency limitations for Subsequent Inpatient Visits (99231-99233), Subsequent Nursing Facility Visits (99307-99310), and Critical Care Consultation Services (G0508-G0509) for an additional year. We support physicians using their clinical judgement to determine the type and frequency of visits that meets the patient's needs while maintaining the appropriate standard of care. **The AOA supports the delay in the implementation of frequency limitations and urges CMS to establish a permanent removal of frequency limits.**

Telehealth Originating Site Facility Fee Payment Amount Update

CMS proposes to update the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (*Telehealth originating site facility fee*) to $31.04, an increase from $29.96 in 2024. The AOA supports adequate payment for facility costs associated with serving as the originating site for a telehealth visit, a service that often plays an important role in connecting patients with specialist care, and thanks CMS for updating the payment amount.

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Payment and Coding for Telemedicine Evaluation and Management Services

The AOA praises CMS for continuing payment parity and treating telehealth as equivalent to in-person services. We appreciate CMS recognizing through these proposals that the work, practice expense, and malpractice costs for E/M services remain the same regardless of whether a service was provided in-person or via telehealth. E/M services are selected on the basis of time or medical decision making (MDM). When selecting an E/M based on MDM (which is most common), the MDM "includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option" and is defined by three key elements: (1) number and complexity of the problem(s) addressed during the encounter; (2) the amount and/or complexity of data to be reviewed or analyzed; and (3) the risk of complications and/or morbidity or mortality of patient management. MDM and the basis for selecting levels of E/M services do not change when a service is provided in-person or via telehealth services, and CMS' proposed policy reflects this reality.

Additionally, during a visit, a physician will review records, take a history, evaluate the patient, formulate a diagnosis and plan, communicate next steps, and write a note. This work is the same whether done for an in-person visit or a telemedicine visit, and these considerations apply to both audio-visual and audio-only services. Further, the vast majority of practices offering telehealth predominantly provide in-person services and functionally maintain their practice expenses when offering telehealth services.[6] **CMS' proposal recognizes the true cost of telehealth and will enable physician practices to leverage telemedicine in providing high quality, longitudinal care and to continue providing this model of care delivery in the future. The AOA strongly encourages CMS to finalize this policy of continuing payment parity.**

While the AOA appreciates CMS's efforts to establish payment for high quality telehealth care, we continue to have concerns around CMS' proposal to assign the newly created CPT codes for telehealth E/M services (9X075-9X091) a Procedure Status indicator of "I", indicating the codes would not be payable. The proposal could result in unintended consequences if finalized, such as bifurcation of billing requirements between private payors and Medicare, or potential challenges with research on telehealth services. With the adoption of the telehealth E/M codes in the CPT code set, AMA will delete the three telephone E/M codes from the CPT code set. CMS proposes to address this issue by having E/Ms rendered via audio-only technology to be appended with a modifier -93. **We urge CMS to issue guidance and FAQs on appropriate billing for telehealth, including audio-only services, if the CPT codes are not adopted for payment.**

Flexibilities Expiring at the End 2024

We acknowledge that CMS does not have the authority to extend all telehealth flexibilities, such as statutory restrictions on geography, site of service, and practitioner type, which existed prior to the COVID-19 PHE and will go back into effect on January 1, 2025, without Congressional action. After this date, Medicare beneficiaries will need to be in a rural area and a medical facility to

[6] Kane, C. "Policy Research Perspectives, Telehealth in 2022: Availability Remains Strong but Accounts for a Small Share of Patient Visits for Most Physicians." American Medical Association. 2023.

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receive non-behavioral health services via telehealth. We encourage CMS to work with Congress to protect Medicare beneficiaries' access to telehealth.

Request for Information for Teaching Physician Services Furnished under the Primary Care Exception

The AOA strongly supports expanding the primary care exception to strengthen our primary care workforce, drive care continuity, improve the quality of training programs, and alleviate burden on teaching physicians. We appreciate the RFI included in this rule, including CMS' solicitation for comments on:

- whether adding certain preventive services or higher-level E/M services to the primary care exception would hinder a teaching physician from maintaining sufficient personal involvement, in the care, to warrant a physician fee schedule (PFS) payment;
- whether the currently required six months of training in an approved program is sufficient for residents to furnish these types of services without the presence of a teaching physician; and
- whether the inclusion in the primary care exception of specific higher-level or preventive services would impede the teaching physician's ability to remain immediately available for up to four residents at any given time, while directing and managing the care furnished by these residents.

Nearly 54% of DOs practice in primary care, partnering with patients and their families throughout every stage of life, including our nation's seniors. DOs train in primary care programs across settings, from teaching hospitals to teaching health center for graduate medical education (THCGME) sites at federally qualified health centers (FQHCs) and rural health clinics (RHCs). Across these settings, residents get broad exposure to diverse patient populations and the range of conditions that primary care physicians must care for on a day-to-day basis. In many primary care specialties, by year 3 of training, residents are well equipped to handle most patient visits, including many level 4 and 5 visits, independently. However, it is still necessary for an attending/teaching physician to be available for certain complex patients. As a result, we believe that the primary care exception should be expanded to allow residents to be able to independently perform higher level E/M services (levels 4 and 5) and preventive visits, as long as a teaching physician is immediately available.

Under current policy, many residents are delivering higher level services with the teaching physician present for the service. However, this requirement is not necessary in many instances and can strain workflows, limiting the time physicians can spend with more complex patients. Expanding the primary care exception will not only promote high quality training and care, but it will free up teaching physicians to dedicate their efforts to patients and situations where they feel they are most needed. To ensure appropriate safety guardrails, CMS could consider only allowing senior residents (those who have completed 24 months of training) to independently perform higher level services, ensuring strong oversight of physicians with less experience.

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The primary care exception is vital to the osteopathic profession's historic emphasis on careers in primary care. **For this reason, we urge CMS to permanently expand the ability for primary care residents to render Medicare services under the primary care exception.**

Evaluation and Management Visits

Office/Outpatient (O/O) Evaluation and Management Visit Complexity Add-on

AOA greatly appreciated CMS' efforts in CY2024 to bolster payment for office-based specialties that rely heavily on E/M services (including primary care, infectious disease, endocrinology, among numerous others), with a focus on supporting the longitudinal relationships that are the foundation of high-quality care. The establishment of the G2211 add-on code for visit complexity has supported comprehensive care by physicians across the country, and the AOA has been actively engaged in educational efforts to support appropriate use of the code. Additionally, ensuring appropriate payment for primary care is essential to promoting access to primary care physicians for Medicare beneficiaries and ensuring a strong primary care workforce. As such, **AOA strongly supports CMS' current proposal to allow G2211 to be billed with annual wellness visits and O/O E/M visits appended with a modifier -25 for delivery of a separate preventive service.** This change would align the billing of the G2211 code with the manner in which primary care is typically delivered. It would enable enhanced payment for the inherent complexity of providing longitudinal care where preventive services are provided alongside E/M visits, and the visits serve as a continuing focal point for patients' overall healthcare needs. **We urge CMS to finalize this proposal**.

Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-on for Infectious Diseases (HCPCS code GIDXX)

CMS proposes a new add-on code to describe the intensity and complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease that is performed by a physician with specialized training in infectious diseases. While we understand CMS' intent is to enhance payment for consultations that may be underpaid, we do not believe there is a clear reason to solely enhance payment for infectious disease specialist consultations via an add-on code when there are various other specialties that frequently provide vital E/M services in inpatient settings whose professional services are undervalued under the current fee schedule. **We believe this proposal reflects the broader issue with undervaluation of E/M services and will continue to work with CMS, as well as legislators and other stakeholders, on strengthening physician payment to meet broader workforce needs. As a result, CMS should not finalize this proposal.**

Enhanced Care Management: Advanced Primary Care Management (APCM) Services

As CMS notes in the proposed rule, the advanced primary care model approach to care, which emphasizes a person-centered approach, longitudinal relationships with physicians, comprehensive care management and care coordination, and collaboration across the care team,

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can foster better outcomes for patients across our healthcare system. We appreciate CMS acknowledging the importance of advanced primary care and working to improve payment for this model of care delivery. We agree with CMS that "the practice and sustainability of the primary care sector is under significant strain," and enhanced reimbursement is essential to ensuring access to high quality care for patients across the country.

While we commend CMS for recognizing the challenges faced by primary care physicians and the need to pay for comprehensive care, the AOA is concerned that the APCM codes as proposed will not have a substantial impact on overall payment to primary care physicians, alleviating documentation burden, or driving the practice transformation to expand the delivery of advanced primary care. These concerns stem from the following issues with the proposed code set that will result in low adoption:

- CMS' proposed payment rates are low and insufficient to drive wide use of the codes, especially in light of the higher reimbursement available for the care management and communication technology-based service codes which CMS prohibits from concurrent billing with APCM;
- The overall structure of the codes' service elements and requirements for billing will favor practices already engaged in advanced primary care and exacerbate inequities in payment between small and independent practices that are struggling to keep doors open and offices that are part of a health system with sophisticated electronic medical records (EMRs), revenue management systems, and larger staffs;
- The practice level capabilities, such as population level management, require substantial investment for which APCM does not adequately reimburse;
- Tying payment for a specific code to reporting specific quality measures or participating under a specific Quality Payment Program (QPP) pathway will discourage adoption; and
- The proposed APCM codes require patient consent for billing, which has been a substantial barrier to the uptake of chronic care management (CCM) and principal care management (PCM) codes.

While AOA overall supports enhanced payment for primary care services and urges CMS to ultimately finalize the APCM codes, modifications to this policy are necessary to ensure (1) equitable payment across settings, (2) appropriate payment that drives practice investments in delivering advanced primary care services, and (3) billing requirements that are not so onerous that they make it difficult for practices to successfully obtain payment. Additionally, CMS notes that it intends for the APCM codes to serve as a foundation, or first step, towards establishing a framework for a hybrid payment model in primary care. The AOA strongly disagrees with CMS that the APCM codes would serve as an appropriate starting point and opposes the creation of a hybrid payment model under the current Part B framework that would be subject to existing fee schedule budget neutrality requirements. We elaborate on these concerns and provide specific recommendations related to hybrid payments later in this letter in response to CMS' RFI on "Advanced Primary Care Hybrid Payment".

Detailed feedback on CMS' APCM proposals and recommendations are described in detail below.

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APCM Service Elements and Practice Level Capabilities

The AOA is concerned that the requirements CMS proposes for billing APCM codes will limit their adoption by (1) limiting payment to only those practices that have the financial resources to have already invested in the advanced capabilities outlined, and (2) creating service requirements that are so restrictive or onerous that the cost prevents participation. Our detailed feedback on the various service elements is as follows.

1. **Patient Consent:** While the AOA recognizes that CMS may have limited statutory authority to designate care management services as preventive or limit cost sharing, it is important to highlight that a key factor limiting the uptake of CCM and PCM codes has been the patient cost sharing requirement, as patients often decline these services when they learn that they entail cost sharing. However, care management services are essential to promoting wellness and preventing deterioration of patients' conditions. We encourage CMS to work with Congress to develop a solution to this challenge.
2. **Initiating Visit:** The AOA agrees that care management services cannot take place for a new patient absent an initial visit and supports this requirement.
3. **24/7 Access and Care Continuity:** Most practices currently have this capability, as reflected by the fact that physicians with hospital privileges generally must demonstrate that they have continuous coverage for urgent patient needs. However, there may be some small and independent practices in under-resourced settings that may not be able to guarantee 24/7 access. That said, promoting advanced primary care entails supporting payment for practices to be able to offer this coverage. Overall, the AOA agrees that advanced primary care management should entail capabilities for patients to have urgent care needs addressed, and for their complete information to be available to the member of the care team treating the patient. AOA asks that CMS provide clear guidance on how this practice capability should be demonstrated/documented to permit billing.
4. **Comprehensive Care Management and Management of Care Transitions:** These services are already elements of the work entailed under CCM and PCM services, and we agree with CMS that they are integral components of care management services. However, these service elements entail substantial staff time and resources that are not adequately paid for at the proposed APCM valuations. We discuss this in more detail below and suggest that modifying CCM and PCM codes may be a preferable approach to supporting adequate payment for these activities.
5. **Patient Centered Comprehensive Care Plan:** The AOA agrees that this service element, as described in the proposed rule, is an important component of comprehensive care management services and a common element of advanced primary care.
6. **Practitioner, Home, and Community-Based Care Coordination:** Care coordination for home and community-based services (such as coordinating home health or skilled nursing, or identifying patients' health-related social needs and connecting them to relevant services) is time and resource intensive and is not adequately paid for under the proposed valuation for APCM codes. We discuss this in more detail below and suggest that modifying CCM and PCM codes may be a preferable approach to supporting adequate payment for these activities.
7. **Enhanced Communication Opportunities:** Offering connected health services and ensuring that patients have continuous access to members of the care team, is important to

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promoting the best outcomes for patients. Most practices already have many of the enhanced communication capabilities outlined in the rule. 77% of small and solo practices, and 72% of mid-size practices across the country offer telehealth services to their patients[7], and a large share of these support patient-initiated digital communications. While access to e-visits, asynchronous consultations, or other electronic communication services supports care management, these services are not adequately paid for under the APCM codes, despite being prohibited from concurrent billing. This is described in further detail in the section on code levels and valuation below.

