AMERICAN OSTEOPATHIC ASSOCIATION

2024 BOARD OF TRUSTEES MIDYEAR RETREAT AND BUSINESS MEETING

JW MARRIOTT CLEARWATER BEACH RESORT (691 S GULFVIEW BLVD, CLEARWATER BEACH, FL) | VIRTUAL

Complete Meeting Registration

Retreat Attire: Resort Casual

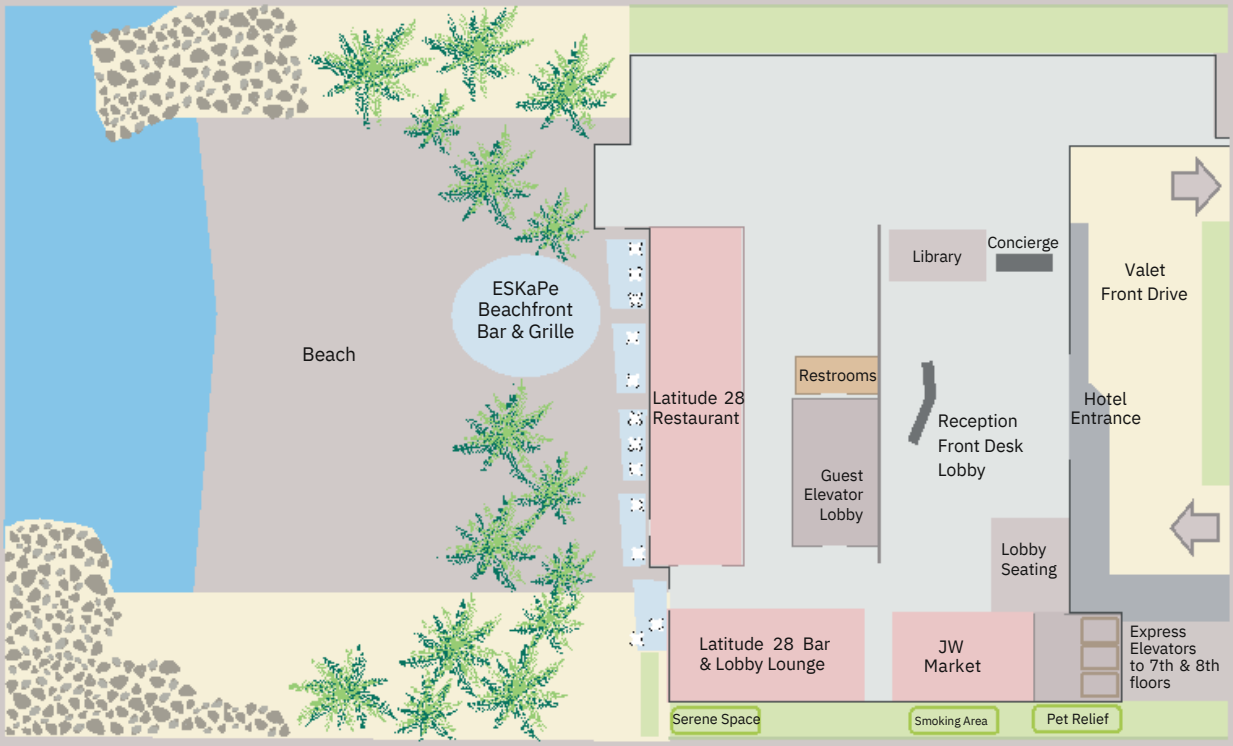
Wednesday, February 21, 2024 MIDYEAR BUSINESS MEETING		
12 – 1 pm ET	Midyear Lunch *(Open to Spouses/Significant Others and Affiliate Guests)*	Kiran Ballroom
1 – 4 pm ET	Midyear General Session	Pallavi Ballroom Zoom
After 4 pm ET	Enjoy time on your own	
6:30 – 9:30 pm ET	Closing Dinner *(Open to Spouses/Significant Others and Affiliate Guests)*	Kiran Ballroom

Thursday, February 22, 2024 MIDYEAR BUSINESS MEETING		
8 – 11 am ET	Midyear Breakfast and Strategic Discussion Topic: Artificial Intelligence	Pallavi Ballroom Zoom

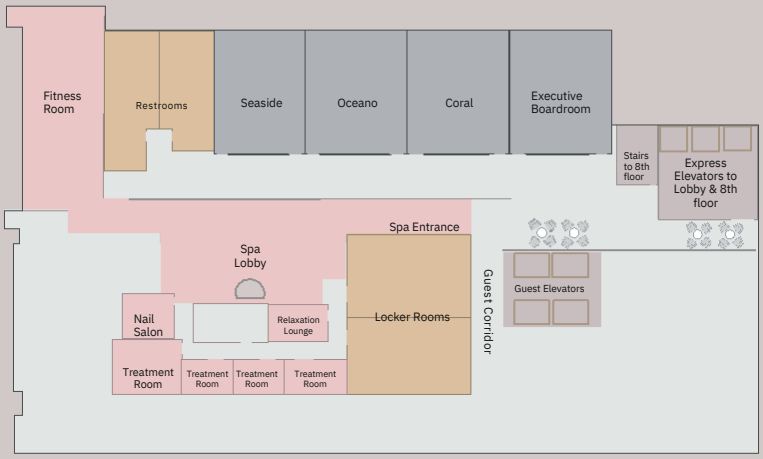
RESORT MAP

AOA Midyear Meeting
February 21-22, 2024

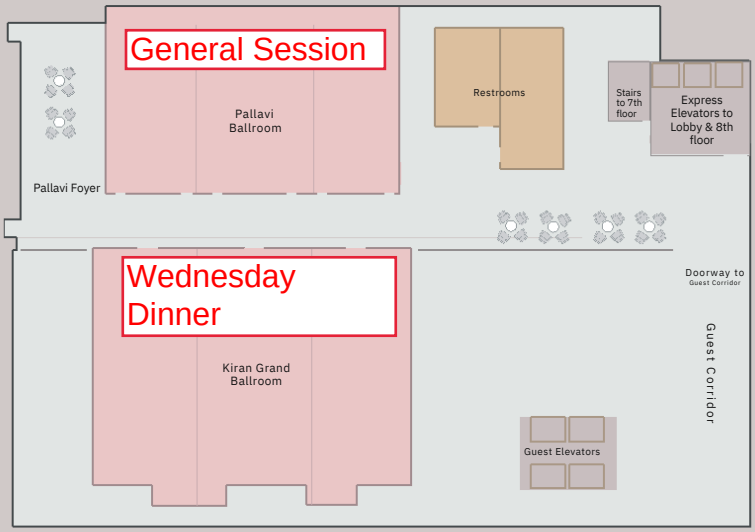
Level 1
Lobby, Latitude 28, JW Market, ESKaPe



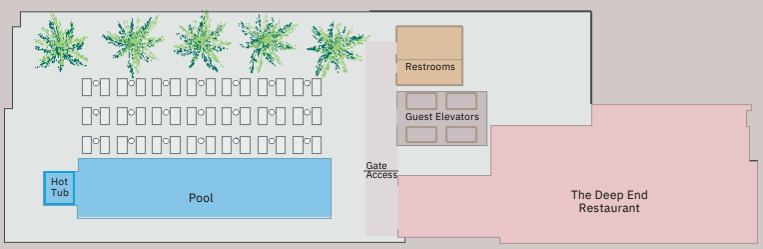
Level 7
Spa & Fitness Center, Meeting Rooms



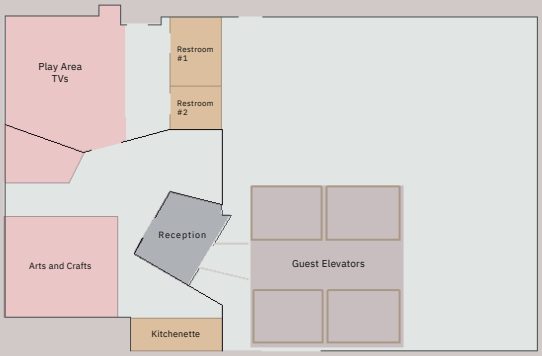
Level 8
Ballrooms & Pre-Function Space



Level 11
Rooftop Pool Deck & The Deep End



Level 12
Kid's Club



Board of Trustees
Midyear Meeting
February 20-22, 2024
JW Marriott Clearwater

AMERICAN **OSTEOPATHIC** ASSOCIATION

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

2024 AOA BOARD OF TRUSTEES MIDYEAR GENERAL SESSION

JW Marriott Clearwater Beach Resort · Pallavi Ballroom

Virtual Participation: Zoom

Please remember to place yourself on mute if not speaking

Wednesday, February 21, 2024 · 1 – 4 pm ET

Time	Agenda Item		Presenter(s)
1 pm	Call to Order and Welcome		Ira P. Monka, DO, FACOFP, President
	Roll Call and Quorum Establishment		Val Carr, Chief of Staff
	Introduction of Guests		Ira P. Monka, DO, FACOFP, President
	Osteopathic Pledge of Commitment / AOA Mission and Vision Statement		Ira P. Monka, DO, FACOFP, President
	Invocation		James M. Lally, DO
1:15 pm	Conflict of Interest Disclosures	Action	Ira P. Monka, DO, FACOFP, President
	Adoption of Agenda	Action	
	Leadership Reports		
1:20 pm	President's Report		Ira P. Monka, DO, FACOFP, President
1:30 pm	President-Elect's Report		Teresa A. Hubka, DO, FACOOG(D), President-Elect
1:40 pm	CEO's Report		Kathleen S. Creason, MBA, CEO
	Governance and Operations Departmental Reports		
1:50 pm	Department of Affiliate Relations		Julieanne P. Sees, DO, Chair
2 pm	Finance Department		Bruce A. Wolf, DO, Chair
2:10 pm	Department of Education		David E. Garza, DO, Chair
2:20 pm	Department of Governmental Affairs		Shannon C. Scott, DO, Chair
2:30 pm	**Break**		
2:35 pm	Membership Department		Kevin V. de Regnier, DO, Chair
2:40 pm	Department of Research and Public Health		Robert S. Dolansky, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

2024 AOA BOARD OF TRUSTEES MIDYEAR GENERAL SESSION

JW Marriott Clearwater Beach Resort · Pallavi Ballroom

Virtual Participation: Zoom

Please remember to place yourself on mute if not speaking

Wednesday, February 21, 2024 · 1 – 4 pm ET

Time	Agenda Item	Presenter(s)
	Organization Reports *Organizations are requested to limit their verbal reports to 5 minutes.*	
3 pm	American Association of Colleges of Osteopathic Medicine (AACOM)	Robert A. Cain, DO, President and CEO
	National Board of Osteopathic Medical Examiners (NBOME)	Lori A. Kemper, DO, MS, Board Chair John R. Gimpel, DO, MEd, President and CEO
	American Association of Osteopathic Examiners (AAOE)	Alexios Carayannopoulos, DO, President
	American Osteopathic Foundation (AOF)	Joseph A. Zammuto, DO, President
	American Osteopathic Information Association (AOIA)	Norman E. Vinn, DO, MBA, Chair
	Advocates for the American Osteopathic Association (AAOA)	Megan Maples, President
	Osteopathic International Alliance (OIA)	Boyd R. Buser, DO, Chair
	Society of Osteopathic Specialty Executives (SOSE)	Carol Houston, President
	Bureau of Emerging Leaders (BEL)	Sarah J. Wolff, DO, Chair
	Student Osteopathic Medical Association (SOMA)	Rebecca Wolff, OMS IV, President
3:55 pm	Closing Remarks	Ira P. Monka, DO, FACOFP, President
4 pm	**Adjournment**	Ira P. Monka, DO, FACOFP, President

Written Organizational Reports

American Association of Osteopathic Examiners (AAOE)
Association of Osteopathic State Executive Directors (AOSED)
Council of Osteopathic Student Government Presidents (COSGP)
Bureau of Emerging Leaders (BEL)

Written Organizational Reports

AMERICAN OSTEOPATHIC ASSOCIATION

AAOE Report to AOA 2024: Pending Legislation of Interest

- **Artificial Intelligence**
- **Georgia HB 887** – Prohibits health care professionals from making decisions or taking action based solely on predictions, recommendations, or decisions made by artificial intelligence, and requires AI decisions to be meaningfully reviewed. The bill requires the Board to establish rules and regulations on standards necessary for implementation, including disciplining a physician who fails to comply with the statute.
- **Associate Physicians**
- **New Jersey S 1832** - Creates a "graduate physician" (GPs) licensure class for individuals who completed medical school but have not completed a postgraduate or residency training or passed USMLE Step 3 or COMLEX Level 3. GPs shall not be required to complete more CME than a physician, but adverse license actions for GPs should follow the standard for physician licensees. GP practice is limited to "primary care services in medically underserved areas… and to procedures that are delegated to [them] by a collaborating physician" under the terms of a collaborative practice agreement (CPA), which may include prescribing controlled substances and cannabis. Lastly, the Board of Medical Examiners is empowered to promulgate rules and regulations regarding licensure and renewal procedures, collaborating physician and CPA guidelines, and licensing fees, among other pertinent issues.
- **Oklahoma SB 1613** – Creates a "provisionally licensed physician" (PLPs) licensure class for individuals that graduated from an allopathic or osteopathic medical school in Oklahoma and have passed USMLE Steps 1 and 2 or COMLEX Levels 1 and 2 within the last two years, but have not completed a postgraduate residency. PLPs must practice according to CPAs, under the guidance of collaborating physicians that are "responsible… for the oversight of the activities of and accept responsibility" for services rendered, which are limited to primary care services only. The Board of Medical Licensure and Supervision and the Board of Osteopathic Examiners are empowered to promulgate rules and regulations regarding licensure and renewal procedures, collaborating physician and CPA guidelines, and licensing fees, among other pertinent issues.
- **Board Authority/COVID-19**
- **Oklahoma SB 1732** - Explicitly allows ivermectin and hydroxychloroquine to be available over-the-counter sans prescription or consultation with a health care professional.
- **West Virginia HB 4324** – Permits pharmacists to dispense ivermectin by standing order - a written and signed protocol authored by one or more physicians or APRNS licensed in the state - to patients without a prescription. Pharmacists must provide ivermectin recipients with information regarding follow up care but "nothing on the information sheet shall discourage the recipient from using ivermectin for the treatment of COVID-19." Lastly, the Boards of Medicine, Nursing, and Pharmacy may not deny, revoke, suspend, or otherwise take disciplinary action against a physician based on a pharmacist's failure to follow standing orders, or a nurse or pharmacist following the statute.

- **Board Structure and Function**
- **Oklahoma HB 2958** – Extends the Medical Board's mandate to July, 1, 2027, in line with the state's sunset law.
- **South Dakota SB 57** – Prohibits any professional or occupational licensing board, commission, or agency; including the Board of Medical and Osteopathic Examiners, from taking adverse action against an applicant or licensee based solely on their criminal history, unless it directly relates to the profession or occupation. The factors to determine the direct relation include the nature and seriousness of the crime, its relationship to the profession, and the person's rehabilitation. The bill also allows prospective applicants to seek a declaratory ruling on potential adverse actions against a potential license based on their criminal history, in which "the agency may specify the length of time for which the agency considers the decision binding, if any."
- **Virginia SB 351** – Moves the regulation of APRNs and certified nursing midwives (CNMs) from joint oversight by the Boards of Medicine and Nursing to solely the Board of Nursing.
- **Virginia HB 502** – Requires all forms or applications to offer any applicant the option of "male," "female," or "nonbinary" when designating sex or gender.
- **Washington HB 1889** – Prohibits the Board from rejecting a license application based solely on the applicant's immigration status.
- **West Virginia SB 161** – Authorizes the Board to issue an emeritus license to physicians, podiatrists, and PAs who have fully retired after actively practicing in the state for at least ten consecutive years. The emeritus license is honorary and does not permit clinical practice and cannot be converted to an active license. Those wishing to return to practice must reapply and meet all reactivation requirements. The emeritus license is valid for life unless the holder resumes clinical practice or the Board revokes it. The bill also requires the Board to establish rules, including the application process, grounds for denial/revocation, and a voluntary relinquishment process for the new license.
- **Continuing Medical Education**
- **West Virginia SB 297** – Establishes that CME credits are valid for three years and gives the Board authority to extend their validity an extra three years, for a total of six years.
- **Death with Dignity**
- **Virginia SB 280 and HB 858** – Allows an adult diagnosed with a terminal condition to request an attending health care provider to prescribe a self-administered controlled substance to end their life. The bill requires that a patient's request be in writing, signed by the patient and one witness, and given an express opportunity to rescind the request; and the medication must be given orally on two occasions.
- **Diversity, Equity, and Inclusion**
- **Missouri HB 2365** – Prohibits state departments from spending money on DEI initiatives.