8. **Patient Population Level Management:** AOA opposes requiring this practice capability for physicians to bill APCM codes as it will limit the number of practices able to take advantage of this newly billable service, and only improve payment for the larger groups or health-system affiliated practices that have the resources to invest in these capabilities. Population management functionalities are almost always an add-on product sold separately from EMR software, and the price point is often not accessible for small and independent practices. Compounding this issue, the actual effort for engaging in the analytics described by this service element (i.e. analyzing patient population data to identify gaps in care and risk-stratifying the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients) generally requires dedicated staff. If CMS wishes to encourage practices to adopt these capabilities, it should identify approaches to help practice make the necessary investments in IT infrastructure and staff. CMS notes that this requirement would automatically be met for practitioners billing for APCM services through a tax identification number (TIN) that is participating in an Accountable Care Organization (ACO) in the Shared Savings Program, as well as providers in the ACO REACH model, Making Care Primary (MCP) model, or Primary Care First. However, it overlooks the fact that many of these APMs provide opportunities for advance payments that enable practices to build up this infrastructure. Meanwhile, the proposed modest payment under APCM without technical or financial support for building infrastructure will not enable practices to make these investments. We foresee that only practices already in an APM will bill these codes, and the codes will do little to drive practice transformation.
9. **Performance Measurement:** This requirement will place an unnecessary administrative burden on practices in order to bill APCM codes. The service elements/activities outlined in the descriptor for this code, including comprehensive care management, continuous access, development of care plans, etc., are activities central to driving high quality care and reducing downstream costs within the healthcare system through appropriate management of patients' conditions. The AOA strongly opposes tying billing of any specific service to reporting specific quality measures or participating in a particular quality program. This proposal is particularly burdensome and unlikely to result in overall benefit to patients.

[7] Kane, C. "Policy Research Perspectives, Telehealth in 2022: Availability Remains Strong but Accounts for a Small Share of Patient Visits for Most Physicians." American Medical Association. 2023.

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APCM Code Levels and Valuation

CMS proposes three APCM codes that are stratified based on patient characteristics indicative of complexity and resource use. AOA supports this approach overall. In regard to GPCM1, clarification from CMS is needed on when this code can only be billed for patients with one chronic condition, as there are discrepancies in the rule preamble and the code descriptor.

While we support CMS' approach to the individual code levels, the payment rates for each code are inadequate to account for the time and resources involved for the required activities. Additionally, the payment differentials between APCM and codes considered "duplicative" and prohibited from concurrent billing will discourage utilization. We urge CMS to consider the following.

- GPCM1 has a total payment of $10, while payment rates for interprofessional consultation services, virtual check-ins, and digital E/M services range between $13 and $17 each. Billing GPCM1 entails substantial documentation burden, time, resources, and advanced practice capabilities. However, the payment rate is less than the rate for any of the individual service elements required if they were billed separately.
- GPCM2 has a total payment of $50, while CCM codes 99487 and 99489 pay $134 and $72, respectively. PCM codes 99424 and 99425 pay $83 and $59, respectively. Physicians already billing CCM or PCM are unlikely to shift to billing APCM which has a lower reimbursement, especially in light of the practice capability requirements that are costly and burdensome. Additionally, while CCM and PCM are time-based, documentation requirements are not substantially different. Regardless of whether a physician bills APCM or another care management code, they still must document the individual service elements/activities they engaged in during a particular month.
- GPCM3 has a total payment of $110. While this may support enhanced care management for dually eligible beneficiaries and have a higher uptake than the other APCM codes, it is important to note that because dually eligible patients often have substantially more complex needs, practices spend more time on care coordination, care planning, and other activities for these patients. As a result, practices will more often meet time thresholds for billing CCM and PCM with this patient population.

AOA applauds CMS for recognizing the complexity associated with caring for dually eligible beneficiaries, who often have more complex social needs that must be accounted for and addressed in addition to medical treatment of their conditions. Additionally, physicians are typically paid less when caring for dually eligible beneficiaries than for Medicare beneficiaries who do not qualify for Medicaid, under state "lesser of" policies that allow states to pay the lesser of the Medicare approved amount or the state's Medicaid rate. In effect, this results in a 20% reduction in payment. We believe that enhancing payment for this population will support access to care for Qualified Medicare Beneficiaries (QMBs).

Overall, to have a truly meaningful impact and encourage practices to more broadly engage in advanced primary care activities, CMS must enhance payment across all three APCM service levels.

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Duplicative Services and Concurrent Billing Restrictions

CMS proposes a list of codes that it views as duplicative of activities captured in the description of APCM. These include various care management services, interprofessional consultations, remote evaluation of patient video/images, virtual check-ins, and online digital E/M services. While we agree that these various services are elements of advanced primary care, we would like to reiterate that the payment rates for the APCM codes are inadequate to fully cover the cost of delivering many of the services considered duplicative. We also discourage CMS from adding additional services to this list that may further disincentivize adoption of APCM codes.

Summary of AOA Recommendations Regarding APCM

Overall, the AOA appreciates CMS' efforts to drive greater investment in the advanced primary care model and support payment for comprehensive primary care services. However, **revising existing care management codes, including CCM and PCM, may be a better approach to promoting advanced primary care.** We welcome the opportunity to work with CMS and other stakeholders to revise these codes and corresponding payment policy to promote broader uptake. **In the meantime, we believe the APCM codes should be finalized, and the following changes are necessary for them to have a meaningful impact:**

- Payment rates must be increased to support investment in staff or infrastructure of advanced primary care activities and fully cover the cost of delivering these services, based on the work and practice expense (PE) associated with the individual service elements;
- Population level management capabilities should not be required for billing APCM;
- Billing APCM should not be contingent on reporting specific cost and quality measures, or participation in specific quality or payment programs, and thus the performance measurement element of the code should be eliminated; and
- Documentation requirements for practice capabilities and service elements should be more clearly defined and provided in guidance.

While the APCM codes should be finalized to support payment for care management, they are inadequate to serve as a foundation for broader hybrid payment efforts. Establishing hybrid payments or other bundled payment approach for office visits within the Part B fee-for-service framework, without statutory changes to budget neutrality and other current program requirements, will have harmful, irreversible consequences on the sustainability of primary care practices across the country. An effort to leverage APCM codes to this end would exacerbate the financial and administrative strain physicians are already experiencing and should not be pursued.

Request for Information: Advanced Primary Care Hybrid Payment

The AOA shares CMS' concern regarding the strain primary care practices across the country face and appreciates the agency's efforts to reduce administrative burden and support appropriate payment. The AOA believes, in principle, that APMs such as a hybrid payment model can drive high quality primary care by simplifying billing, reducing administrative burden associated with many quality measure requirements, and supporting investment in advanced primary care

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capabilities and infrastructure. However, policy must be shaped in a manner that enables these goals to be realized. As a result, the AOA believes that any hybrid payment approach should conform to the following:

1. Any bundled or episode-based payment methodology should be developed through a physician-led process to ensure that bundles account for the right services, offer appropriate payment, and minimize reporting burden.
2. Any model should account for the resources and investments required to engage in the necessary practice transformation for successful participation.
3. While participation should be incentivized, it must remain optional.
4. Payments should be updated annually to account for increases in the cost of practicing medicine.
5. Any model should protect physicians' independent judgement and ability to develop care plans in partnership with patients, enabling physicians to make decisions related to treatments, services, medications, and referrals based on the best interest of the patient;
6. Payment should be predictable and enable small and independent practices, as well as practices in under-resourced settings, to participate successfully and reasonably manage revenue.
7. Any total per beneficiary payment methodology should be outside the physician fee schedule fee-for-service budget neutrality parameters and must be sufficient to broadly account for the range of services primary care physicians provide when delivering comprehensive, coordinated care, and should not result in a net reduction in payment for services (excluding payment adjustments associated with risk-bearing), including when accounting for beneficiary cost-sharing.
8. Payments should be risk adjusted in a manner that appropriately reflects physicians' patient populations, accounting for social risk factors, diagnoses and patient complexity, income/dual eligibility status, and other factors. Additionally, models should account for the unique care needs of rural and underserved populations, ensuring appropriate access to vital services for these populations.
9. When physicians are accountable for total costs, they should be granted relief from administrative burdens and be exempted from MIPS, only being subject to a limited set of high-impact quality measures that are most meaningful to physicians and patients.

While we appreciate CMS issuing an RFI on designing hybrid payments for primary care, current statute would not support a hybrid model under the physician fee schedule. We offer the following input on CMS' requests should the agency be granted broader flexibility by Congress.

1. *Streamlined Value Based Care Opportunities*

How can CMS better support primary care clinicians and practices who may be new to population-based and longitudinal care management?

- Practices currently participating and succeeding in population-based or other value-based arrangements are typically affiliated with larger groups, hospitals, or health system that have the resources necessary to support investment in practice transformation. Succeeding in such arrangements entails having dedicated staff to support care management and coordination, and other advanced primary care activities; adoption of sophisticated health

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IT that supports population management and tracking of quality and cost metrics; revenue cycle management tools that enable practices to manage revenue and expenses under a completely new payment framework; and office staff who are knowledgeable and capable to support this practice model. This type of transformation requires financial investment to adopt these capabilities, as well as technical support so that practices can build institutional knowledge on how to succeed. Small and independent practices typically lack these resources, and any effort to transition to a hybrid model without supporting these costs up front will create tremendous strain for practices, jeopardizing access to care.

What are the primary barriers to providing particular strategies or support needed for pediatric clinicians and practices?

- A key differentiation between pediatric offices and general family medicine or internal medicine practices is that few pediatric patients have multiple chronic conditions. Pediatric offices spend much more time and effort on preventive services relative to care management, as compared to family and internal medicine practices. However, both of these types of services are generally undervalued under the current fee schedule, which would need to be addressed to support all primary care specialties under a hybrid payment model.

Should CMS evolve the proposed APCM services into an advanced primary care payment that includes E/M and other relevant services, or maintain a separate code set for APCM?

- The AOA strongly opposes evolving APCM into a broader payment bundle. We believe this will force a model of care delivery onto primary care practices that they are not equipped to support. Any effort to create a broader bundle should be done in collaboration with the physician community, fully account for the range of services primary care physicians deliver, and ensure net payment that is no lower than would otherwise be made under the current billing framework. As reflected in the valuation of APCM codes, attempting to value such a payment bundle within the confines of current Part B requirements, including budget neutrality, may result in undervaluation that would ultimately harm primary care practices. Should CMS wish to move forward with exploring the development of payment bundles, it must be done in collaboration with the CPT Editorial Panel and the Relative Value Scale Update Committee.

CMS has historically used information presented by the Relative Value Scale Update Committee to determine PFS payment rates. Are there other sources of data on the relative value of primary care services that CMS should consider when setting hybrid payment rates?

- The AOA strongly supports the RVS Update Committee (RUC) as the entity best suited to provide recommendations to CMS on the relative values of physician services, as well as their cost inputs. As defined under law, physician payment is based on three primary components: physician work, practice expense, and malpractice liability insurance expense. Physician work is determined based on the time, intensity, and complexity of individual services physicians provide. The relativity of each of these components of physician work, as well as the direct cost inputs for services across settings, cannot be appropriately determined without direct physician input. The RUC is the entity best

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situated to make recommendations regarding resource inputs for services. The RUC is comprised of volunteer physicians across specialties who work to evaluate the value of services based on a system of relativity, utilizing survey data generated by physicians in active practice who render a given service. The RUC process generates granular data to describe the physician time, work relativity, clinical staff time, medical supplies and medical equipment used in providing services to patients.

- Input from practicing physicians and clinical physician leadership via the RUC process is essential to the process of valuing services because these individuals are in the field and intimately understand the inputs for the services they provide to patients. There is no other entity that collects data with the level of detail and broad specialty input as compared to the RUC, and thus equally capable of assessing the value of services.
- While data can be obtained related to physician time spent on services, this data would most likely be generated by the EMRs of large health systems that have substantial efficiencies relative to small practices. There is currently no way to systematically collect data from small and independent practices beyond surveys, and a shift away from the RUC process would disadvantage these physicians who play vital roles in their communities.

2. *Billing Requirements*

How can CMS reduce the potential burden of billing for population-based and longitudinal care services?

- This question requires further study and is critical to effectively developing a hybrid payment model. Most existing value-based models that provide episode or population-based payments calculate such payments based on the total number of services rendered during a benchmark period. As a result, these systems rely on FFS billing to estimate the volume and value of services rendered, which becomes the benchmark to which performance is measured against. Under ideal circumstances, a population-based payment model would reduce billing and documentation burden by enabling physicians to focus on caring for patients and less on reporting individual services. However, such an approach has not yet been developed and tested.

Are there particular types of items or services that should be excluded from the advanced primary care bundle?