- **Gender-affirming Care (GAC)**

- **Maryland SB 119** – Amends the definition of "legally protected health care" to include certain gender–affirming treatment, including medications and supplies, and prohibits state employees and agencies from "providing information, expending time or money… [relating to] any interstate investigation or proceeding seeking to impose civil or criminal liability on, or administrative sanction against, a person for any activity relating to legally protected health care."
- **Missouri SB 726** – Removes the August 28, 2027 expiration date of the **Save Adolescents from Experimentation (SAFE) Act**, the Missouri law enacted in 2023 that prohibits health care professionals from providing gender-affirming care.
- **Missouri HB 1520** – Repeals the exception to the prohibition on GAC from the **Save Adolescents from Experimentation (SAFE) Act** that allows minors to continue care so long as they had begun prior to the passage of the bill as well as the sunset of the prohibition on August 28, 2027.
- **Missouri HB 1519** – Prohibits discrimination against health care professionals who refuse to assist in medical procedures or treatments relating to GAC.
- **Health care Professionals Scope of Practice**
- **Maryland HB 76 and SB 18** – Permits pharmacists who have completed at least 20 hours of practical training and at least two CME hours related to immunizations to order and administer vaccinations to individuals who are at least five years old.
- **Washington SB 5983** – Permits medical assistants with telehealth supervision to provide intramuscular injections for syphilis treatment.
- **International Medical Graduates**
- **Virginia HB 995** – Permits the Board to grant a provisional license to a qualified physician licensed in a foreign country, for a period of up to two years, that meet the following criteria:
    - Has received a degree from a medical school recognized by the World Health Organization;
    - Is licensed in another country and practiced medicine for at least five years;
    - Has a valid ECFMG certificate (however, the Board may waive this condition "at its discretion where the applicant is unable to obtain the required documentation from a noncooperative country);
    - Has passed USMLE Steps 1 and 2; and
    - Has entered into an agreement with a medical care facility defined under **Va. Code § 32.1-3** "that provides an assessment and evaluation program designed to develop, assess, and evaluate the physician's nonclinical skills and familiarity with [state] standards… "according to criteria developed or approved by the Board."
    - Licensees practicing under this statute may apply for a renewable two-year extension if they:
    - Practice in a medically underserved area;
    - Achieve a passing score on USMLE Step 3; and

- Enter a full-time employment relationship with a medical facility.
- After at least two years of practice under the renewable license, the physician may apply for a full, unrestricted license.
- **Wisconsin SB 900** – Establishes the "international medical program" which establishes a process for granting provisional licenses to international physicians that meet the following criteria:
- Graduate of any medical school, residency program, medical internship program, or other program approved by the ECFMG "that is substantially similar to the training required to qualify to practice medicine and surgery in [the] state;"
- Have practiced as a fully licensed physician in their country for at least five years after completing a residency program;
- Is in good standing with the medical licensing or regulatory agency for at least five years preceding the application to the program;
- Has passed all steps of the USMLE;
- Has federal immigration status and employment authorization;
- Speaks fluent English, and
- Has an offer for employment as a physician in the state.
- Provisional licenses can be converted into permanent licenses after three years of good standing. The bill also allows the Board to determine the countries in which an individual practicing as a PA or physician associate qualify as a PA in the state, and allows the Board to grant PA licenses to qualified international applicants who meet the requirements defined under **Wis. Stat. § 448.974**.
- **Interstate Medical Licensure Compact**
- **Florida HB 1549** – Enters Florida into the IMLC.
- **Licensure Portability**
- **Florida SB 1600** - Creates a licensure pathway based on endorsement for professions that do not currently have a similar process in place. Qualifying applicants must hold a valid, active license in another jurisdiction for at least five years prior to application, passed recognized licensing exams if necessary, have no pending disciplinary actions, satisfied prior disciplinary actions if necessary, complete Florida-specific continuing education courses and/or relevant jurisprudence exams, and comply with any insurance requirements.
- **Georgia HB 880** – Permits the Board to issue a license to a military spouse who is licensed and in good standing in another state.
- **Virginia HB 511** – Adds assisted living facilities to the list of eligible health care employers a health care practitioner licensed in another jurisdiction may temporarily practice, for one 90-day

period, if the practitioner is contracted by, or has received an offer of employment in the Commonwealth.

- **Medical Ethics**
- Virginia SB 153 – Establishes the right of a medical practitioner, health care institution, or health care payer to not participate in, or pay for any medical procedure or service that violates their conscience.
- **Medical Marijuana**
- Florida HB 1435 – Provides that veterans are not required to pay the fee for the issuance or renewal of a medical marijuana registry identification card.
- Florida HB 1677 – Permits individuals with a medical cannabis card from another state to bring cannabis into Florida.
- South Dakota SB 10 – Requires health care practitioners to notify an individual's primary care provider when issuing a medical cannabis certification.
- South Dakota SB 11 – Prohibits practitioners from referring a patient to a medical cannabis clinic that the practitioner or an immediate family member has a financial relationship; violators are subject to a misdemeanor.
- **Mental Health**
- Virginia HB 813 – Permits individuals 16 years or older and capable of giving informed consent the ability to accept or refuse treatment for a mental or emotional disorder for which their parent or guardian has given consent. The bill also requires that a parent or guardian be notified by the health care provider of the minor's drug or substance abuse, or potential for self-harm.
- **Miscellaneous**
- Wisconsin SB 905 – Ensures that health care providers cannot refuse or end a direct primary care agreement with a patient solely based on the patient's health status. A provider can, however, decline care if their practice is full or if the patient's condition requires services they cannot offer. The bill also prohibits discrimination based on protected characteristics such as race, gender, or age. Termination of the agreement is allowed only for specific reasons like non-payment, patient non-compliance, fraud, abusive behavior, provider discontinuation, or if the relationship is no longer therapeutic.
- West Virginia SB 208 – Establishes a tax credit for physicians who are new graduates and practice in the state for at least six years.
- **PA Compact**
- Colorado SB 24-018 – Enters Colorado into the PA Compact.
- Oklahoma SB 1654 - Enters Oklahoma into the PA Compact.

- **Rhode Island HB 7083** – Enters Rhode Island into the PA Compact.
- **Tennessee SB 1727** – Enters Tennessee into the PA Compact.
- **Pain Management/Prescribing Practices**
- **California SB 607** – Extends the requirement that before directly dispensing or issuing the first prescription for a controlled substance containing an opioid, the prescriber must discuss the risks to all patients, not just minors.
- **Maryland SB 246 and HB 127** – Authorizes pharmacists and licensees to prescribe and dispense nPEP (non-occupational Postexposure Prophylaxis), which helps to prevent HIV infection after virus exposure.
- **West Virginia SB 295** – Makes opioid treatment programs – such as those that dispense and administer methadone - illegal and gives established programs 120 days after the bill's effective date to assist patients in transitioning care. Violators are subject to a fine up to $2,500.
- **PAs/APRNs**
- **Arizona HB 2582** – Adds CNMs and PAs to the list of professionals that pharmacists may enter into a collaborative practice agreement with.
- **Tennessee HB 1687** – Authorizes a nurse practitioner or PA to perform the mandatory physical examination of a public safety dispatcher or emergency call taker if included in the written protocol developed by the supervising physician and NP or PA.
- **West Virginia SB 169** – Authorizes PAs to own their own practice.
- **Reproductive Care**
- **Florida HB 1519** – Prohibits health care professionals from providing abortion services, unless it is to save the life of a pregnant woman. The bill also expands the ban on public funds to organizations that provide abortions that were the result of incest or rape. Violators are subject to a felony punishable by imprisonment of up to 10 years and a fine up to $100,000.
- **Kentucky SB 99** – Permits health care professionals to provide an abortion when there is a lethal fetal anomaly, when the pregnancy is the result of rape or incest, and when the fetus has not reached viability as determined by the good-faith medical judgment of the physician.
- **Oklahoma SB 1828** - Prohibits "internet service providers [in the state from]... allow[ing] a web page... to sell, attempt to sell, or provide information for the purchasing of abortion-inducing drugs."
- **Virginia SB 278** – Declares that providing or receiving an abortion or gender-affirming care is a right, and prohibits health care professionals from being disciplined or criminally charged for providing those services, and prohibits the state's law enforcement officers from investigating, aiding, or in any other way assisting an investigation into an individual suspected of receiving or rendering such care.

- **Virginia HB 519** – Prohibits the Board of Medicine from disciplining a doctor for providing or receiving abortion care that is legal in the Commonwealth, regardless of where it occurs. The bill clarifies that certification or licensing issues related to abortion apply only when it is against the laws of the Commonwealth. The bill updates existing law, which currently includes grounds for license refusal or disciplinary action for "criminal" abortions.
- **Washington HB 2115 and SB 5960** – Permits prescribers to request that their national practitioner identification number or health care facility name be used on the label of abortion medication instead of their name.

ASSOCIATION OF OSTEOPATHIC STATE EXECUTIVE DIRECTORS

2023 - 2025 OFFICERS

PRESIDENT
MICHELLE W. LARSON, CAE, CMP
2544 Blairstone Pines Drive
Tallahassee, FL 32301
E-mail: michelle@foma.org
Phone: (850) 878-7364

PRESIDENT-ELECT
AMANDA RICHARDS
Executive Director
Maine Osteopathic Association
29 Association Drive
Manchester, ME 04351
Email: amahan@mainedo.org
Phone: (207) 623-1101

PAST PRESIDENT
DIANA EWERT, CAE
Executive Director
Pennsylvania Osteopathic Medical Association
1330 Eisenhower Blvd.
Harrisburg, PA 17111-2395
Email: dewert@poma.org
Phone: (717) 939-9318 x11

TRUSTEES
JAMIE HUESTON
Executive Director
Alabama Osteopathic Medical Association
PO Box 31
Rockville, IN 47872
Email: jamie@aloma.org
Phone: (205) 570-5576

KRIS NICHOLOFF, JD
Executive Director
Michigan Osteopathic Association
2445 Woodlake Circle
Okemos, MI 48864-5941
Email: kn@domoa.org
Phone: (517) 347-1555

ALLISON LEBEOUF, JD
Executive Director
Oklahoma Osteopathic Association
4848 North Lincoln Blvd.
Oklahoma, OK 73105-3335
Email: allison@okosteo.org
Phone: (405) 528-6102

HOLLY MACRISS
Executive Director
Osteopathic Physicians & Surgeons of California
2015 H Street
Sacramento, CA 95811
Email: Holly@opsc.org
Phone: (916) 822-5246

AOSED MAILING ADDRESS:
AOSED COORDINATOR
2544 Blairstone Pines Drive
Tallahassee, FL 32301
E-mail: michelle@foma.org
Phone: (850) 878-7364

Feb. 2024

AOSED presentation to AOA Board of Trustees

It is an honor and a pleasure to have been elected by my peers to serve as the president of AOSED. DO's are family and we are blessed to work with and for the very best in the profession! As Divisional Societies of the AOA, state associations know that we are a critical partner in the AOA's future and within the profession. Together, with the AOA, AOSED is proud to represent 186,000 osteopathic physicians and medical students.

AOSED is here to support you, our leaders, and the osteopathic profession from students to residents to physicians providing patient care. Our goal is to ensure you can practice medicine to the full extent of your training. To ensure you can get and retain your license. To prove to legislators and health systems that non-physician clinicians cannot practice medicine because they are neither as good as nor just like you.

AOSED is working on our current committees: education, marketing and social media being of great importance, to states small and large. We appreciate you and are learning from our colleagues and state officers, who currently serve on AOA Bureaus, Committees and Councils. We have the upmost confidence in the future of osteopathic medicine and the principals it was founded on. As Dr. Andrew T. Still so eloquently said "The science of osteopathy is founded upon a knowledge of the fact that man is a compound of body, mind, and spirit."

AOSED believes in lifelong learning and adjusting to benefit our students and physicians. Our ability to provide you with relevant, current, high quality, evidence-based continuing medical education is engrained in everything we do. We want you to walk away from our programs, with new information and the ability to provide quality healthcare to your patients.

We appreciate you and our state officers, who volunteer your time and expertise daily, to make sure we have the tools for our associations to succeed and grow!
AOSED's learning management system: The CME Center has helped countless DO's earn quality education, for their state & specialties, while supporting participating states in the process. The CME Center continues to put quality education at your fingertips!

We assure you that AOSED leadership remains strong. Change is good, change is sometimes hard, but it helps us to grow. AOSED is embracing this next generation of members and our future leaders… your future leaders.

You, as osteopathic physicians, are unique and distinct in your education and training. Dave Grohl says, "No one is you, and that is your power." This quote celebrates uniqueness and should remind you that your distinct qualities and perspectives are the source of your power. Embrace it.

We look forward to partnering with the AOA on projects and initiatives that make us better individually and has a whole. Thank you for all that you DO.

Respectfully,
Michelle W. Larson, CAE, CMP
AOSED President

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000
osteopathic.org

Bureau of Emerging Leaders Workgroup Report

Name	Projects	Leads	Members
Advocacy	**Goal: Provide support for DO Day** • Assist with BEL Scholarship orientation & recipient experience. • Work to improve trainee and new physician in practice (NPP) turnout. **Goal: Assist with Osteopathic Advocacy Network**	Shawn Hamm, DO Sean Johnson, DO Selena Raines, DO	42
Communications	**Goal: Increasing click through/interaction rate (past 0.8%) of our quarterly Looking Forward newsletter** • Enhance engagement by introducing compelling topics and interactive components (polls, discussions, feedback, etc.). • Coordinate release dates with associated social media and app presence to improve viewability. **Goal: Identify and fix list serve issues** **Goal: Constituent Member Welcome Letter** • Developed three letters to welcome and orient new AOA members, tailored for students, trainees, and NPPs. • Increase constituent awareness of the BEL presence and representation. **Goal: Assist in dissemination of board certification information** • Form partnerships to help disseminate board certification workgroup content to trainees and NPPs.	Tim Beals, DO William Rinaldi, OMS IV Anjali James, DO	16

142 E. Ontario St.
Chicago, IL 60611
312.202.8000
osteopathic.org

Resolutions	**Goal: Mentorship through resolution process** • Review opportunities for student resolutions • Webinar on resolution writing (COSGP completed, SOMA has not responded) • HOD primer **Goal: Create meaningful resolutions** • Bylaws: Increasing flexibility around BEL representation at the House of Delegates (fellow seat). • Explore the impact of match processes outside the match and how it affects DOs. • Increase access to mental health resources in the ED. • Recognizing intellectual and developmental delay as a health disparity. • +/- Opposing private equity acquisition in healthcare. **Goal: Ensure informed insight for the HOD** • Run the BEL Caucus. • Engage with the major student organizations (COSGP, SOMA, SNMA, OBI, SAAO, SMOPS, AMA MSS Chair, Latino Medical Society). **Goal: Increase opportunities for involvement** • Provide information on active trainee & NPP members to their relevant states and specialties. • Enhance engagement opportunities for constituents to craft resolutions.	Daniel Krajcik, DO Sara Lohbauer, DO Ashley Gerard, OMS III	25

142 E. Ontario St.
Chicago, IL 60611
312.202.8000
osteopathic.org

Events/Scholarships	**Goal: Understand what motivates our constituents to choose their events and conference**
	• Survey
	
	Goal: Creating community at AOA events
	• All
	  ○ AOA basic flier w/ "alphabet soup" and events for new members of the profession
	• HOD
	  ○ Social gathering going into the weekend to help with networking and idea exchange.
	  ○ BEL summit
	• OMED
	  ○ Mixer at OMED with social scavenger hunt. Positive feedback. "Most engaging interactive upbeat mixer."
	  ○ OMED primer webinar and FAQs
	  ○ BEL primer/welcome presentation or panel on the first day of OMED
	  ○ Increase workshops aimed at NPPs & trainees on professional and personal development.
	• DO Day
	  ○ Working with OBI and SOMA to do a combined social event.
	  ○ Name tag ribbons to designate veteran and first-time attendees.
	
	Goal: Impact assessment and optimization of scholarship program
	• OMED Scholarships: Successfully continued engagement with multiple recipients for the last three years. Formalized introduction, schedule, expectations, & feedback. Appreciate AOA's support.
	• DO Day Scholarships: Assessment to be done. Selected members notified Feb 20th. Appreciate AOIA's support.
		Nigel Jagoo, DO
		Alissa Hendricks-Wenger, OMS III
			28

142 E. Ontario St.
Chicago, IL 60611
312.202.8000
osteopathic.org

***New* BEL Structure**	**Goal: Creation of larger network of young leaders and alignment between similar osteopathic groups** • Collaborative Cohort • BEL Summit **Goal: Optimizing time spent in collaborative efforts** • Reorganization of meetings to decrease report time and increase collaboration and idea exchange. **Goal: Optimizing transitions** • Creation of transitional transition documents **Goal: Increased communication to and from AOA on topics important to our cohort**	Sarah Wolff, DO Maria Jones, DO Caelin Smith, OMS III	6
***New* Public Relations**	**Goal: Create a structure and direction for increasing BEL and AOA awareness** **Goal: Increase BEL awareness** • Creation of baseline BEL Awareness Toolkit • Creation of BEL member liaison program to societies and different regions • Identification of the need for an updated/useable osteopathic family calendar on app (AOA calendar didn't have OMED or other events) • Increasing presence at COMs: Prerecorded videos of BEL or BOT members, following Dr. Monka's directive, email COMs regarding BEL members in their areas for meet and greet or other activities.	Brianne Howerton, DO Neal Monka, DO Devanshi Patel, OMS IV	34

142 E. Ontario St.
Chicago, IL 60611
312.202.8000
osteopathic.org

***New* Public Relations Cont'd**	**Goal: Increase BEL constituent engagement**
	• Increase trainee engagement through cohort meetings. Alignment with AACOM's Residents and Fellows Council.
	• BEL presentations at COSGP, SOMA, OBI, etc.
	• Creation of membership feedback mechanisms. Look at the formalized process for submission of member and constituent feedback.
	• See Social Media*
	
	Goal: Provide impact by using the BEL and constituents as AOA Brand Ambassadors
	• Proposal for yearly presentations/webinars: Match, DO Day, board prep, etc.
	• Standardize BEL member expectations for engagement at public events.
	• Working towards creation of student and trainee pitch decks for AOA
	• Working with Jay put effort and projects towards AOA workgroup directives.
	