- Overall payment through an advanced primary care bundle must be net-positive relative to current FFS payments, ensure revenue stability, and account for high-cost services. There are a broad range of services primary care physicians provide to ensure patients can conveniently and affordably access the care they need. Delivery of these services often requires substantial investment expenses far beyond what would be covered under a typical E/M service, chronic care management, or Communication Technology Based Services (CTBS). This can include purchasing equipment for certain preventive screenings (e.g. bone density scan machines for osteoporosis screening); maintaining supplies for wound care; stocking vaccines; or purchase, storage, and administration of high-cost medications (e.g. injectable HIV medications and PrEP). If high cost or high overhead services are not appropriately paid for, this may prevent practices from offering comprehensive care,

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exacerbate financial challenges primary care physicians face, and necessitate referrals to other providers, which will increase costs to the Medicare program over the long term.

Care management coding and payment require beneficiary cost sharing. Has beneficiary cost sharing been a barrier to practitioners providing such services?

- Nearly 66% of Medicare beneficiaries are eligible for CCM services, but these codes accounted for only 2.3% of all eligible claims. Similarly, transitional care management (TCM) services were only found on 9.3% of claims for the total eligible population. While one key barrier is the time-based nature of the codes, a large number of physicians also report that beneficiary cost-sharing is another main barrier, as many patients don't fully understand the value of these services or are unwilling to pay separate cost-sharing for them. As a result, development of any payment bundle or care management service must consider this patient reaction. While the concept of reducing beneficiary cost sharing may encourage patients to seek out primary care services, we would like to emphasize that any reduced payments to physicians through changes to cost sharing should be made up by the Medicare program to ensure that physicians are made whole on the costs of delivering care. Because CMS does not currently have authority to reduce this cost sharing, developing a hybrid payment absent statutory change would have harmful consequences for patient access to care and out-of-pocket costs.

Are there Health IT functions beyond what is proposed for APCM services that clinicians should be required to bill for an advanced primary care bundle? What should CMS consider in the design of the advanced primary care bundle to effectively incorporate Health IT standards and functionality, to support interoperability and the aims of advanced primary care?

- It is important to note that while substantial advances have been made in recent years toward a more interoperable health system, interoperability is not yet in a state where small and independent practices not affiliated with a health system have easy access to patient data outside their facility. While health information exchanges support this effort, many small and independent practices lack much of the data that supports effective population management and analytics. As a result, imposing additional IT requirements may not yield better outcomes.
- Aside from functionalities of the EMR, it is important to note that success under a hybrid payment model requires upgrading revenue management software to support such a practice model. This investment would become a de facto requirement for practices, as without it, they would not succeed.

3. <u>Person-Centered Care</u>

What activities that support the delivery of care that is coordinated across clinicians, support systems, and time should be considered for payment in an advanced primary care bundle that are not currently captured in the PFS?

- As previously noted, success under a bundled payment model requires investing in IT infrastructure, staff to support population management, and staff to support care coordination activities not fully captured under the MPFS. These elements are either not

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currently paid or are underpaid. Many practices that have these capabilities developed them through participating in CMMI models.

4. *Health Equity, Social, and Clinical Risk*

What risk factors, including clinical or social, should be considered in developing payment for advanced primary care services?

- Ultimately, risk adjustment methodology must account for a broad range of factors, including social risk factors, diagnoses and patient complexity, income/dual eligibility status, and other factors.

Should CMS incorporate Community Health Integration and/or Principal Illness Navigation services and payment into an advanced primary care bundle?

- Regardless of whether it is included in a bundle, these services are important to comprehensive care and CMS should continue to pay for them at adequate levels.

5. *Quality Improvement and Accountability*

How can CMS ensure clinicians will remain engaged and accountable for their contributions to managing the beneficiary's care?

- Small practices currently face numerous barriers to entry into APMs. First, they tend to lack the staff and technical infrastructure required to effectively participate in most quality-based models. Second, thin margins preclude them from being able to take on additional risk or make the significant financial investments needed to effectively participate in APMs. Third, small practices within AOA's membership report significant concerns regarding onerous quality reporting that takes time away from physicians' ability to see patients. Finally, physicians report a fear of failure within the APM model due to inability to track performance in real-time and make needed course corrections. To ensure quality measures under the hybrid payment model actually contribute to high quality care while reducing burden, we advise the following:
  - Use of cost measures should be minimal, as physicians are already responsible for managing overall costs under bundled payment models, and cost measures should not hold physicians accountable for factors outside their control.
  - Clinical quality measures used for primary care should align with CMS' universal foundation measures and should not impose additional, overly burdensome measures that would transplant a reporting framework similar to MIPS into a new APM.
  - Measure reporting should focus on electronic and claims-based measures that can be determined with less reporting burden from the physician.
  - Physicians should be provided with regular feedback on their performance on various measures in timeframes as close to real-time as possible to ensure that they can improve care quality, and to avoid challenges faced by physicians under MIPS.
- Ultimately, any new quality measurement framework should avoid repeating the same mistakes in MIPS and reduce overall burden, especially if physicians are already being held accountable for overall costs in a bundle.

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Cardiovascular Risk Assessment and Risk Management

CMS is proposing two new G-codes for cardiovascular (CV) risk assessment and risk management. AOA supports CMS' efforts to build on the success of the million hearts model and couple payment for risk assessment and corresponding risk management for patients with CV disease risk. AOA urges CMS to finalize the proposal and requests two clarifications. First, we ask CMS to issue guidance on the extent to which these services can be billed alongside intensive behavioral therapy for CV disease (G0446). Second, we request that CMS provide guidance on appropriate billing and documentation.

Strategies for Improving Global Surgery Payment Accuracy

Expand Applicability of Transfer of Care Modifiers
In the proposed rule, CMS raises concern that global surgical payments are not valued appropriately and expresses interest to revalue global surgical packages that support patient-centered care. The agency cites data indicating that a large number of E/M visits included in payment for global surgical packages are never furnished.

In an attempt to improve the accuracy of valuation and payment for global packages, as well as to better identify the practitioners providing preoperative, surgery, and post-operative care to Medicare beneficiaries, CMS is proposing to require the use of transfer of care modifiers (modifier -54 for procedures, -55 for post-operative care, or -56 for pre-operative care) for all 90-day global surgical packages in all cases when a physician plans to furnish only a portion of a global package. This includes formal, documented transfers of care (current policy) and informal, non-documented but expected transfers of care.