	Goal: Assess and assist with social media member engagement
	• Increasing AOA social media connections: (Provided list of AOA pages for major affiliates, COMs, journals, foundations, and associated groups).
	  ○ Increases ability to follow, repost, and connect.
	• Increasing BEL member content of interest (These have since declined)
	  ○ BEL takeover
	  ○ "BEL Thursday"
	  ○ Concept video: "We're DOs, of course we…"
	  ○ Occasional trend "flash content" with quicker turnaround for increased content relevance (increase traction)
	  ○ FB page Linktree to BEL newsletter		

American Osteopathic Association Board of Trustees Midyear Meeting, COSGP update

Caroline Dorothy Rizea, OMS-III
COSGP National Chair

Introduction:

On behalf of the Council of Osteopathic Student Government Presidents (COSGP), I am pleased to have the platform to report to you all of the hard work we have put in this year. As students, we appreciate every opportunity to collaborate with organizations like the AOA to better the student experience and leave our mark on this incredible profession. This year has flown by, and looking back on all we have accomplished is truly incredible. We could not do what we do everyday without you, and I can not thank you enough for your continuous support.

Year in review:

Members of COSGP represented their state societies at the AOA HOD in July, and attended the National Osteopathic Student Caucus alongside SOMA. This event prepared students for HOD and created a platform for students to discuss the student opinion prior to the House. We had students stand up and speak on the Floor at the HOD on topics which they were passionate about. We have seen a continued passion for legislation and advocacy this year. Our Legislative Affairs chair has been working with our Parliamentarian to teach resolution writing to students, and prepare them for HOD this year. We have gratefully had the opportunity to work with members of the BEL to truly understand the art of resolution writing.

In October, we all came together again, but this time in Orlando for OMED 2023. We had a two day long conference filled with guest speakers from the AOA BOT, NBOME, AACOM, BEL, CSA, and COSGP alumni. We also welcomed our newest addition, Touro COM Montana, for the first time to COSGP. Students had the opportunity to network with other students and take place in school discussions to learn more about how other COMs address student concerns. Our students enjoyed all OMED had to offer and already cannot wait for next year.

Our executive board members of COSGP had incredible opportunities to travel this year to represent our organization and DO students as a whole. Historically, the COSGP Chair attends multiple meetings and conferences throughout the year to represent DO students, but this year, I opened up some of these to the rest of the executive board. A large emphasis I made to the board this year was that everyone should have the opportunity to shine where they most shine. This allowed our Global Health representative to attend the Osteopathic International Alliance meeting in London, our Clinical Education representative to attend the NRMP Match Summit Meeting, and our Parliamentarian and Legislative Affairs representative to attend the AMA-MSS midyear meeting. Our members were engaged in these meetings sharing the DO student opinion and brought information back to present to the rest of the council. I had the incredible opportunity to sit on a panel for the MedHub UME Healthcare Summit, where I answered discussion questions alongside an MD student and MD resident. As the only DO representative on the panel, I was proud and spoke strongly about COSGP and all of the surrounding Osteopathic Organizations.

Looking forward:

- The second annual National DO Day of Service will be held the weekend of April 20th, 2024. Region chairs are working with our COSGP Programs representative to finalize on a charity where all proceeds will go to from T-shirt and hat sales.
- The Justice, Equity, Diversity, and Inclusion program (JEDI) is still growing and will expand further throughout COMs in the next academic year.
- COSGP submitted an abstract that has been accepted for an oral presentation at Educating Leaders in Kansas City. We will be presenting data collected from both DO students and the Committee on Student Affairs, to discuss recommendations for the concerns seen in medical education from both the student and student affair perspective. We are thrilled for this opportunity and collaboration with CSA. Our presentation will take place on April 17th at 9:45 am CST.
- COSGP will be meeting for one last time this year in Kansas City, after Educating Leaders. Elections will be held to elect a new group of students for the Executive Board.

Again, thank you for the support and encouragement you always provide COSGP. I wish I could be in person with you all at this meeting, but please know that I am with you in spirit. This has been an amazing year and being Chair has been the opportunity of a lifetime. I am looking forward to seeing you all at Educating Leaders or at HOD in July. Although late, Happy New Year to you all and I hope it is a year full of health, happiness, and DO pride.

Respectfully,

Caroline Dorothy Rizea, OMS III
COSGP National Chair
University of New England College of Osteopathic Medicine

Board of Trustees Midyear General Session

Wednesday, February 21, 2024 · 1 – 4 pm ET

JW Marriott Clearwater Beach Resort · Pallavi Ballroom

AMERICAN OSTEOPATHIC ASSOCIATION

Call to Order and Welcome

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

Roll Call and Quorum Establishment

Val Carr, Chief of Staff

AMERICAN OSTEOPATHIC ASSOCIATION

Introduction of Guests

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

Osteopathic Pledge of Commitment

I pledge to:

Provide compassionate, quality care to my patients;
Partner with them to promote health;

Display integrity and professionalism throughout my career;
Advance the philosophy, practice and science of osteopathic medicine;
Continue life-long learning;

Support my profession with loyalty in action, word and deed; and
Live each day as an example of what an osteopathic
physician should be.

Mission and Vision Statements

Mission

The AOA is the professional home for osteopathic physicians and students, providing education, board certification and is the champion of the advancement of the distinctive osteopathic profession.

Vision

The AOA aspires to be the “North Star” of the osteopathic profession by advancing the interests of osteopathic physicians and students and promoting excellence in patient care consistent with the distinctive osteopathic philosophy.

Invocation

James M. Lally, DO

AMERICAN OSTEOPATHIC ASSOCIATION

Action Items

- Conflict of Interest Disclosures
- Adoption of Agenda

Leadership Reports

AMERICAN OSTEOPATHIC ASSOCIATION

President's Report

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

President-Elect's Report

Teresa A. Hubka, DO, FACOOG(D), President-Elect

AMERICAN OSTEOPATHIC ASSOCIATION

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

CEO’s Report

Kathleen S. Creason, MBA, CEO

AMERICAN OSTEOPATHIC ASSOCIATION

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Governance and Operations Departmental Reports

AMERICAN OSTEOPATHIC ASSOCIATION

Department of Affiliate Relations

Julieanne P. Sees, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

Bureau of Affiliate Relations (BAR)

DIRECT LINK TO AOA BOT

INPUT INTO POLICY DEVELOPMENT

FORUM FOR INFORMATION EXCHANGE

ADVISE AOA ON CRITICAL ISSUES

COLLABORATE ON LEADER EDUCATION

AWARD RECOGNITION PROGRAMS

FY24 Goals:

- Foster a Collegial Environment
- Communicate Affiliate Perspectives to AOA Leadership
- Develop Affiliate Leader Education
- Evaluate and Recommend Nominations for Bob E. Jones, CAE and Outstanding Affiliate Awards

BAR Activity

- Bureau Meetings: Nov 2023, Feb 2024 and May 2024
- Collaboration on Affiliate Leader Meeting scheduled for Nov 6-7, 2024
- Discussed economic challenges faced by affiliates and how the AOA can strengthen support for affiliates
- Reviewed opportunities for AOA and affiliate collaboration on DEI programs

Department of Affiliate Relations Overview

SOMA
STUDENT OSTEOPATHIC MEDICAL ASSOCIATION

Assure meaningful, collaborative partnerships and bidirectional communication

- Affiliate Workspace resources
- SOMA and AAOA management services
- Liaison between AOA and the leadership of 70+ affiliates
- Clearinghouse for AOA information
- Affiliate News conveys important AOA information to affiliate leaders

Departmental Highlights

- New Feature: How did they **DO** that?
- Affiliate News Redesign and Revised Publication Schedule
- Affiliate Student Group Alignment Toolkit
- AOA Resource Hub
- Video Tutorial for Affiliate Workspace
- COM Leadership Engagement Initiative

Affiliate Relations Team

Valerie Bakies Lile, CAE
AVP, Affiliate Relations

Hope Hurley
Dir., Affiliate Relations

Josie Scumaci
Sr. Mgr., Affiliate Relations

Elizabeth DiGiacomo
Administrative Mgr.,
Affiliate Relations

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Finance Department

Bruce A. Wolf, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

Finance Department

Personnel Recap

- CFO hired
- Assessing and aligning staffing/responsibilities

Strategic Activities

- Strategic Finance Task Force support
- Finance departmental review and recommendations
- External vendor services and fees review (banking, investment, accounting services)
- Monthly building operations and lease review

Finance Department

Operations

- FY24 balanced budget; revenues $33M
- Implementing new accounting software
- Updating standard operating procedures for all finance department functions
- Completing unfinished audits and tax work
- Implementing internal customer focus

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Department of Education

David E. Garza, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

Bureau of Osteopathic Education Goals

- Provide governance oversight to the Program and Trainee Review Council and provide necessary feedback on issues impacting graduate medical education
- Provide governance oversight to the Council on OMED and act as peer reviewers for AOA CME content when requested
- Review and revise the AOA CME requirements in preparation for the 2025-2027 CME Cycle
- Review and make recommendations to the 2024 AOA House of Delegates regarding all education-related sunset policies to ensure that policies are timely and relevant.

BOE Accomplishments

- Peer reviewers for ACCME joint sponsored education
- Reviewed AOA Category CME Sponsor eligibility policy
- Feedback to the AOA Board Certification Work Group and Foundational Competencies for Undergraduate Medical Education
- Recommended nominees to ACGME Review Committees, AAMC focus group, and NRMP Board of Directors
- Formed two sub-groups:
  - GME Equity
  - OMT Credentialing Guidelines
- Revised CME faculty exemption process

What's on deck

- Guidelines for OMT privileging
- Review the AOA Category 1 CME Sponsors Accreditation Requirements
- Sunset policy review for 2024 House of Delegates
- Review the open comment process for revisions to educational policies
- Working with BOS, review the 2025-2027 Certification CME Cycle Requirements
- Continued focus on GME equity for osteopathic medical students

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Department of Governmental Affairs

Shannon C. Scott, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

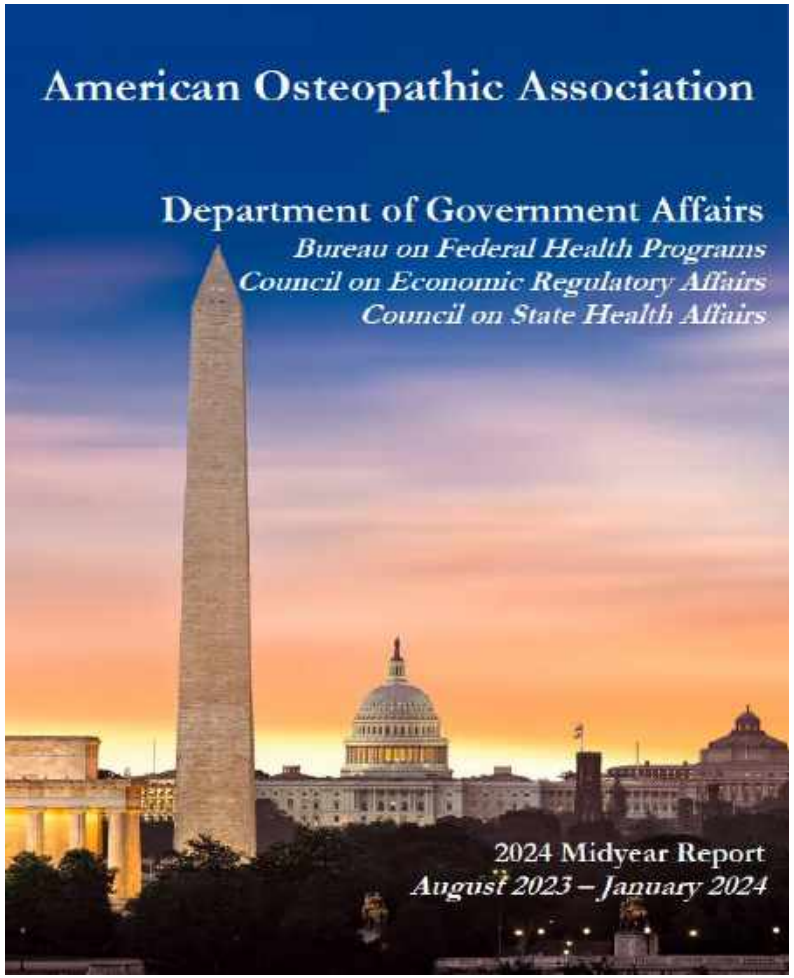
2024 Department of Governmental Affairs

Department of Government Affairs

- Bureau on Federal Health Programs
- Council on Economic and Regulatory Affairs
- Council on State Health Affairs

December 14 meeting discussed current political landscape and impact on:

- Physician payment reform
- Graduate medical education
- Implementation of ICD-11
- DO Day 2024



Department of Governmental Affairs: Bureau and Councils

Bureau on Federal Health Programs (BFHP)

George Thomas, DO, Chair

- BFHP met on January 19
  - 2019 Sunset Policies
  - Update OMT Guidance
  - Congressional Speakers
- Meeting May 2024
  - “End-of-Year” Package

Council on Economic Regulatory Affairs (CERA)

Linda Delo, DO, Chair

- CERA met on August 24
  - CY24 Medicare Physician Fee Schedule
- Meeting March 2024
  - 2019 Sunset Policies

Council on State Health Affairs (CSHA)

Thomas Dardarian, DO, Chair

- CSHA met on September 18
  - State Activity
- Meeting March 2024
  - 2019 Sunset Policies
  - Review of White Papers

2023 Federal Legislative Highlights

- Prevented a 15% payment cut to laboratory services that would have taken effect on January 1, 2024
- Partnered with 40 state and specialty osteopathic organizations to address Medicare physician payment cuts
- Passing legislation in the House that reauthorizes the THCGME program for 7 years with an increase in funding to provide stability in training and grow the number of medical residents/programs
- Opposing the Dept. of Veterans Affairs Supremacy Project, which would create national standards that would circumvent state licensure laws to expand scope

2023 Regulatory Highlights

- Partnered with 49 affiliates urging CMS to finalize its Promoting Interoperability and Improving Prior Authorization Processes rule
- Engaged with CMS on the CY2024 Medicare Physician Fee Schedule
- Developed educational resources on regulatory issues including:
  - A comprehensive guide on COVID-19 public health emergency flexibilities and policies that expired in 2023
  - Overviews of the 2024 MPFS proposed and final rules
  - Webinars on 2024 MPFS changes and policy issues in addiction medicine
- Submitted 2 comment letters and engaged with the National Committee on Vital Health Statistics to address issues with ICD-11

2023 Federal Advocacy Highlights

2023 State Advocacy Highlights

- In 2023, 50 states held regular legislative sessions.
  - We sent:
    - 20 letters
    - 10 grassroots alerts
    - In conjunction with 8 state/specialty affiliates
- 81% success rate:
  - Defeating:
    - Scope bills in AZ, IN and VA
    - Shortcuts to physician licensure in AZ and VA
    - Health plan modifications aimed at steering patients to preferred physicians and facilities in TX.
  - Enacting:
    - $1m med mal damages cap in IA
    - Medicaid funding rate increase in GA

AMERICAN OSTEOPATHIC ASSOCIATION

Good Morning,

As dedicated physicians who have always placed patient care and safety at the forefront of our practice, we are once again facing a critical issue that requires immediate attention and unified action. Last year, the New Jersey State Legislature considered a bill (A2286 and S1522) that would authorize independent practice for Advanced Practice Nurses (APNs) without physician oversight and collaboration. Fortunately, due to our advocacy efforts, the bill did not proceed through the legislative process.

However, there is a renewed push to advance this legislation. This bill threatens to compromise the high standards of medical care that we have worked tirelessly to maintain. The New Jersey Association of Osteopathic Physicians and Surgeons (NJAOPS) and the American Osteopathic Association (AOA) continue to fight back against this bill and we once again need your help reaching out to your state lawmakers to tell them that scope of practice expansion without meeting educational and practice requirements is dangerous.

Will you join your colleagues and me by emailing your state lawmakers, asking them to oppose this bill?

ACT NOW!

NJAOPS and the AOA recognize and value the important role of non-physician clinicians in the healthcare team, however, the extensive training and education that physicians undergo are essential in providing the comprehensive care and clinical judgment that patients deserve.

Thank you for your attention to this matter and your ongoing support of the profession.

Sincerely,

George Scott, DO
President
New Jersey Association of Osteopathic Physicians and Surgeons (NJAOPS)

2024 State Activity

- In 2024, 46 states hold regular legislative sessions
  - 34 states are currently convened*
- So far, we have sent:
  - 13 letters
  - 3 grassroots alerts
- Issues include:
  - Prescriptive authority for psychologists in WA
  - Removal of medical board oversight of APRNs in VA
  - Combining DO/MD medical boards in WV
  - Truth in Advertising ("-ologist" bills) in AZ & FL
- Emerging issue:
  - Creation of unproven shortcuts to physician licensure continues this year in HI, ID, NJ, OK, TN, WI, VA

2024 STATE PRIORITIES

AOA AMERICAN OSTEOPATHIC ASSOCIATION

SCOPE OF PRACTICE & NEW LICENSURE TYPES

Support the physician-led, team-based model of care and uniform, evidence-based licensure pathways for all clinicians based upon scope of practice.

OSTEOPATHIC EQUIVALENCY AND RECOGNITION

Ensure that the osteopathic profession and credentials are recognized as equivalent to their allopathic counterparts. Educate legislators about current osteopathic terminology, and the distinctive philosophy and practice of osteopathic medicine. Support DO licensure and regulation by osteopathic medical boards in dual board states.

TRUTH IN ADVERTISING

Support legislation that requires all health care providers to affirmatively communicate their degrees and licensure types to patients, restricts "-ologist" titles to physicians, and requires entities offering physician board certification to possess legitimate training and testing requirements.

PUBLIC HEALTH

Work to increase public awareness and implement evidence-based recommendations and best practices related to public health issues. Support funding to strengthen our public health care infrastructure and workforce, address health care disparities and social determinants of health, and establish a robust national strategy to combat future public health emergencies.

PHYSICIAN WORKFORCE

Support legislation that expands the physician workforce by increasing funding for graduate medical education, especially in high-need specialties and locations, and expanding financial incentives to facilitate care for the underserved.

TELEMEDICINE

Support the delivery of appropriate health care services, including the prescription of controlled substances, through telemedicine and other communications-based technologies. Advocate for coverage and payment parity between these services and similar services delivered in-person.

PRESCRIPTION DRUG MISUSE, ABUSE AND DIVERSION

Support evidence-based approaches that balance the need to curb prescription drug misuse with ensuring access to appropriate, timely health care. Support legislation that promotes non-pharmacological pain management modalities, such as osteopathic manipulative treatment.

ACCESS AND AFFORDABILITY

Support access to timely, affordable, high-quality care for all patients. This includes:

- Supporting network adequacy and transparency standards for insurers.
- Supporting stabilization of state health insurance exchanges and expanding Medicaid.
- Supporting access to affordable prescription drugs, including by regulating Pharmacy Benefit Managers.
- Supporting the removal of arbitrary burdens in step therapy and prior authorization.
- Supporting physician self-regulation by protecting the authority and autonomy of state medical boards, and opposing legislation that interferes with professional self-regulation, the physician-patient relationship, or physicians' ability to provide evidence-based information and care to their patients.

INTERSTATE MEDICAL LICENSURE COMPACT

Support enactment of the Compact, which enhances physician license portability and increases patient access to care.

*as of January 31, 2024

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

BREAK

AMERICAN OSTEOPATHIC ASSOCIATION

Membership Department

Kevin V. de Regnier, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

Membership Department

Department of Membership

- Bureau of Membership (BOM)
- Bureau of Emerging Leaders (BEL)
- Bureau of International Osteopathic Medicine (BIOM)

Bureau of Membership 2023-2024 Goals/Objectives

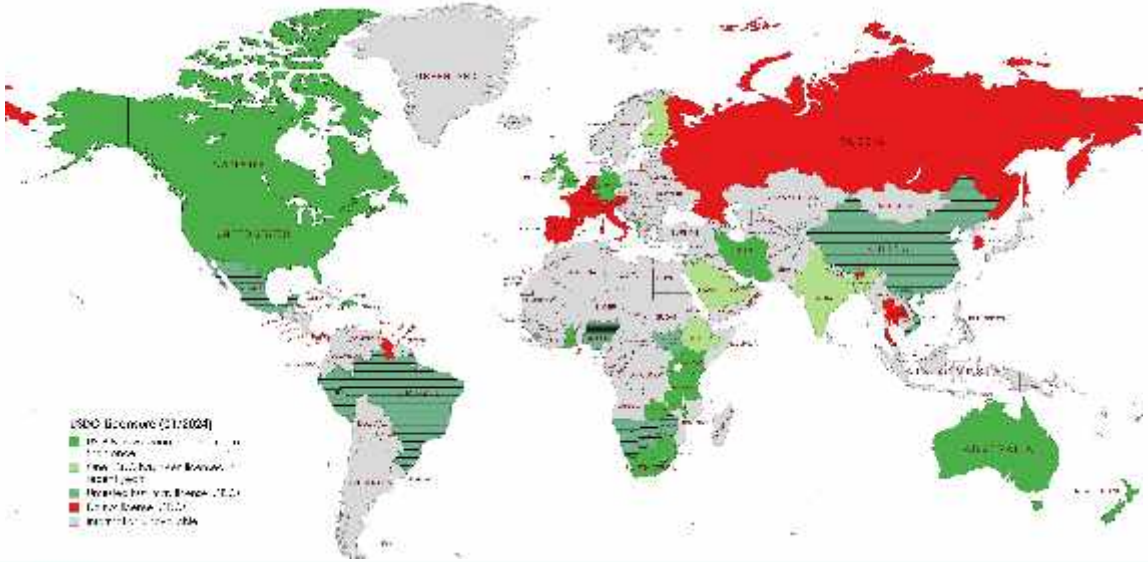
- Provide governance oversight with respect to membership services, dues structure/fees, membership renewal processes Membership Workgroup recommendations
- Recommend specific membership initiatives for membership growth and engagement
- Collaborate with the COMs on promotion of osteopathic medical student membership
- Enhance AACOM partnership to increase sharing of student information as it relates to residency match data

Bureau of Membership Operational Updates

- Further develop the dues renewal process in Fonteva
- Enhance prospective member recruitment initiatives
- Elevate current member and prospective member website experience
- Continue marketing plan targeting osteopathic medical students for membership recruitment (in collaboration with SOMA)
- Finalize the development member engagement tool
- Enrich the New Member Onboarding
- Expand payment offerings

Bureau of International Osteopathic Medicine (BIOM)

- Chaired by Frank Tursi, DO
- Goal: expand recognition of the osteopathic medical model and practice rights for DOs abroad.
- OMED Seminar & BIOM Abstract Competition



- Recent progress:
  - International Association of Medical Regulatory Authorities
  - India
  - Canada

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Department of Research and Public Health

Robert S. Dolansky, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

Bureau of Osteopathic Research and Public Health

Description

- Directs all AOA research and public health activities
- Manages all research grant and fellowship programs
- Develops public health initiatives and educational programs
- Advises AOA on public health and research policy

2023-2024 BORPH Public Health Initiatives

- Immunization promotion and addressing vaccine hesitancy
- Integration of OMM/OPP into opioid addiction and treatment
- Opioid Crisis Prevention
- Living Well/Aging Well - The role of osteopathic distinctiveness in addressing body, mind, & spirit, healthy aging, and overall wellness

Immunization Promotion and Addressing Vaccine Hesitancy

- RSV Initiative
- Influenza Prevention and Treatment
- COVID-19 Prevention and Treatment Education
- Pneumococcal Vaccine Modules

AOA: Social Media Messaging During National Influenza Vaccination Week (Dec. 4 – 8, 2023)

Videos were developed and posted to the AOA's 5 social media platforms (86,000+ combined followers)

- Dr. David Garza
- Dr. Jennifer Caudle
- Dr. Peter Gulick
- Ways to Use Social Media to Educate Patients and the Public
  - (Influenza and RSV prevention messaging examples)

Integration of OMM/OPP into Opioid Addiction and Treatment Opioid Crisis Prevention

- Pain Management and Opioids: Balancing Risks and Benefits - Michael D. Cheshire, DO OMED23 Symposium
- Funded by Collaborative for REMS Education (CORE REMS)
- Available through October 2024 on AOA Online learning platform
- Meets the Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) Medication Access and Training Expansion (MATE) Act which requires at least eight hours of training on opioid or other substance use disorders

Living Well/Aging Well

The role of osteopathic distinctiveness in addressing body, mind, & spirit, healthy aging, and overall wellness

- Produce 1 -2-page informational sheets for physicians to use when talking to patients and as handouts for patients
- Specific Topics:
  - Dementia and cognitive disease, addressing prevention, patients' fears, and brain health
  - Diabetes, including safety and management
  - Hypertension and blood pressure control, including safety and management
  - Loneliness and isolation and its impact on health
  - Healthy weight/obesity

Living Well/Aging Well

The role of osteopathic distinctiveness in addressing body, mind, & spirit, healthy aging, and overall wellness

- Web page developed on the AOA website includes 11 patient handouts developed by BORPH last year
  - Cancer detection and screening including:

Breast cancer	Prostate cancer
Cervical cancer	Lung cancer
Colorectal cancer	Skin cancer
Testicular cancer	Genetic Screening for Cancer

  - Role of physical activity in promoting mental health, disease prevention, & healthy aging
  - Addressing the mental health of patients
  - Healthy nutrition on a budget to address food insecurity

BORPH Research Activities
2023 OMED Poster Session and Student Poster Competition

- 166 abstracts were submitted,122 accepted, 5 withdrawn, for a total of 117 posters
- 97 osteopathic medical students participated in the Student Poster Competition. 19 judges working in teams of 2 scored the presentations
- 9 students were awarded cash prizes
- The recorded posters are available to view on AOA Online Learning
- DOs can earn two (2) AOA Category 2-B CME credits by viewing the recorded ePosters over the next year
- Accepted abstracts were published in the December 2023 Journal of Osteopathic Medicine

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Organizational Reports

AMERICAN OSTEOPATHIC ASSOCIATION

American Association of Colleges of Osteopathic Medicine (AACOM)

Robert A. Cain, DO, President and CEO

AMERICAN OSTEOPATHIC ASSOCIATION

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

National Board of Osteopathic Medical Examiners (NBOME)

Lori A. Kemper, DO, MS, Chair
John R. Gimpel, DO, President and CEO

AMERICAN OSTEOPATHIC ASSOCIATION

AOA & NBOME: 90 Years of Standing Up Together, for our Patients and the Profession

NBOME
NINETY YEAR ANNIVERSARY 1934-2024

AOA
AMERICAN OSTEOPATHIC ASSOCIATION

NBOME CELEBRATES 90TH ANNIVERSARY

Celebrating 90 years of protecting the public by providing the means to assess competencies for osteopathic medicine & related health care professions.

NBOME FOUNDERS

Charles Hazzard, DO
AOA President 1903

Asa Willard, DO
AOA President 1910

Arthur G. Hildreth, DO
AOA President 1925

NBOME

- **PROTECTING THE PUBLIC** BY PROVIDING THE MEANS TO **ASSESS COMPETENCIES FOR OSTEOPATHIC MEDICINE** AND RELATED HEALTH CARE PROFESSIONS

NBOME BOARD OF DIRECTORS

STANDARD SETTING FOR COMLEX-USA

- Review standards every 3-5 years for minimum competence for passing
- May result in a change in the cut score needed to pass an examination
  - Level 2-CE pass rate with new standard - **93%** (2023-2024 partial cycle)
  - Level 2-CE pass rate with previous standard - **94.5%** (2022-2023 cycle)
- Periodic review ensures COMLEX-USA reflects current education and training standards required for licensure

	COMLEX-USA Level 1	COMLEX-USA Level 2-CE	COMLEX-USA Level 3
IMPLEMENTATION	**May 2024**	**June 2023**	**January 2024**

CORE COMPETENCY CAPSTONE FOR DOs

C3DO Prototype for Pilots assessed:

- Patient-physician interpersonal and communication skills
- History-building and hands-on physical exam
- OMT skills

Initial Design:

- Multi-station OSCE model using standardized patients
- Delivered at COM campuses, NBOME oversight and QA
- Competency-based (badge concept)-skills at level of entry into residency program

CORE COMPETENCY CAPSTONE FOR DOs

C3DO Phase 2 Pilots (2024) - planning & prep underway

March 2024-2025: Phase 2 Pilots

ATSU-KCOM, ARCOM, CUSOM, MU-COM, MWU/AZCOM, Rowan-VirtuaSOM, UNECOM, UNTHSC/TCOM

July 2025: Announcement on Future Program

AI IN ASSESSMENT

Past

December 2023 Board Retreat (SOAR) on AI in daily life, osteopathic medical practice, osteopathic medical education, and assessment

Present

Using safe and valid applications of AI in assessment operations

- Enhancing scoring accuracy and productivity in COMLEX-USA Level 3 (“CDM questions”)
- Assisting with exam assembly and reviewing test taker feedback
- Reviewing COMLEX-USA blueprint for bias and fairness
- Comparing learner-centered objectives across COMs for COMAT

Future

Established a board-led task force to further investigate AI in assessment

- Safely using generative AI for developing test content
- Eliminating bias and misinformation by using Large Language Models
- Addressing ethical and intellectual property issues

ADVOCACY WINS FOR DO APPLICANTS IN GME

Residency specialty leadership groups continue to voice their support of a holistic applicant review process, and the acceptance of the COMLEX-USA credential as part of that process for DOs

Family Medicine
Oct 2022

Pediatrics
May 2023

Psychiatry
Apr 2023

Obstetrics & Gynecology
Sep 2023

PM&R
May 2023

Emergency Medicine
Oct 2023

Anesthesiology
May 2023

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

American Association of Osteopathic Examiners (AAOE)

Alexios Carayannopoulos, DO, President

AMERICAN OSTEOPATHIC ASSOCIATION

Disclosures

- Consulting:
  - CEO and Founder Pain Spine and Rehabilitation Consulting, Inc.
- Board Positions:
  - Rhode Island Board of Medical Licensure and Discipline
  - Rhode Island Board of Occupational Therapy
  - American Society of Pain and Neuroscience
- Royalties:
  - Springer Press
- Research Funding:
  - DARPA, NIH, Talosix, Mainstay Medical, Aspen Medical, Brown University
- Travel Support:
  - AOA, NBOME, ASRA, FSMB

Who We Are

- **All DOs who serve on state medical licensing boards** (“AAOE Fellows”)
  - DOs sit on 47 out of 51 US boards
  - 125 DOs are currently serving
  - 13 Independent Osteopathic Medical Boards
- Unified **authority in osteopathic medical licensure** and **discipline**.
- **Voice of US osteopathic medicine:**
  - Federation of State Medical Boards (FSMB)
  - Osteopathic International Alliance (OIA)
  - International Association of Medical Regulatory Authorities (IAMRA)
- **Monitors** and **responds to national regulatory, licensing issues**
- **Monitors, informs,** and **educates** on international issues affecting US DOs

AAOE Representation on National Boards & Committees

- **AOA**
  - Council on State Health Affairs: **Dr. Wieting**
  - Bureau of Osteopathic Education: **Dr. Wieting**
- **FSMB**
  - Board of Directors:
    - **Dr. Geimer-Flanders:** FSMB Treasurer; **Dr. Willett**
  - Board of Director Nominees/Candidates 2024 FSMB House of Delegates:
    - **Drs. Carayannopoulos and Wieting**
- **NBOME**
  - *C3DO Task Force 2023*: **Drs. Carayannopoulos, Khandelwal**
  - *COMLEX LEVEL 3 Standard-Setting 2023:* **Dr. Carayannopoulos**
  - *Board Retreat 2023:* **Dr. Carayannopoulos, R. Richards**
  - *Liaison Committee 2023*: **Dr. Carayannopoulos**

AAOE Internationally

- **International Association of Medical Regulatory Authorities**
  - AAOE nominee Boyd Buser, DO, elected to IAMRA Board 11/2023, Bali.
- **Osteopathic International Alliance**
  - A. Carayannopoulos/AAOE at Annual General Meeting 10/2023, London.
- **AOA Bureau of International Osteopathic Medicine**
  - A. Carayannopoulos/AAOE

AAOE Meetings

- **Annual Educational Summit**
  - OMED 2023, Orlando
  - Educational topic:
    - *Impact of Artificial Intelligence (AI) on Medical Regulation*
  - Establishment of task forces:
    - Bylaws Review
    - Website/Communications

AAOE Initiatives

- **AAOE Task Forces:**
  - *Bylaws Review*
    - Reassessing mission & vision
    - Goals: foster osteopathic distinctiveness and awareness of AAOE/role of medical boards among next generation of physicians.
  - *Website/Communications*
    - Revamp website – up-to-date, relevant and friendly for users.
    - Identify new communication tools for direct information-sharing among Fellows.
- **Joint Osteopathic Organization Leadership (JOOL) coalition:**
  - NBOME, AACOM, AOA, COCA, AAOE
  - JOOL Task Forces: AI and Research Masterfile

Artificial Intelligence

- FSMB AI Committee 2023: **Dr. Khandelwal**
- JOOL AI Task Force AI 2024: **Dr. Khandelwal**
- **FSMB AI Symposium 2024: Dr. Carayannopoulos, R. Richards**
  - Overview of “regulatory mosaic” of entities with partial authority over AI
  - AI can alleviate administrative burden, improving physician burnout & shortage issues
  - Clinician & medical board oversight is needed:
    - Legal definition of “practice of medicine” may need updating to account for AI
    - Clinicians must retain ultimate decision -making authority, or face discipline
    - “Standard of Care” does not currently require use of AI, but this may change
  - Guidelines and regulations must address:
    - Ethics, equity and access
    - Liability, accountability and responsibility
    - Impact on medical education and physician and patient autonomy
    - Informed consent and privacy

2024 Activity Impacting State Medical Boards

- **Georgia:** Bill directing medical board to regulate AI in healthcare.
- **New Jersey:** Lawsuit against state medical board over telehealth regulations.
- **West Virginia:** Legislation to combine the DO and MD licensing boards.
- **Multiple states:** Proposing licensure for unmatched medical graduates.
- **Multiple states:** Proposing licensure for international medical graduates without US residency training.