While the AOA supports ensuring accurate payment for surgical services and payment is provided to the physician who truly renders each component of a service, **we caution against utilizing such data to revalue services absent physician input via the RUC. This may result in inappropriate payment reductions that harm the delivery of care.**

Post-operative Care Services Add-on Code
CMS proposes to establish a new add-on code that would account for resources involved in post-operative care for a global package provided by a physician who was not involved in furnishing the surgical procedure and does not benefit from the global surgical payment, such as a patient's primary care provider. Primary care physicians often provide post-operative care without benefitting from the global surgical payment. **CMS' proposal will help address this issue of inadequate payment and we urge it to be finalized.**

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Advancing Access to Behavioral Health Services

Safety Planning Interventions

CMS seeks to better support efforts by physicians to address risk of suicidality and overdose among patients in crisis across settings. To this end, CMS proposes new HCPCS codes for 2 services. CMS proposes to create an add-on G-code, GSPI1, that would be billed along with an E/M visit or psychotherapy when safety planning interventions are personally performed by the billing practitioner in a variety of settings. CMS also proposes to create a monthly billing code to describe the specific protocols involved in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a behavioral health or other crisis encounter, as a bundled service describing four calls in a month, each lasting between 10-20 minutes. **The AOA urges CMS to finalize these proposals as they will support payment for comprehensive behavioral health services and potentially life-saving interventions for patients in crisis.**

Digital Mental Health Treatment Services

CMS is proposing payment to billing practitioners for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. The payment encompasses software devices cleared by FDA to treat or alleviate mental health conditions. The 3 HCPCS codes created would cover device supply, first 20 minutes of treatment services, and each additional 20 minutes of treatment services.

CMS is moving forward with this proposal in recognition of the PE costs associated with DMHT and interest by providers to offer these services. CPT codes have been developed under remote therapeutic monitoring (RTM) services for digital cognitive behavioral therapy. However, these services are contractor priced and many stakeholders argue they don't account for the latest technology. It is AOA's understanding that CPT has been engaged in ongoing efforts to improve coding for these services over the last several meetings, as part of a broader overhaul of RPM/RTM codes. **While the AOA supports action to establish immediate payment for these services in the short term, we are concerned about creating two sets of codes for the same service, resulting in an unnecessarily complex coding and payment environment. AOA urges CMS to either postpone this proposal or revisit this proposal if it moves forward and align its policies with CPT coding and RUC valuations following completion of the AMA process.**

Opioid Treatment Programs (OTP)

CMS is proposing to make permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, so long as all other applicable requirements are met. Additionally, the agency is proposing to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.

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CMS also intends to update payment for intake activities furnished by OTPs to include payment for social determinants of health risk assessments to adequately reflect additional effort for OTPs to identify a patient's unmet health-related social needs or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an opioid use disorder (OUD). CMS is also proposing to pay for OTPs to provide new medications to patients, including a new nalmefene hydrochloride product, Opvee®, and a new injectable buprenorphine product, Brixadi®. **The AOA supports these proposals and urges finalization to support improved access to substance use disorder treatment, and delivery of comprehensive services that address the full spectrum of patients' health and health-related social needs**.

Medicare Part B Payment for Preventive Services

Comprehensive payment for preventive services, and reduced patient cost sharing for such services, is essential to improving population health. Osteopathic physicians are trained in a whole-person approach to care that emphasizes prevention, and we believe the following proposals support improved public health outcomes.

Hepatitis B Vaccine Cost and Administration

Medicare Part B pays for the hepatitis B vaccine for individuals who are at high or intermediate risk of contracting hepatitis. CMS proposes to redefine patient risk such that anyone who is not fully vaccinated for hepatitis B to be at an intermediate risk of contracting the hepatitis B virus as their risk would be above zero. Additionally, CMS would change the definition of patient risk to make the physician assessment no longer necessary. CMS also proposes to align payment for hepatitis B vaccinations in RHCs and FQHCs with payment for pneumococcal, influenza, and COVID-19 vaccinations in those settings. **While AOA supports these coverage and payment changes, we urge caution in removing the requirement for a physician order of hepatitis B vaccines**.

Proposed Fee Schedule for Drugs Covered as Additional Preventive Services

In light of recent development of preventive physician administered drugs, such as injectable PrEP, CMS proposes a fee schedule for drugs covered as additional preventive services (DCAPS) as follows:

- Use existing Part B drug pricing mechanisms to maintain consistency across Part B including DCAPS
- Determine payment limit for a DCAPS drug using Average Sales Price (ASP) methodology or alternative pricing mechanism if ASP data is not available for a particular drug.
- Update the fee schedule quarterly

This would apply to drugs such as PrEP for HIV prevention. In addition to paying for PrEP medication, CMS is modifying payment rates for the 3 HCPCS codes for PrEP services to reflect the relative resource costs associated with the counseling and drug administration portions of the service, pending finalization of the national coverage determination. **The AOA supports these changes that respond to advancements in preventive products and promote access to high quality, effective preventive services.**

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Expanded Colorectal Cancer Screening

CMS proposes to enhance its colorectal cancer (CRC) screening coverage to promote access and remove barriers for much needed cancer prevention and early detection, particularly within rural, and communities of color that are especially impacted by the incidence of CRC. In response to recommendations by the United States Preventive Services Task Force, CMS is proposing to introduce coverage for Computed Tomography Colonography; broaden the definition of complete CRC screening to include a follow-on screening colonoscopy after a positive result from a Medicare-covered blood-based biomarker test; and eliminate coverage for the barium enema procedure. **AOA supports efforts to improve and expand Medicare Part B coverage of CRC screening and urges finalization of these provisions**.

Federally Qualified Health Centers and Rural Health Clinics

Care Management Services

Since 2016, RHCs and FQHCs have been able to bill for Chronic Care Management (CCM) services through a consolidated care management code (G0511). However, this single code represents 22 care management services, which presents serious billing and reimbursement issues. CMS proposes allowing these entities to bill individual care management codes, including the newly proposed APCM services. This will ensure more accurate coding and payment, and also enables FQHCs and RHCs to bill time-based add-on codes, which may provide meaningful payment considering the patient population these sites care for. **The AOA supports this change, which aligns payment to FQHCs and RHC with the method in which care is delivered and may enhance payment for vital services provided to underserved, and often complex, patients.**

RHC Conditions for Certification and FQHC Conditions for Coverage

CMS proposes to remove productivity standards that evaluate the total hours of an RHC's operation and whether a majority of those hours involve primary care services. These have historically limited RHC payment rates and placed unnecessary burdens on physicians at RHCs. While no longer enforcing this standard, CMS proposes to establish in regulation that RHCs and FQHCs must provide primary care services. **AOA supports this proposal, which would ensure access to comprehensive services at FQHCs and RHCs while ensuring appropriate payment**.

Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment Reductions

CMS states that it will move forward with statutorily required implementation of phased-in payment reductions for clinical diagnostic laboratory tests as required under the *Protecting Access to Medicare Act (PAMA)*. Implementation of these cuts presents a serious threat to patient care. Currently, patients often face delays in getting appointments at laboratory facilities to receive clinical lab services, and many of these facilities face staffing shortages. These payment cuts will

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intensify challenges for capacity constrained clinical labs, which will be compounded by many practices operating in-house labs being forced to no longer offer these services.

Delays in access to laboratory services, or receipt of lab results, result in the downstream effect of delayed care, potential deterioration of patients' conditions, and even avoidable hospitalizations when patients don't receive timely care. **Preserving payment for clinical laboratory services is essential to timely, high-quality care and can help ensure lower long-term health care costs through appropriate management of patients' conditions and preventing hospitalizations.**

Updates to the Medicare Shared Savings Program (MSSP)

Health Equity Benchmark Adjustment

CMS proposes to adjust an accountable care organization's (ACO's) historical benchmark based on the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid. CMS' stated goal is to incentivize practices serving higher proportions of beneficiaries from underserved communities to enter and remain in the program. **APMs should appropriately account for the complex needs, costs, and social risk factors for caring for certain underserved patient populations, and thus we support this proposal.**

Prepaid Shared Savings

CMS proposes to establish a new "prepaid shared savings" option in which eligible ACOs with a history of shared savings can be approved for advance shared savings they can use to invest in enhanced care services, care coordination, or infrastructure. The **AOA has long supported CMS providing advance or up-front additional payment to practices to support infrastructure investments focused on improving care quality and succeeding in value-based arrangements. We urge CMS to finalize this proposal and grant practices substantial flexibility in how they use these funds.**

APM Performance Pathway (APP)

CMS proposes two key changes to the APM performance pathway, including requiring that MSSP ACOs in the APP report all measures under the newly created APP Plus measure set, and moving forward with sunset of the Web Interface and removal of the MIPS clinical quality measure (CQM) reporting option for ACOs. **The AOA strongly opposes these proposals.** Concerns regarding the APP Plus measure set are discussed further below.

Updates to the Quality Payment Program

MIPS Performance Threshold

The AOA applauds CMS' proposal to maintain the MIPS performance threshold at 75 points for the 2025 performance year. In 2024, AOA expressed concern to CMS regarding raising the

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performance threshold at a moment where CMS does not have accurate data on performance due to the COVID-19 public health emergency. In addition to seeking extreme and uncontrollable circumstance (EUC) exemptions from MIPS due to the PHE in 2024, practices have been faced with yet another challenge as a result of the Change Healthcare cyberattack that disrupted practices across the country. AOA appreciates CMS' recognition of the challenges many practices face, and the decision of many small and independent practices to seek EUC exemptions over the last several years. Delaying changes to the performance threshold will enable CMS to collect performance data over a longer period of time. We urge CMS to continue delaying any increases to the threshold until at least 2027 to enable the agency to have 3 years of data post-PHE to base changes upon.

Traditional MIPS

Quality Performance Category

CMS proposes 2 key scoring changes under the quality performance category. First, CMS proposes to shift away from its established scoring approach to multiple data submissions from the same clinician or group by scoring the most recent data submission rather than utilizing the highest of the scores. **AOA opposes this proposal and believes that CMS should adopt policies that will best enable the success of physicians reporting under MIPS. AOA urges CMS not to finalize this proposal and continue relying on the highest scoring submission.**

Second, the agency proposes to modify the methodology it utilizes for scoring topped out measures from a single benchmark methodology that caps the total number of points that can be earned at seven to apply a flat benchmarking methodology to a subset of topped out measures. This proposal would only apply to topped out measures that are (1) part of a specialty measures set with limited measure choice and a high proportion of topped out measures, and (2) in areas that lack measure development, which precludes meaningful participation in MIPS. Many physicians, particularly sub-specialists with limited MIPS measures to choose from, have expressed concern that CMS' approach to topped out measures limits their ability to report meaningful measures and perform successfully under the program. **AOA supports this proposal but urges CMS to take an inclusive approach to identifying topped out measures to which this policy would be applied. An inclusive approach would ensure that physicians across specialties that have limited measures to select from can benefit from this scoring methodology change and have greater chance for success under MIPS.**

Additionally, as CMS emphasizes a shift towards reporting of outcome measures instead of process measures, this has created two challenges. First, there are not a sufficient number of measures to support reporting for many physicians, and second, many outcome measures don't fully reflect the work physicians undertake to improve care quality or account for factors beyond their control. For example, many physicians may partner with their patients to reduce their A1c levels (quality measure 204 "Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)") but may be penalized as the patient did not successfully reduce A1c levels below 9% within a given performance year. We urge CMS to work to improve existing quality measures, recognize the

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importance of process measures to quality improvement, and ensure that physicians are not unfairly penalized by these efforts.

CMS is also proposing to maintain the data completeness criteria of 75 % through the 2027 and 2028 performance periods for all available collection types. This increase will place greater administrative burden on physicians and fails to recognize the current state of health IT and interoperability, which are often inadequate to support physicians' ability to aggregate data for reporting. This is particularly challenging for physicians practicing at multiple sites or who are members of an ACO. **The AOA urges CMS to revert the threshold to prior policy of a 60 % data completeness criteria.**

Cost Performance Category

CMS proposes three key changes to this category that AOA wishes to comment on. First, CMS will add six new episode-based cost measures in 2025 which include Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, Rheumatoid Arthritis, and Respiratory Infection Hospitalization. Expanding the number of episode-based cost measures available is necessary to support the success of different specialists under the cost performance category, and we applaud CMS' ongoing effort to expand the measures available. However, we urge CMS to take a cautious approach to implementation by initially making these measures optional.

Second, in response to concerns about cost performance category scoring having a negative impact on physicians' final scores, CMS proposes to modify the methodology for scoring cost measures beginning with the 2024 performance period. Specifically, CMS would tie the median score to a point value derived from the performance threshold and assign points above and below the median based on a standard deviation. **The AOA is optimistic that this policy change will help practices disadvantaged by the cost category because (1) they belong to a specialty without applicable cost measures, resulting in inappropriately low scores and unfair penalties; or (2) they belong to small or independent practices that struggle to succeed under this category relative to physicians in larger health system that have tools to track performance and better manage costs.**

Third, CMS proposes to adopt a cost measure exclusion policy that would apply when CMS makes an error in calculating the cost measure which would result in a negative impact on the measure score. The AOA urges CMS to finalize this policy. **Additionally, AOA would like to reiterate its concerns with the total per capita cost measure including issues with patient attribution, risk adjustment, and potential outliers. In particular, we remain concerned that the TPCC measure holds physicians accountable for costs they may not be able to control, such as drug prices, including services and drugs administered by other physicians. We urge CMS to remove this cost measure to support equitable performance measurement under MIPS.**

Improvement Activities Performance Category

CMS proposes three key changes to this category on which AOA wishes to comment. Most notably, CMS proposes to eliminate "high" and "medium" weighting for measures that has made

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reporting under this category unnecessarily complex. Instead, the agency will simply require MIPS eligible clinicians to report two improvement activities to receive full credit. **The AOA supports eliminating measure weights to streamline reporting and make this category less complex and burdensome.**

Second, in addition to modifications to the overall measure inventory, CMS proposes to add two new population health improvement activities, which include "Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake" and "Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk." Overall, AOA supports the addition of these measures and believes that they can meaningfully promote public health and high-quality care.