Thank You!

- ***AAOE would like to extend a special Thank You to the AOA for its ongoing support!***

- **Annual Business Meeting & Elections**
  - April 19th at the FSMB Annual Meeting in Nashville
    - *Open to the public - please join us!*

  More information: https://www.aaoe-net.org/

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

American Osteopathic Foundation (AOF)

Joseph A. Zammuto, DO, President

AMERICAN OSTEOPATHIC ASSOCIATION

Celebrating our Impact

AMERICAN OSTEOPATHIC ASSOCIATION

Mission Focused

The American Osteopathic Foundation supports programs and services that promote Osteopathic medicine and enhance patient-centered care through:

- Educational Scholarships
- Grants for Innovative Research
- International Humanitarian Outreach
- Community Investments
- Industry Honors

Celebrating 75 Years!!

This year marks our 75th Anniversary!

Join us as we reflect on our journey, celebrate our achievements, and look forward to a future filled with even greater impact!

Strategic Priorities in 2024

Impact Study (New)

- Assess AOF's impact over the last 75 years.
- Refine system for measuring and evaluating future impact and outcome measurements.

Project Future

- Facilitate Forums to discuss vision and opportunities for the osteopathic profession in a rapidly evolving medical landscape.
- Define and articulate the profession's distinctive human-centered philosophy to increase health outcomes.

Health, Hope and Healing Campaign (New)

- Launch quiet phase.
- Announce at Honors 2024.
- Increase investments at all stages of a DO's journey, from medical school, to residency, through practice.

Impact Measurements: Sharing Historic Milestones

1949

Incorporated as The Osteopathic Foundation.

Provided student loans.

1960

Name changed to National Osteopathic Foundation.

Started Grants & Scholarships.

1999

Celebrates 50 years.

Name changed to American Osteopathic Foundation.

2000

DEI Programs Launched.

First Minority Scholarship Awarded.

2002–2017

Recognition launched. Educator of the Year, Physician of the Year, Lifetime Achievement.

AAOA Fund / Spouse recognition.

2019

Outstanding student loans forgiven.

First million-dollar gift received.

2020

Scripps Health Partnership launched.

Nat'l DETECT Study reaches 40,000 participants.

2021

SOMA-Fund / Student expansion.

Second million-dollar gift received.

Expanded DEI programs.

2022

Project Futures launched.

Increased engagement throughout profession.

2023

Record breaking fund distribution.

DOCare Fund / International expansion.

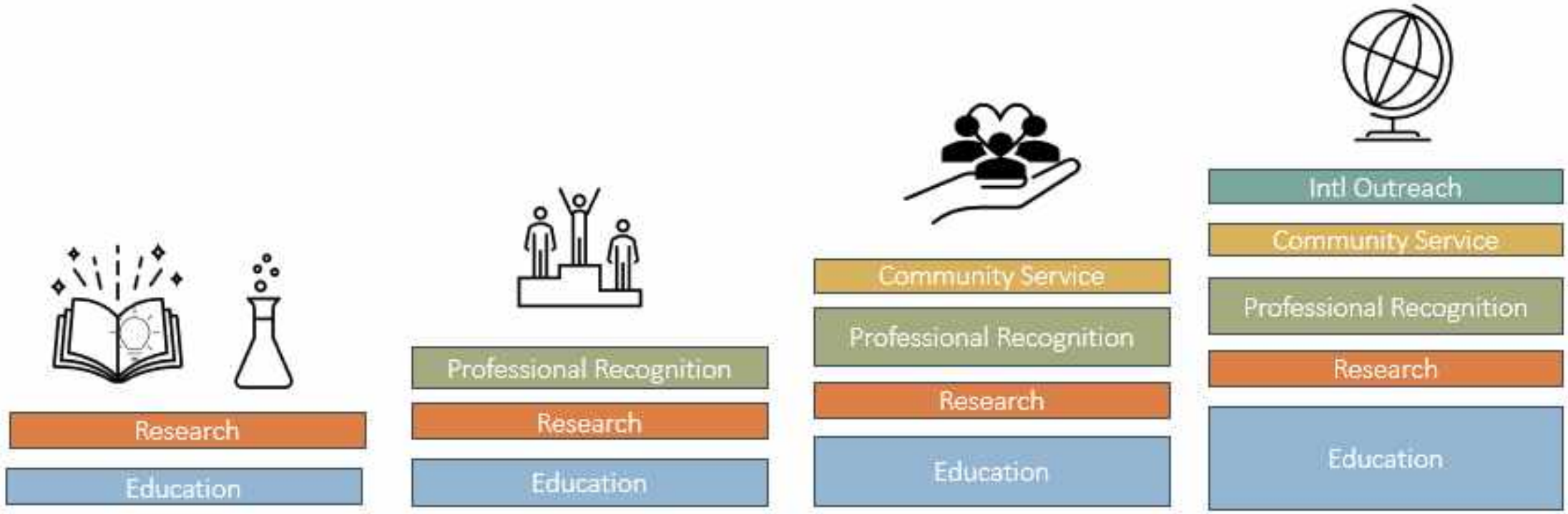
2024

75th Anniversary Celebration!

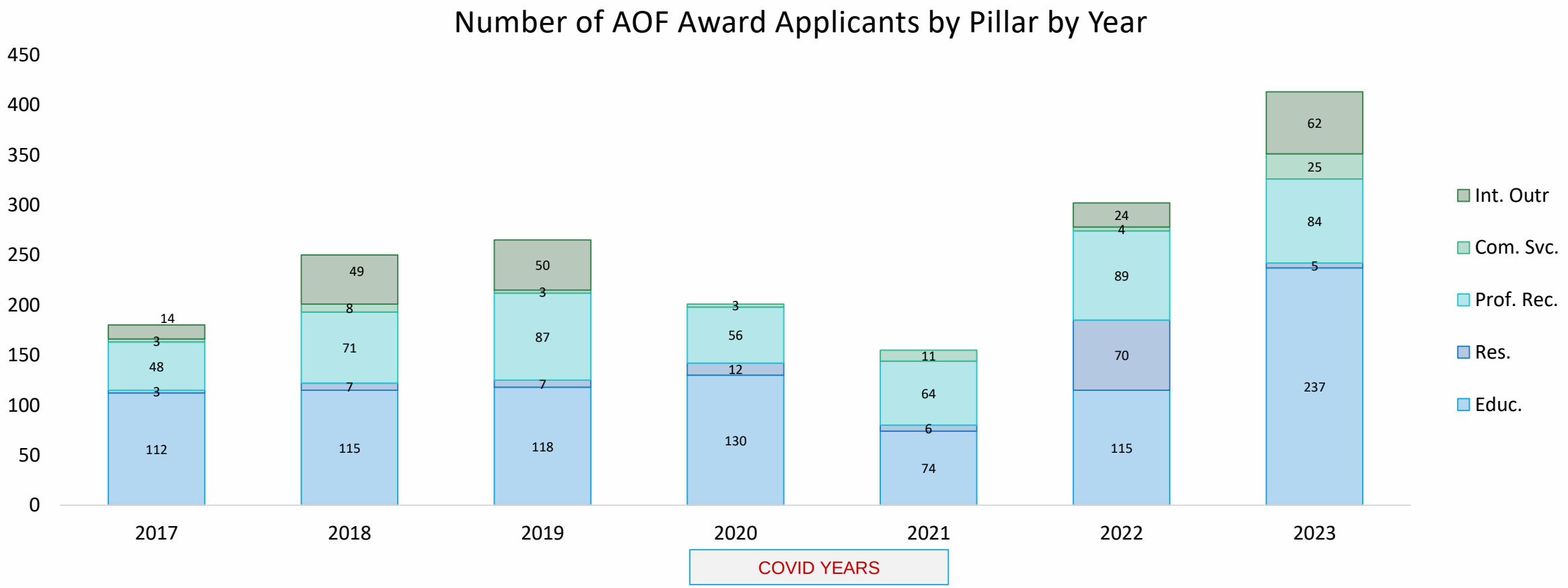
Impact study.

Campaign will be launched.

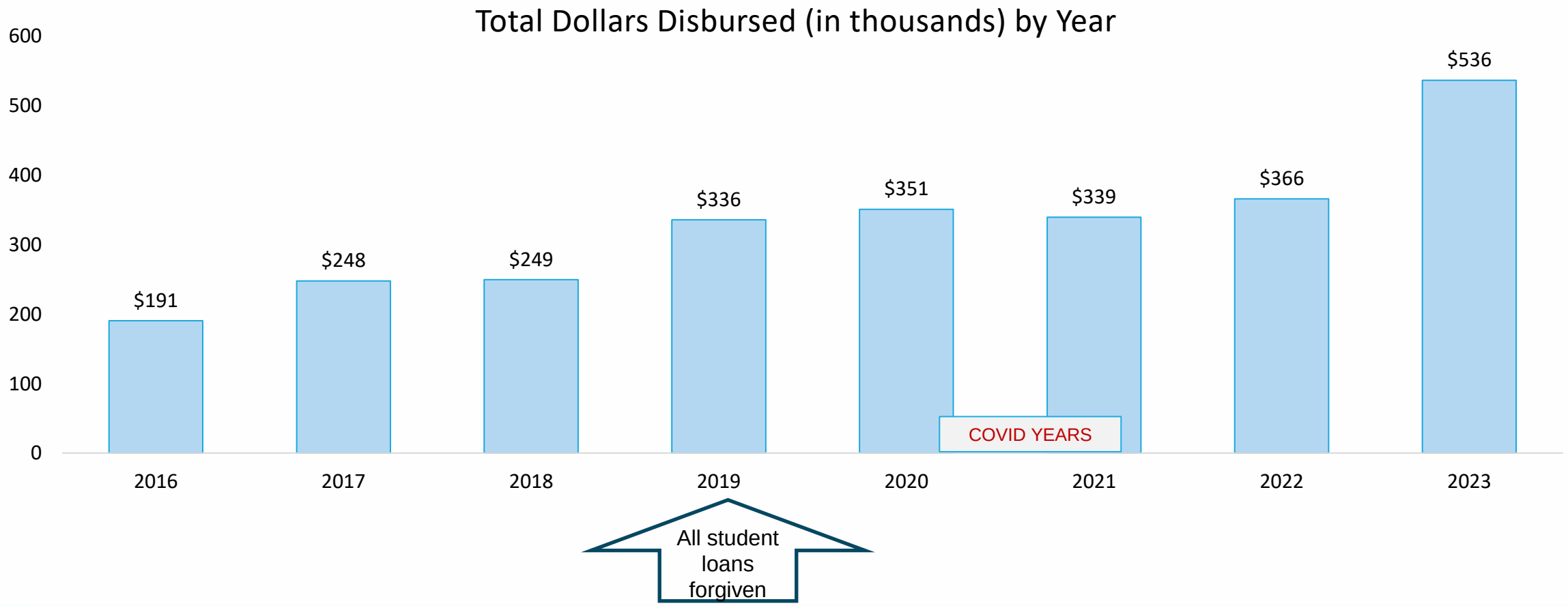
Highlighting Diversified Programs



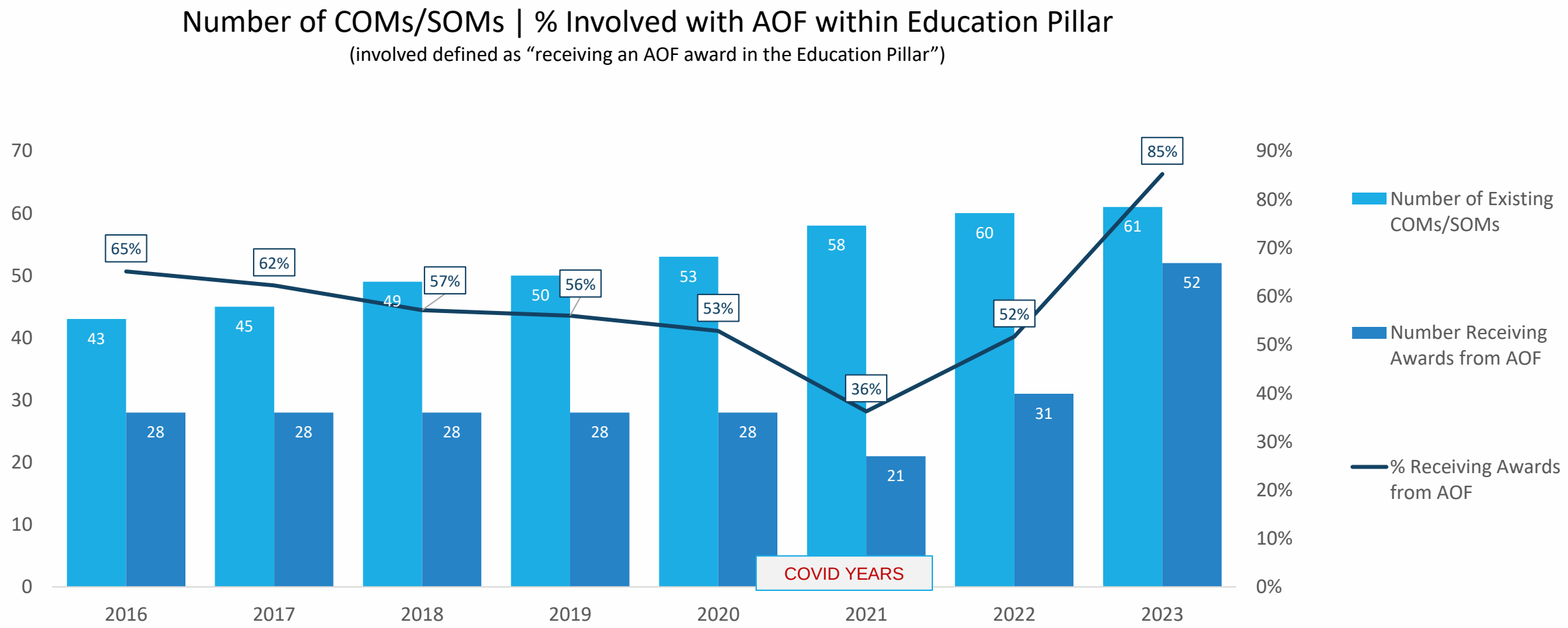
Last 7 Years: Demand has Doubled



Last 7 Years: Distributions have Tripled

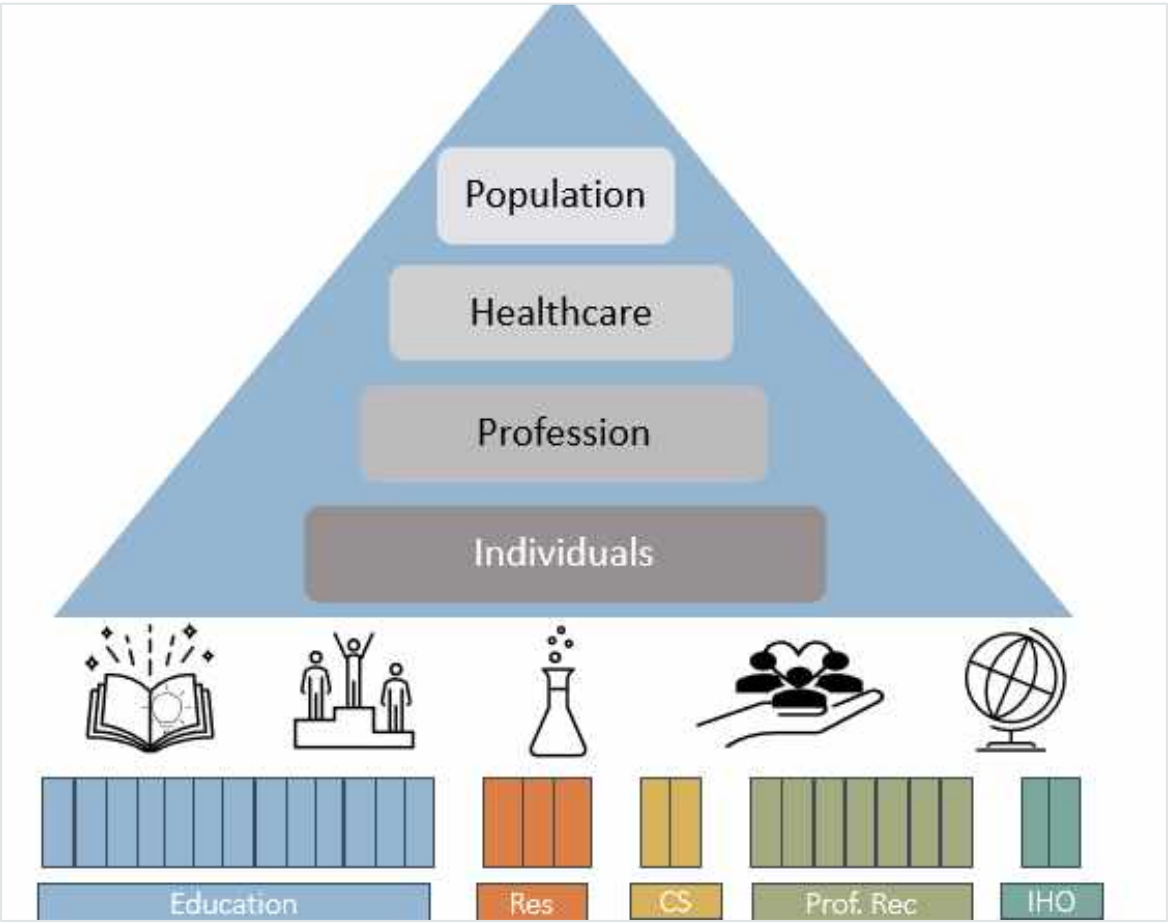


Last 7 Years: Growth in COM/SOM Engagement



Recognizing AOF's Overarching Impact

"The foundation houses rich history of the profession, promoting excellence, encouraging innovation, and using successes of the profession to move the needle forward."