Last, CMS proposes to make a parallel scoring change as is proposed with the quality category regarding multiple data submissions. As proposed under the quality category, CMS proposes that when a clinician or group has multiple data submissions, it will consider the most recent submission toward the final score. **AOA reiterates that it opposes this approach to scoring and believes that CMS should retain its policy of utilizing a clinician or group's highest scoring submission toward calculation of a final score.**

MIPS Value Pathways (MVPs)

MVP Scoring
CMS proposes to update the scoring of population health measures in MVPs by using the highest score of all available population health measures and proposes to remove the requirement for MVP participants to select a population health measure at the time of MVP registration. While AOA appreciates that CMS' intent with this proposal is to drive improved performance, we believe that the measures overall do not adequately measure care quality across all specialties and may disadvantage some specialists. **We urge CMS to reevaluate how it applies population measures to MVPs.**

Subgroup Reporting
CMS states that it will move forward with previously finalized policy that in the 2026 performance period/ 2028 MIPS payment year, multispecialty groups that chose to report an MVP (not traditional MIPS) will not have the option to report an MVP at the group level, and instead would need to participate at the subgroup, individual, or (if applicable) alternative payment model (APM) entity level. CMS states that this change is necessary to ensure that specialists within multispecialty groups can more effectively participate in the MVP program. **The AOA urges CMS to reconsider this policy to support practices in reporting based on the approach that will best enable their success.**

New MIPS Value Pathways
CMS proposes to establish six new MVPs around the following areas: (1) Complete Ophthalmologic Care, (2) Dermatological Care, (3) Gastroenterology Care, (4) Optimal Care for

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Patients with Urologic Conditions, (5) Pulmonology Care, and (6) Surgical Care. The AOA appreciates CMS' efforts to create new MVPs that reflect a broader range of specialties and the unique ways in which they deliver care. However, a larger number of MVPs alone does not translate to program improvement and improved specialist participation. Many of these new MVPs do not recognize the needs of sub-specialists, and fundamental issues with inadequate numbers of measures for many specialists still need to be addressed. The AOA supports the development of additional MVPs, but believes that non-primary care MVPs should be designed in a manner that meets the needs of different types of clinicians including (1) clinicians who predominantly treat specific conditions or are involved in specific episodes of care, (2) generalists who may perform a range of procedures or treat many different conditions. The AOA supports the AMA's proposed stratified, condition/episode specific approach to MVP development for non-primary care specialties.

The newly created Surgical Care MVP reflects many of the challenges noted above. For example, the MVP is intended to apply to a diverse range of surgical specialties (from neurosurgery to cardiac surgery) but only three quality measures are broad enough to apply across multiple surgical specialties. The other measures are specific to coronary artery bypass grafts, pain and functional status after lumbar surgery, anastomotic leak, and biopsy for invasive breast cancer. The MVP seeks to lump many unrelated surgical specialties together as if their approaches to care and needs are similar. The AOA urges CMS to revise its approach to MVPs and work with stakeholders, particularly the various specialty societies, toward a new approach to MVP development that recognizes the distinct needs of different specialists and sub-specialists. **The AOA does not believe that a complete transition to MVPs and sunsetting traditional MIPS by 2029 is reasonable. CMS should focus its efforts on working with stakeholders to ensure that the development of new MVPs meets the needs of clinicians across specialties before determining a timeline for traditional MIPS' sunset. We urge CMS to refine MVPs based on the recommendations presented during the roundtable convened by AMA in May 2024.**

APM Performance Pathway (APP)

APP Plus Measure Set

CMS proposes to create within the APM Performance Pathway (APP) the APP Plus quality measure set beginning with the CY2025 performance period/2027 MIPS payment year to align with the Universal Foundation measures under the CMS National Quality Strategy. This would add five measures from the universal foundation to the APP (in addition to the six measures already included in the APP). The APP Plus measure set would be required for Medicare Shared Savings Program Accountable Care Organization (ACO) participants, and optional for other APP participants. CMS should not finalize this proposal. While AOA has advocated for alignment across quality programs with CMS' universal foundation of measures, a key benefit of participating in the APP and in the MSSP is relief from quality reporting burden. A substantial increase in reporting requirements may create a disincentive for participation in APMs. Participating in APMs that drive accountability for cost and quality should be accompanied by reduced reporting burden. **The new APP Plus measure set, and required reporting by MSSP**

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ACOs, will increase administrative and reporting burden without necessarily improving care quality, and the AOA urges CMS to withdraw this proposal.

Request for Information: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

CMS solicits input on a broad range of topics related to implementation of an ambulatory specialty care APM that is based on the MVP framework and implemented as a mandatory model. **First, the AOA wishes to emphasize that it opposes mandatory participation in CMMI models as this can jeopardize access to care by requiring small, independent, and rural practices to participate when they are unequipped to succeed.** Additionally, we are concerned with CMS' approach to using MVPs as the foundation for developing an APM in light of the concerns we previously raised regarding inadequate measure sets, flaws in existing measures, and inappropriate comparisons between specialties. Additionally, we do not believe the 60-day comment period provided in this rule is adequate to fully evaluate the list of questions and model considerations presented by CMS. We ask that the agency work with AOA and the relevant medical specialties to develop any new model, subsequently seek public input, and ensure that the model is designed in a manner that will enable participants to succeed. We also refer CMS to the principles for model design we highlight in the "Request for Information: Advanced Primary Care Hybrid Payment" section of our comments, as many of the concerns highlighted there would also apply to any new ambulatory specialty care model.

Conclusion

The AOA is pleased to have the opportunity to comment on the CY2025 Medicare Physician Fee Schedule Proposed Rule. We look forward to continuing to work with CMS on developing final regulations. Should you have any questions regarding our comments or recommendations, please contact John-Michael Villarama, Vice President for Public Policy at jvillarama@osteopathic.org at any time should we be able to support your efforts.

Sincerely,

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