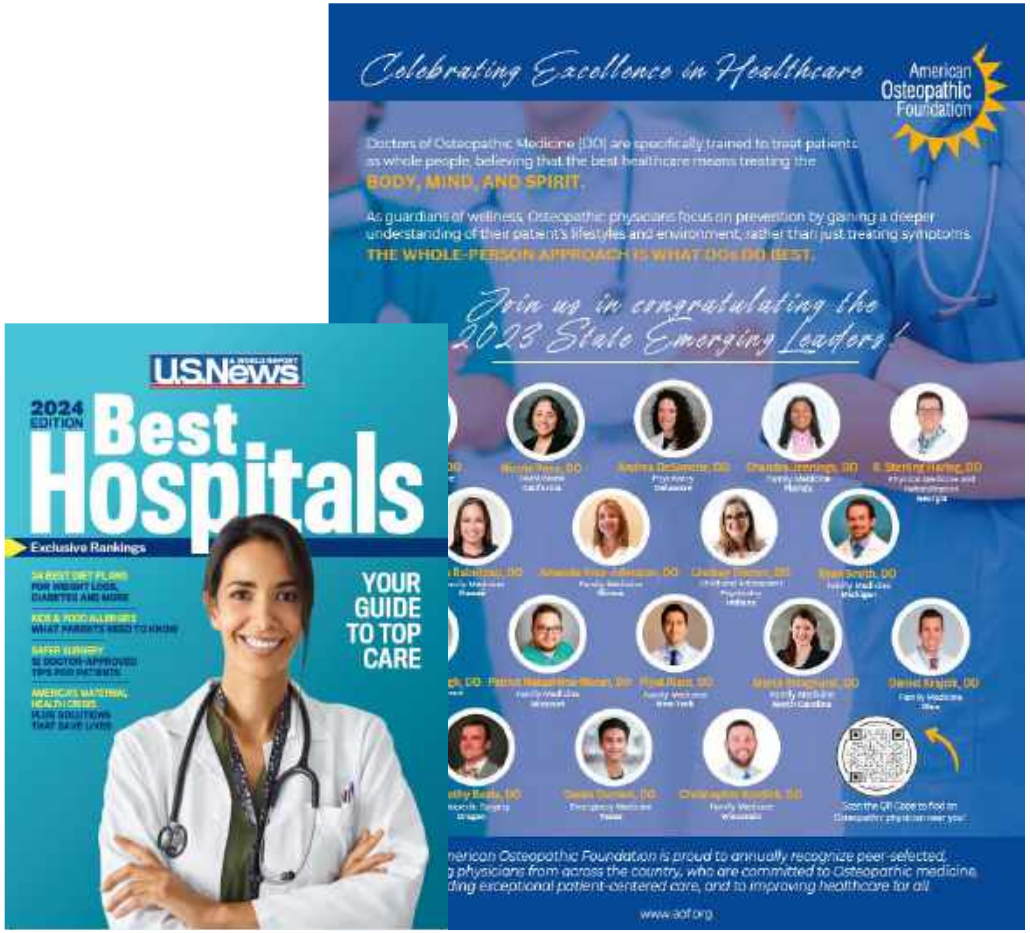


Mapping Engagement along the Osteopathic Journey

CAREER JOURNEY	Undergrad/ Year 0: Applying	Year 1-2: Classroom	Year 3-4: Rotations	Year 5-7: Residency	Year 8+ Subsp. Training Year 8+ Adv. Fellowship	Year 8-18: New DO	Faculty Role Year 19+: Long-term DO Organizational Work	Retirement & beyond
NEEDS	• Information	• Financial • Guidance • Research opportunities • Research funding • Recognition	• Financial • Research opportunities • Research funding • Recognition	• Research opportunities • Research funding • Recognition • Debt reduction	• Research opportunities • Research funding • Recognition • Debt reduction	• Research opportunities • Research funding • Recognition • Debt reduction	• Research seeds • Research funding • Recognition • Innovation / motivation • Give back	• Opportunities to engage • Safe space to convene, share thoughts and concerns • Give back • Leave a legacy
RELATIONSHIP WITH AOF	• Knowledge seeker	• Applicant • Recipient • Rep on board	• Applicant • Recipient • Rep on board	• Applicant • Recipient	• Applicant • Recipient • Collaborator • Volunteer reviewer • Potential donor	• Applicant • Recipient • Collaborator • Volunteer reviewer • Board member • Potential donor	• Recipient • Volunteer reviewer • Board member • Collaborator • Networker • Donor	• Promoter • Collaborator • Networker • Donor • Mega donor

Continue to Celebrate our Partnerships

- State Emerging Leaders Recognition (49% of State Associations)
- Collaborate Research Grants
- Financial Scholarships (85% of COMs)
- Licensure Grants
- NAM Osteopathic Fellowships
- National Scripps DETECT Study



Finding New Ways to Honor Resource Partners

- We can never say THANK YOU enough.
- We value and appreciate all donors.
- *AOF inducted 850+ individuals into the Consecutive Giving Program in 2023 recognizing donors who gave for 20+ years.*

***Pictured**: AOF CEO Rita Forden honors Dr. William Anderson for giving to the Foundation consecutively for over 30 years.*

…More to Come in 2024

- Our 75th Anniversary celebration will official kick-off later today.
- Additional updates and insights will be provided at Mid-Year.
- Industry-wide announcements will be made during the 2024 Honors Gala in San Antonio, TX.

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

American Osteopathic Information Association (AOIA)

Norman E. Vinn, DO, MBA, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

AOiA
AMERICAN OSTEOPATHIC INFORMATION ASSOCIATION

About the AOIA

- *Vision* Serves as the premier catalyst for health care transformation and innovation by the osteopathic community.
- *Mission* To support the osteopathic profession through advocacy, member-focused resources, strategic partnerships and data driven innovation including digital health initiatives.

AOiA
AMERICAN OSTEOPATHIC INFORMATION ASSOCIATION

Programs & Services Supporting DOs

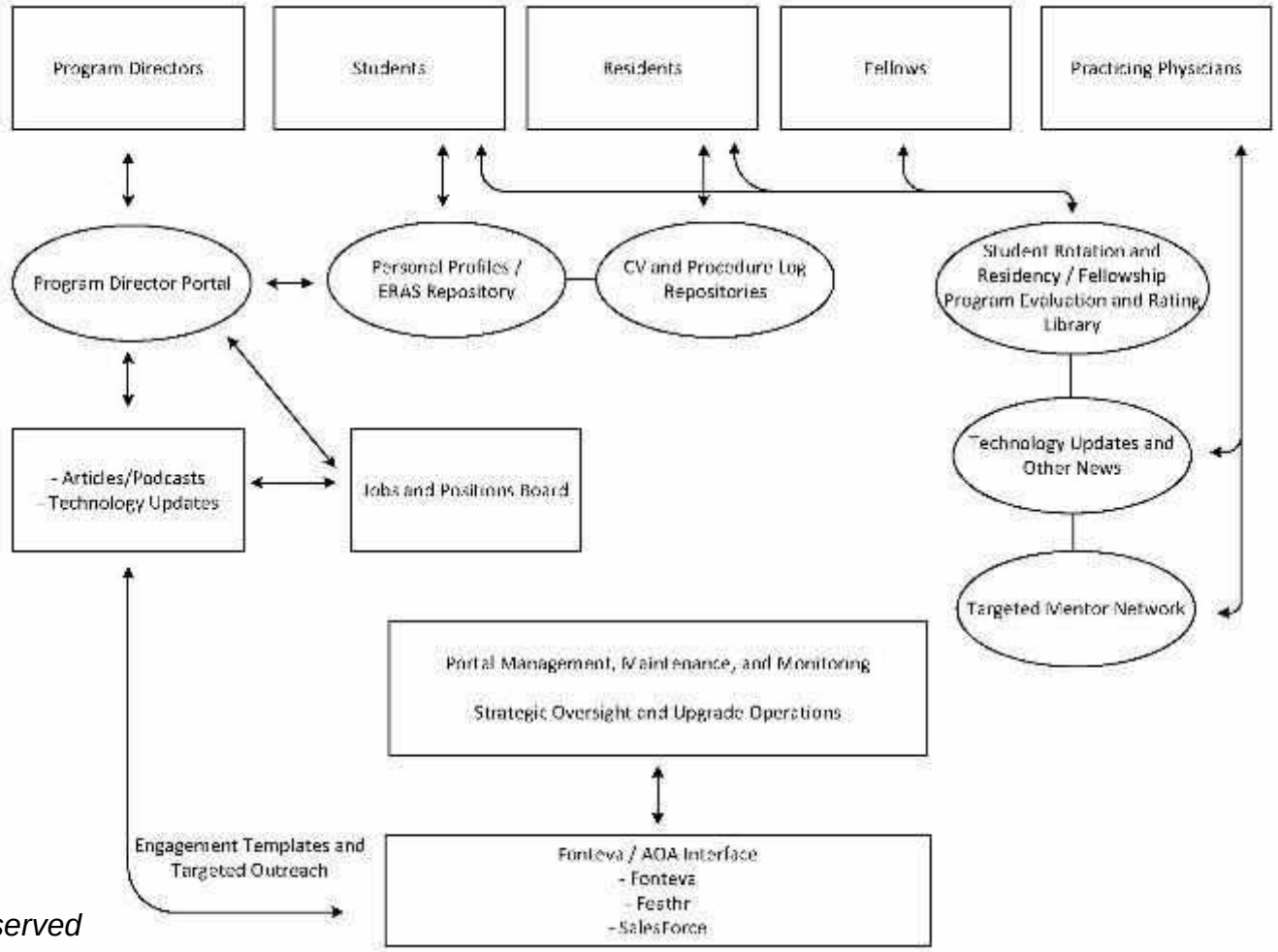
Our Landmark Programs

- Career Center
- Member Value
- Physician Services
- Profiles
- Store

Next on Our Roadmap

- Digital Health & Innovation
- Student Profiles

Student Profile Ecosystem Diagram



©2024 AOIA | All Rights Reserved
Confidential & Proprietary

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Advocates for the American Osteopathic Association (AAOA)

Megan Maples, President

AMERICAN OSTEOPATHIC ASSOCIATION

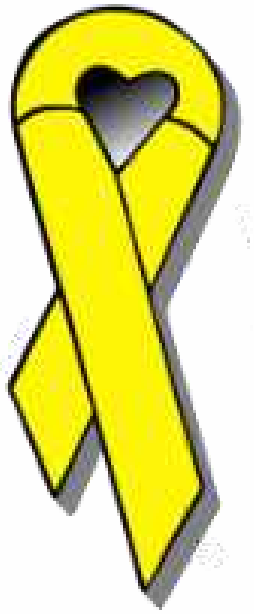
Advocates for the AOA Mission & Purpose

- Our mission is to support and promote the osteopathic profession. Our Advocate network is vast, ranging from physicians to family and friends. We cover the globe, creating a strong, close network of people who understand that osteopathic medicine isn't a trend or a passing fad, but the best type of medical care possible.

AOF Partnership

- Donna Jones Moritsugu Award
- Holiday Hug Award

Mental Health Awareness



Student Advocate Association (SAA)

- Focus on getting SAA on more med-school campuses
- OMED Travel Fund
- Provide medical roadmaps
- Quarterly calls with SAA Presidents to get them connected to each other and to the national board

OMED 2023

- Family Fun Event
- AAOA HOD & Installation Reception
- Fun Run
- SAA Workshop
- AAOA Booth

Fun Run 2023

Starting Line Sponsors

AMERICAN OSTEOPATHIC ASSOCIATION

NEW YORK INSTITUTE OF TECHNOLOGY
College of Osteopathic Medicine

Registrations Sponsors

College of Osteopathic Medicine
MICHIGAN STATE UNIVERSITY

Course Sponsors

NBOME

SCHOOL of OSTEOPATHIC MEDICINE

Fit Sponsors

School of Osteopathic Medicine

Joseph A Gialmo, DO

Healthy Sponsors

Team Lally

Midwestern University

Florida Osteopathic Medical Association

NJAOPS

Pace Setter Sponsor

afoma

Strategic Plan

Revamped 2024

Pillar 1	Pillar 2	Pillar 3
Education & Visibility	Advocacy & Community	Collaboration & Partnership

- Vision Statement: To be the recognized leader in worldwide efforts for the promotion and support of the osteopathic profession through education, advocacy, and collaboration.

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

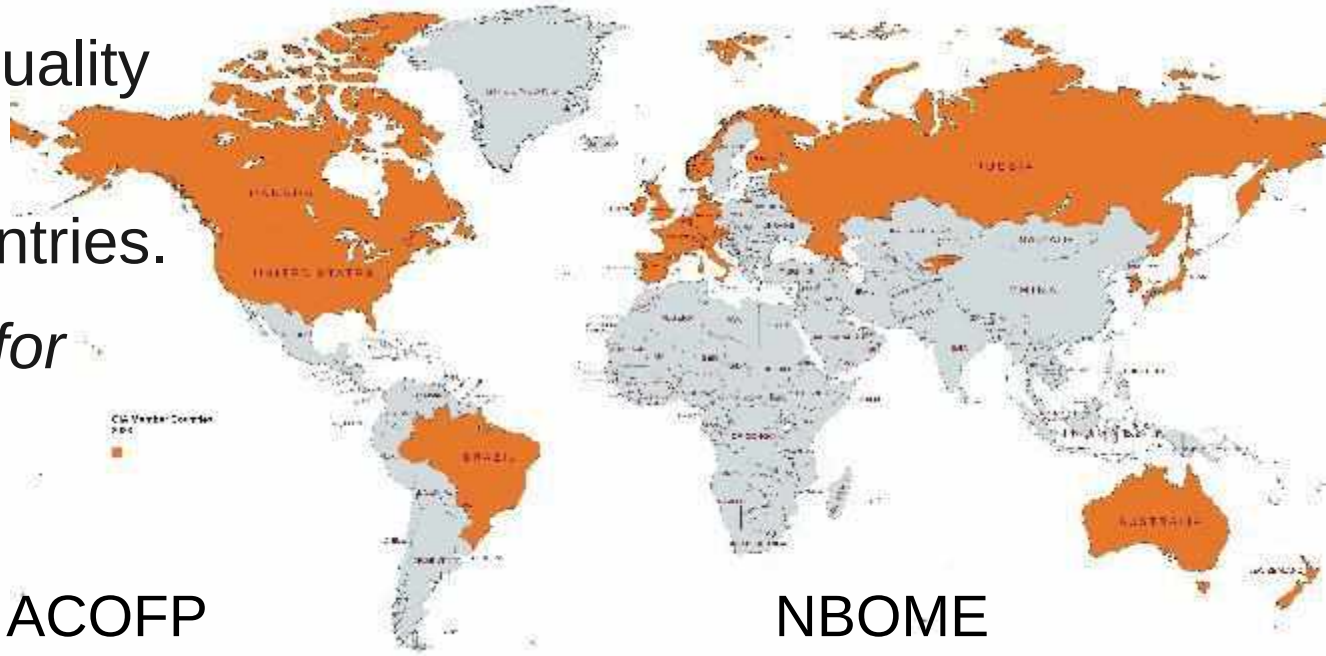
Osteopathic International Alliance (OIA)

Boyd R. Buser, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

About Us

- OIA unites the global osteopathic profession to support systems of regulation that promote patient access to safe, high-quality osteopathic healthcare.
- OIA represents 78 members in 21 countries.
- *Thank you to our US members below for supporting the global osteopathic profession!*



AOA AAO AACOM AAOE ACOFP NBOME
VCOM (VA) MUCOM OSUCOM SOMA UNECOM
KCOM WVSOM TCOM TUCOM (CA) COMP BUCOM

Annual General Meeting and Conference
London, England, October 2023

- Joint conference with British Institute of Osteopathy & University College of Osteopathy
- Over 500 attendees
- Dr. Rebecca Giusti re-elected to OIA Board for second three-year term

World Health Organization Update

- Designated Technical Officer, Dr. Pradeep Dua, presented at 2023 AGM and Conference in London
- Triennial Collaboration Plan (2024-2026) submitted to WHO Executive Board; awaiting approval confirmation
- Met via Zoom with TCIM leadership on Jan. 29 to discuss next steps in updating Benchmarks for Training
- International Glossary project progressing

Save-the-Date: OIA AGM & Conference - Oct. 24-26, 2024 Sydney, Australia

- Joint conference with Osteopathy Australia and Osteopaths New Zealand
- For more information and the speaker application (due 2/29), please visit:

https://oialliance.org/2024-sydney-australia/

- *We hope to see you there!*

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Society of Osteopathic Specialty Executives (SOSE)

Carol Houston, President

AMERICAN OSTEOPATHIC ASSOCIATION

Some Recent Highlights from the Specialty Societies

- Increased CME offerings
  - On-demand
  - Monthly webinars
  - Hybrid meetings
- Increased membership
- New membership recognition awards
- Increased opportunities for students and residents
- Focusing on mentorship programs
- Striving to revive and re-engage our membership
- 100% participation in OMED 2023

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Bureau of Emerging Leaders (BEL)

Sarah J. Wolff, DO, Chair

AMERICAN OSTEOPATHIC ASSOCIATION

BEL Members

- Caelin Smith, OMS III
- Ashley Gerard, OMS III
- Alissa Hendricks-Wenger, OMS III
- William Rinaldi, OMS IV
- Devanshi Patel, OMS IV *

- Maria D. Jones, DO
- Nigel S. Jagoo, DO
- Neal Monka, DO
- Brianne Howerton, DO
- Brian M. Fiani, DO
- Anjali James, DO
- Sara A. Lohbauer, DO *

- Sarah J. Wolff, DO
- Tim Beals, DO
- Sean Johnson, DO
- Daniel Krajcik, DO
- Selena G. Raines, DO
- Shawn Hamm, DO*

- Kevin V. de Regnier, DO
- Priya Garg, MBA

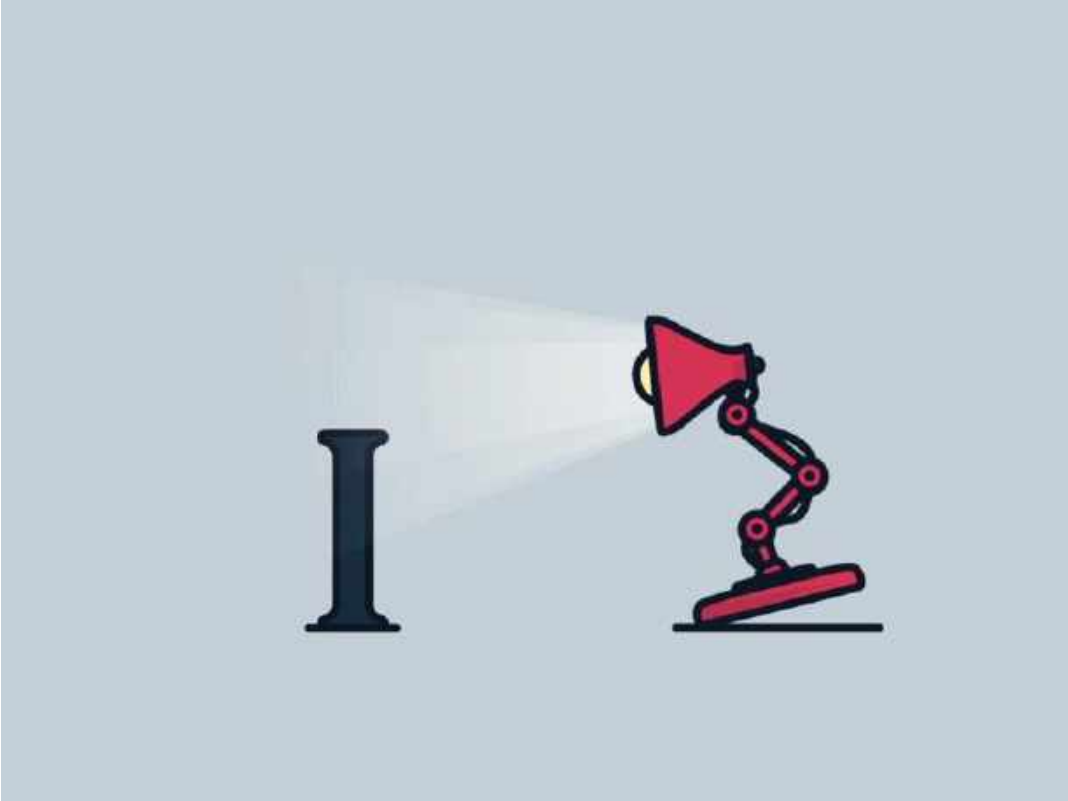
BEL

- **Mission**
  - The representative body and advocate for all osteopathic medical students, osteopathic physicians in postdoctoral training, and early-career osteopathic physicians.
- **Things we did well**
  - Found our purpose
  - Created a structure
  - Creation of workgroups
  - Created scholarships
  - Made ourselves known in the leadership pipeline

BEL

- **Mission**
  - The representative body and advocate for all osteopathic medical students, osteopathic physicians in postdoctoral training, and early-career osteopathic physicians.
- **Things we wanted to do better**
  - Unify voice and provide information/context to those representing us on multiple stages
  - Reflect the voice of our constituents (not just leaders)
  - Working as an osteopathic community and not in silos (POND)
  - Develop leaders & community
  - Be a “known” entity among our peers
  - Help make impact on AOA projects and initiatives

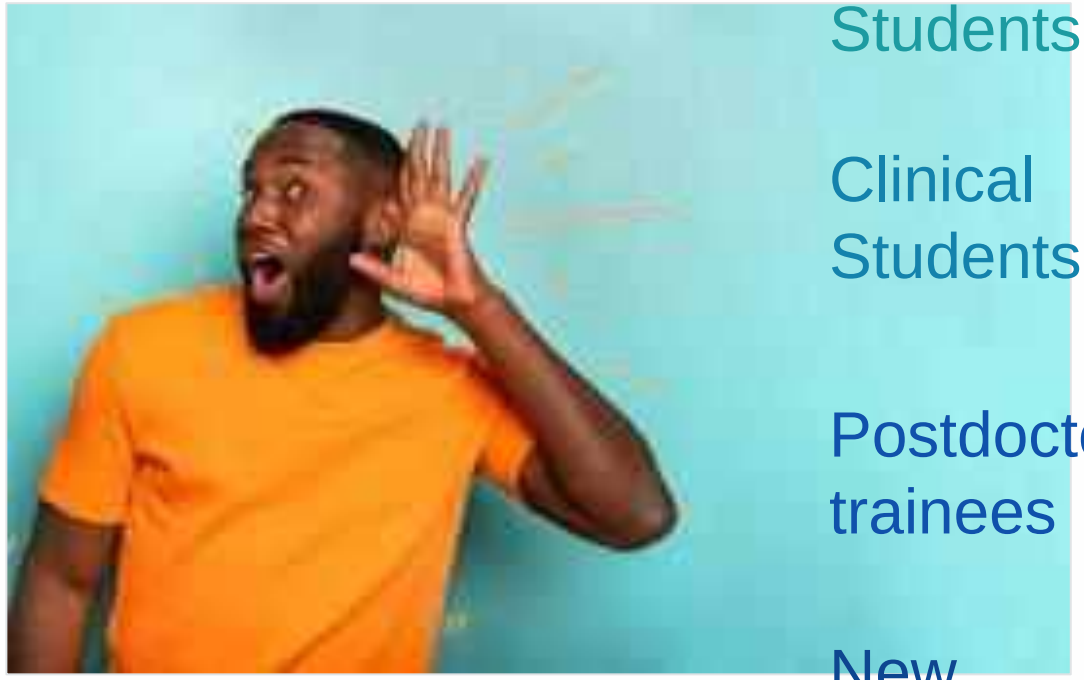
BEL Collaborative Cohort



BEL Collaborative Cohort

Invited Members

- BEL members
- AOA B/C/C applicants and members
- Workgroup members
- Leaders of affiliated/similar groups (SOMA, COSGP, AACOM's RCC, ACGME and NBOME representatives, TIPS Fellows, and more)
- Other



Preclinical Students

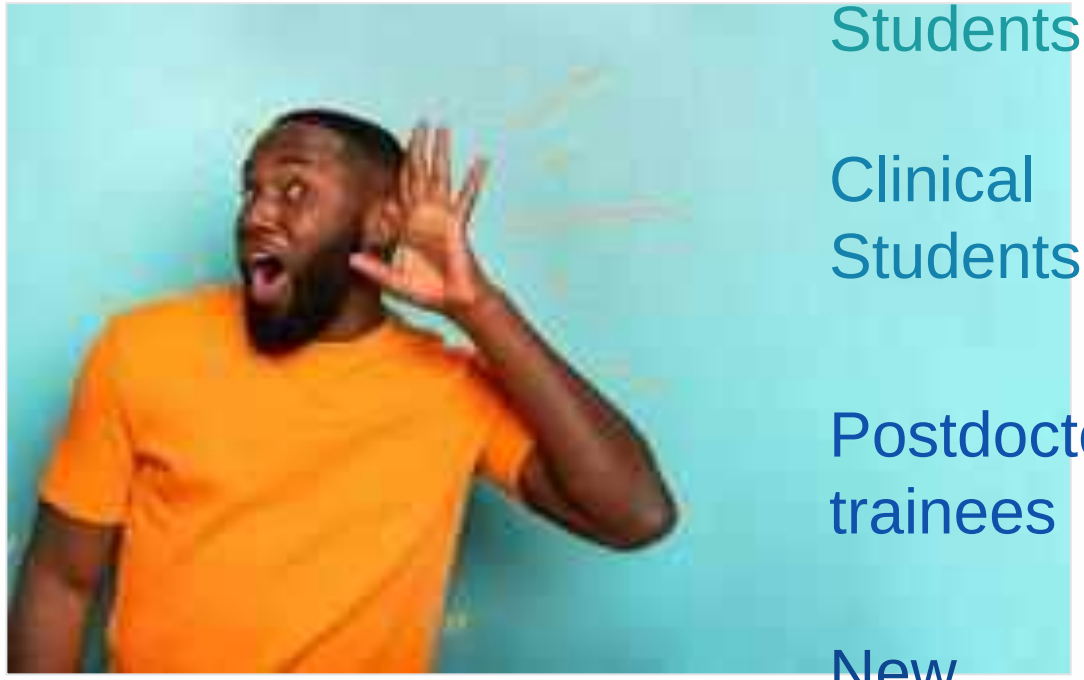
Clinical Students

Postdoctoral trainees

New Physicians in Practice

BEL Collaborative Cohort

- Engage and unify active constituents
- Listen, identify, and escalate concerns or ideas specific to that cohort
- Create actions, help triage, and provide responses based on concerns
- Provide a platform for AOA leaders to disseminate information broadly
- Get feedback on AOA initiatives
- Build a stronger sense of community
- Provide a communication pathway outside HOD resolutions



Preclinical Students

Clinical Students

Postdoctoral trainees

New Physicians in Practice

BEL Members

- Caelin Smith, OMS III
- Ashley Gerard, OMS III
- Alissa Hendricks-Wenger, OMS III
- William Rinaldi, OMS IV
- Devanshi Patel, OMS IV *

- Maria D. Jones, DO
- Nigel S. Jagoo, DO
- Neal Monka, DO
- Brianne Howerton, DO
- Brian M. Fiani, DO
- Anjali James, DO
- Sara A. Lohbauer, DO *

- Sarah J. Wolff, DO
- Tim Beals, DO
- Sean Johnson, DO
- Daniel Krajcik, DO
- Selena G. Raines, DO
- Shawn Hamm, DO*

- Kevin V. de Regnier, DO
- Priya Garg, MBA

BEL Collaborative Cohort Members

- Caelin Smith, OMS III
- Ashley Gerard, OMS III
- Alissa Hendricks-Wenger, OMS III
- William Rinaldi, OMS IV
- Devanshi Patel, OMS IV *
- Fawad Alam-Siddiqui, OMS III
- Monzer Alatrach, OMS II
- Maha Ali, OMS II
- Kaitlyn Alicz, OMS III
- Caitlin Blaukovitch, OMS IV
- Dylan Bogle, OMS II
- Andrew Browning, OMS II
- Nicholas Cristofari, OMS III
- Jennifer Domnitz, OMS II
- Deepa Elangovan, OMS II
- Lauren Evelti, OMS III
- Jantzen Faulkner, OMS IV
- Ian Finnegan, OMS III
- Steve Guzman, OMS III
- Dalia Hassan, OMS III
- Cassandra Holub, OMS III
- Adaku Ikoh, OMS IV
- Nandini Jojode, OMS III
- Peter Khoury, OMS II
- Kathleen Kind, OMS III
- Stephanie Koplitz, OMS IV
- Scott Landman, OMS IV
- Amber Lee, OMS IV
- Luigi Loizzo, OMS III
- Blaine Marie, OMS III
- Riya Nag, OMS IV
- Jordan Paluch, OMS III
- Annaleah Peterson, OMS IV
- Daniel Resnick, OMS IV
- Caroline Rizea, OMS III
- Beneshia Robinson, OMS II
- Chandrika Sanapala, OMS III
- Tillie Schumann, OMS III
- Anthony Sciuva, OMS III
- Alyssa Seawright, OMS II
- Tianfu Andy Shang, OMS II
- Amber Shirley, OMS III
- Jasmine Stewart, OMS III
- Matthew Stokell, OMS IV
- Zoe Sweet, OMS II
- Bailey Walker, OMS IV
- Kevin Weiss, OMS III
- Megan Wijesinghe, OMS II
- Margo Winter, OMS III
- Rebecca Wolff, OMS IV
- Maria D. Jones, DO
- Brianne Howerton, DO
- Nigel S. Jagoo, DO
- Anjali James, DO
- Neal Monka, DO
- Sara A. Lohbauer, DO *
- Hannah Boehler, DO
- Palmer Coleman, DO
- Kaitlyn Dressman, DO
- Hajere Hatollari, DO
- Aubrey Jackson, DO
- Rachel Jeter, DO
- Kaitlyn Kilpatrick, DO
- Amanda Milburn, DO
- Zachary Morehouse, DO
- Shahmir Naveed, DO
- Alexis Ousley, DO
- Prabjot Parmar, DO
- Aerial Petty, DO
- Annie Phung, DO
- Angela Pluguez, DO
- Stephen Poos, DO
- Tyler Ramsey, DO
- Ashwin Shankar, DO
- David Shumway, DO
- Hannah Thompson, DO
- Sarah J. Wolff, DO
- Tim Beals, DO
- Brian M. Fiani, DO
- Sean Johnson, DO
- Daniel Krajcik, DO
- Selena G. Raines, DO
- Shawn Hamm, DO*
- Carisa Champion, DO
- Alexis Cates, DO
- Owais Durrani, DO
- Caleb Hentges, DO
- Harika Kantamneni, DO
- Tim Lemaire, DO
- Angelo Mascia, DO
- Shoji Samson, DO
- Ryan Smith, DO

BEL Meeting Structure

- 7:15 **Welcome**
- 7:17-7:40 **Cohort Discussions**
- 7:40-8 **Invited guest presentation or topic**
  - Addresses from AOA leadership
  - AOA Membership Workgroup
  - AOA Board Certification Workgroup
- 8-8:30pm **Cohort members depart & BEL meeting starts**
  - Roll call, pledge, agenda, COI
  - Cohort discussion debrief
  - Workgroup questions or review
  - Open discussion

Cohort Topics

- Love the AOA people & staff
- Appreciate Dr. Monka's workgroups & efforts to gain traction
- BOT advisor and leadership participating in calls

Cohort Topics of Interest

Students

- AACOM & COCA concerns
  - Differences in OMM expectations between schools
  - Lack of osteopathic identity in clinical years
  - GME training slots compared to growth in profession
- Payment for external rotations
- FAIR Act
- Competition w/ APPs for training may require enhanced mentor & preceptor training
- AOA & AACOM relationship
- More communication re: changes to licensing and match processes
- Minimal relatability with social media content

Residents & Fellows

- AOA board certification
  - Unclear information
  - Program noncompliance
  - Payment issues
- Access & time off for professional development, healthcare reform or advocacy
- Wellness curriculum
- Opportunity for AOA to be more responsive by building on provided feedback
- Defense of the osteopathic reputation
- Single site for updated information/calendars
- Need for engaging & trending email and social media content

New Physicians

- Member value benefits/education/ advocacy focusing on the following issues will help engage DOs:
  - Underpayment & fair market compensation issues (e.g., outdated RVU models)
  - Coding changes
  - Student loan servicer issues
  - OCC confusion &/or duplication
  - Noncompete clauses
  - Mandates for nonphysicians in rural communities
  - Private equity acquisition
- Concerns about inability to pay multiple organizational membership dues
  - Dues + add-ons
  - Payment vs engagement

BEL Workgroups

- Advocacy
  - Chaired by Shawn Hamm, DO
- Communications
  - Chaired by Tim Beals, DO
- Events/Scholarships
  - Chaired by Nigel Jagoo, DO
- Public Relations
  - Chaired by Brianne Howerton, DO
- Resolutions
  - Chaired by Daniel Krajcik, DO
- BEL Structure
  - Chaired by Sarah J. Wolff, DO

Workgroups

Name	Leads	Members
Advocacy	Shawn Hamm, DO Sean Johnson, DO Selena Raines, DO	42
Communications	Tim Beals, DO Anjali James, DO William Rinaldi, OMS III	16
Events/Scholarships	Nigel Jagoo, DO Alissa Hendricks-Wenger, OMS III	28
Resolutions	Dan Krajcik, DO Ashley Gerard, OMS III Sara Lohbauer, DO	25
BEL Structure *New*	Sarah Wolff, DO Maria Jones, DO Caelin Smith, OMS III	6
Public Relations *New*	Brianne Howerton, DO Neal Monka, DO Devanshi Patel, OMS IV	34

Ways to make the BEL more successful

- Review purpose of the BEL
  - Currently creating and executing innovative programing to serve the AOA mission
  - Subject to guardrails of the AOA BOT

- Increase engagement/leadership opportunities for constituents

Engage with us

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Student Osteopathic Medical Association (SOMA)

Rebecca Wolff, OMS IV, President

AMERICAN OSTEOPATHIC ASSOCIATION

Working for the Future of Osteopathic Medicine

Recruiting Engaged Future Leaders

- **3,432 new SOMA members**
- **1 new chapter added at OMED**
  - Touro College of Osteopathic Medicine - Montana
- **1 new chapter expected - Spring 2024**
  - Rocky Vista University Montana College of Osteopathic Medicine
- **Impacting the future of the profession**
  - Students continue traveling on this leadership trajectory into their careers
  - SOMA-AOA recruitment teamwork

Growing Interest in Osteopathic Medicine

- **74 new PreSOMA members**
- **Engaged in pursuing osteopathic careers**
  - ~50 in-person attendees at OMED
- **Pre-Medical Student Programming**
  - Med school application bootcamp
  - Cultural competency and addiction medicine seminars
  - MCAT workshop
  - DO vs. MD info session
  - Campus tours & highlights
- **ShaDO 2024**
  - >40 COMs represented
  - >250 future osteopathic medical student attendees

Fostering Student Interests

- **A new generation of research engagement**
  - SOMA Research Project
    - Mentors for osteopathic medical students pursuing surgical subspecialties
  - National SOMA Research Symposium
  - The Future D.O. Volume 1, Issue 2
    - Abstracts, perspective pieces, poetry contest, visual arts
- **A focus on osteopathic medicine and wellness**
  - OPP in Action Award
  - OMT Workshops and QPR Training
  - Charity Miles 2024

Fostering Student Interests

- **Emphasizing diversity, equity, and inclusion**
  - Addressing disparities in sickle cell care and advocacy
  - Mistrust in medicine - narrative medicine workshop
  - Advocacy 101 with Dr. Cates
  - Food insecurity workshop
  - Buprenorphine and Narcan training

Working to Enact Positive Change

- **SOMA House of Delegates**
  - Resolution topics highlights:
    - *Supporting research and data collection on long-COVID*
    - *Acknowledgement and advocacy for increased education of healthcare disparities impacting Native American and Alaska Native populations*
    - *Augmented NRMP results and data reporting to address DO match disparities*
    - *Trauma-informed medical education*
    - *Standardization of preclinical grading systems*
    - *Obesity education within medical school curriculum*
    - *Medical student parental leave policies*

Representing the Osteopathic Medical Student Voice

- **Sharing membership feedback**
  - NBOME Liaison Committee & SEP
  - NBME Student Roundtable
  - NRMP Summit
  - COCA Commision Meetings
- **Serving as the voice of our membership**
  - AMA-MSS House of Delegates
  - SNMA House of Delegates
- **Recent efforts along stakeholder organizations**
  - Council of Osteopathic Student Government Presidents
  - Osteopathic International Alliance
  - United Leaders in Advocacy

The Future of SOMA

- **A new generation of SOMA leadership**
  - President-elect: Cassie Holub, OMS III
  - Vice President-elect: Kailey Jacobson, OMS III
  - National Board of Directors Chairperson-elect: Nick Cristofari, OMS III
  - Parliamentarian-elect: Nate Gentry, OMS III
  - Treasurer-elect: Sneha Polam, OMS III
  - Secretary-elect: Amy Chiou, OMS II
  - Region I Trustee-elect: Chethana Gallage, OMS II
  - Region II Trustee-elect: Julia Moore, OMS II
  - Region III Trustee-elect: Maria Rollinger, OMS II
  - Region IV Trustee-elect: Josh Connor, OMS II
  - Region V Trustee-elect: Grace Hwang, OMS II
  - AOA Student Trustee Nominee: Palmer Ford, OMS III

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Closing Remarks / Adjournment

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

For this evening:

6:30 pm – Closing Midyear Meeting Dinner in the Kiran Ballroom, 8th Floor

9:30 pm – Hospitality Room in the Pallavi Foyer, 8th Floor

AMERICAN OSTEOPATHIC ASSOCIATION

Midyear Strategic Breakfast Discussion

Thursday, February 22, 2024 · 8 – 11 am ET

JW Marriott Clearwater Beach Resort · Pallavi Ballroom

AMERICAN OSTEOPATHIC ASSOCIATION

Opening Comments

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

Clinical Artificial Intelligence (AI) & Large Language Models (LLM)

David O. Shumway, DO, Capt, USAF

AMERICAN OSTEOPATHIC ASSOCIATION

About Me:

COI/Financial Disclosures:

- I have no financial connections to any AI or LLM products, companies, developers discussed in this presentation, and no relevant disclosures.

AI Use Disclosure:

- Chat-GPT (GPT-4) and Open Evidence (OE-2) were used in the creation of this presentation. Sources and generated text were reviewed, edited by me and content re-produced in my own words where necessary.

Presentation Outline:

- Basics & Background of AI/LLMs
- Current Clinical Applications of AI
- What CAN it do? Future Applications of AI
- Current AI “Big Issues” in Medicine
- Call to Action: The Future of AI is Osteopathic

Why This Matters: Why Are We Here?

- Artificial intelligence (AI) is already rapidly changing healthcare as we know it forever.
- AI is clinically relevant to you. If not now, it soon will be.
- Osteopathic medicine is the best situated profession in the world to guide the development of clinical AI.
- It is our duty as physicians to take an active part in the development of this technology.

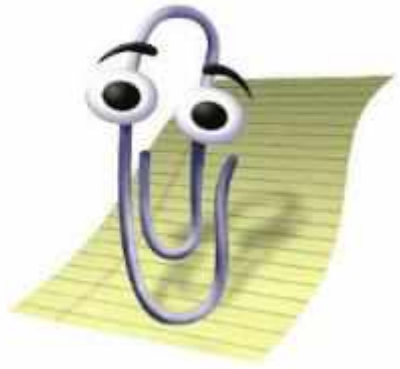
Voices:

- “When it comes to technology, I think doctors in general tend to be conservative because we’re dealing with caring for human lives. **In this situation, we can’t afford that conservatism.** We have to be proactive in shaping how these things enter the world of health care” — Nigam H. Shah, Chief Data Scientist, Stanford Health

- “In the end, **AI reflects the principles of the people who build it,** the people who **use it,** and the **data upon which it is built**” — Joe Biden, President, USA

Basics & Background of AI/LLMs:

- Artificial Intelligence = simulation of human intelligence in machines
  - Allows them to perform tasks that typically require human-like cognitive functions
  - Can learn, reason, problem-solve, perceive, understand and produce language.
- Highly integrated into modern life:
  - Voice assistants, facial recognition, predictive text, driverless cars, automated tele-receptionists, anthropomorphic paper-clips.



Basics & Background: A Brief History of AI[1]

- Early logical framework proposed by Alan Turing in 1950.
- First AI program “Logic Theorist” presented, and the term “AI” officially coined at DSRPAI in 1956.
- Further development through DARPA over the next 20 years, special focus on a speech recognition and language processing programs.
- Moore’s Law = limiting factor in A.I. advancement.
- “Big Data” and Large Language Models.

Basics & Background: A Brief History of AI in Medicine

- Use in EHR (1970-1990's)
  - MYCIN – computerized infectious disease consultation system (1977)
  - Decision support & drug interaction warnings
  - Quality metric tracking, billing and coding support
- Use in Imaging/Radiology (1990's)
  - Basic CAD applications/measurements (1990's)
  - Deep learning/CNN for pathology recognition (2008-2010)
- Use in Echocardiography (2010's)
  - Improved image acquisition/measurements, higher diagnostic accuracy
- Use in Endoscopy (2010's)
  - Automatic polyp detection improved performance over human endoscopist (2022)

Basics & Background: AI Terminology

- **Narrow vs General AI**
  - Narrow AI: current/historical technology; designed to perform specific tasks
  - General AI: emerging/future technology; human-like intelligence that can learn, interpret, and apply knowledge to any domain.
- **Machine Learning**
  - Deep Learning: utilizes neural networks to analyze and learn from large amounts of data, often without explicit human understanding (“Black Box”).
  - Reinforcement Learning: utilizes human influence to guide AI development by using rewards or penalties based on its performance.

Basics & Background: AI Terminology

- **Natural Language Processing (NLP)**
  - The process of a computer reading, understanding, and interpreting human language.
  - Also involves translation and production of language.
- **Optical Character Recognition (OCR)**
  - Involves the detection and recognition of printed or handwritten characters
  - Converts photos, scanned images, and un-editable formats into editable and searchable text that can be accessed by a word processor.
- **Ambient Dictation**
  - Emerging application of LLM NLP in healthcare and legal settings; “AI Scribe”
  - Pairs voice recognition with NLP and generative AI functionality.
- **Prompt**
  - The way a user inputs, queries, or communicates with a LLM AI.

Basics & Background: AI Terminology

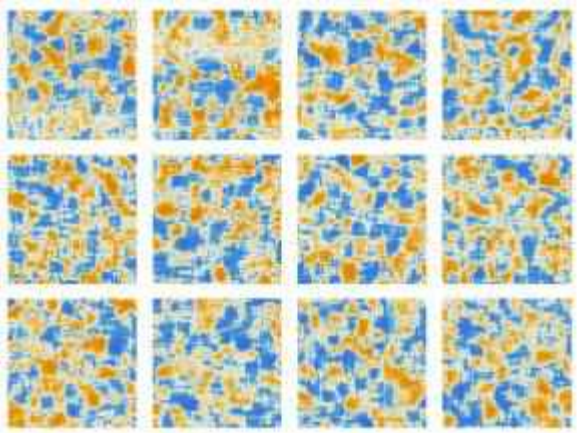
- **Large Language Models (LLM)**
  - Artificial intelligence algorithms based on neural networks designed to understand, generate, and manipulate human-like language.
  - Trained on vast amounts of data.
  - Complexity and capabilities of an LLM is directly related to size.
    - Number of “weights” (training parameters)
    - Amount of training data
  - Indistinguishable from humans[2,3]

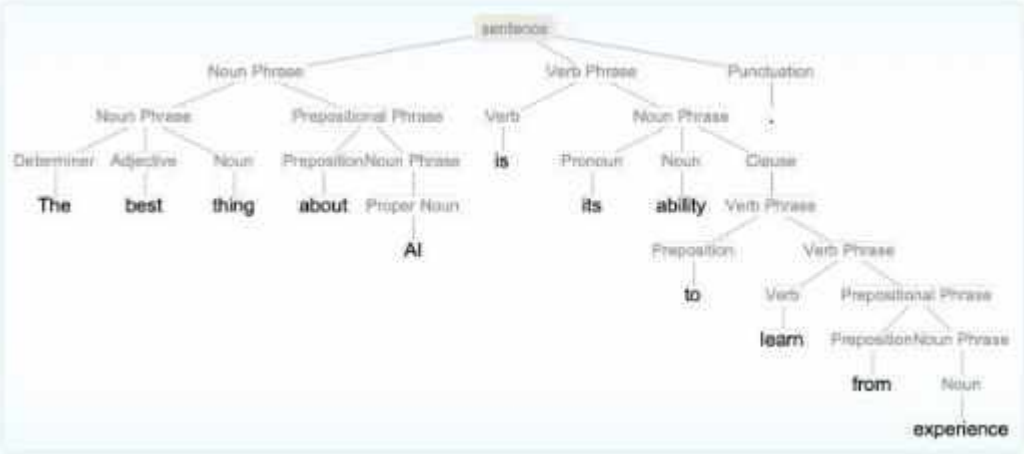
Basics & Background: How to Train a LLM[4]

- “Probabilities”
  - ‘tokens’
- “Temperature”
- Neural nets
  - ‘nodes’
  - ‘weights’
- Machine learning
- “Transformer”
  - Modularization
  - ‘Attention’

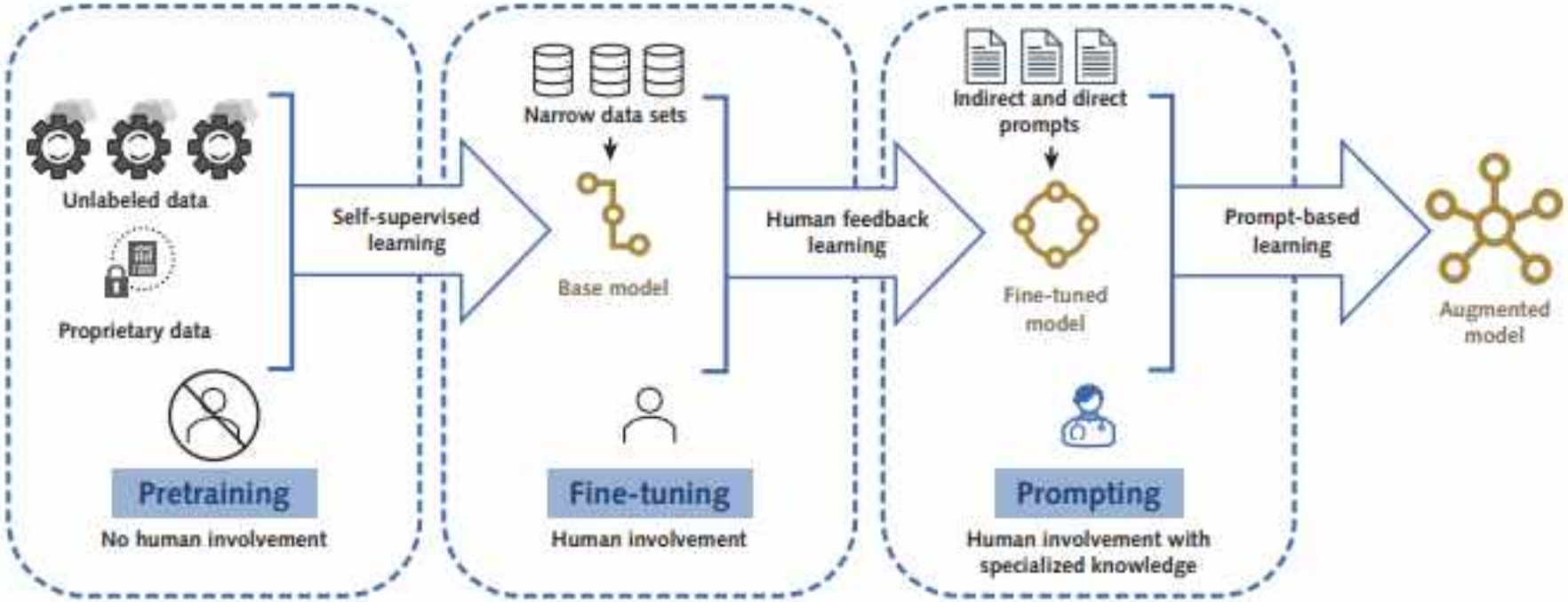
The best thing about AI is its ability to

learn	4.5%
predict	3.5%
make	3.2%
understand	3.1%
do	2.9%

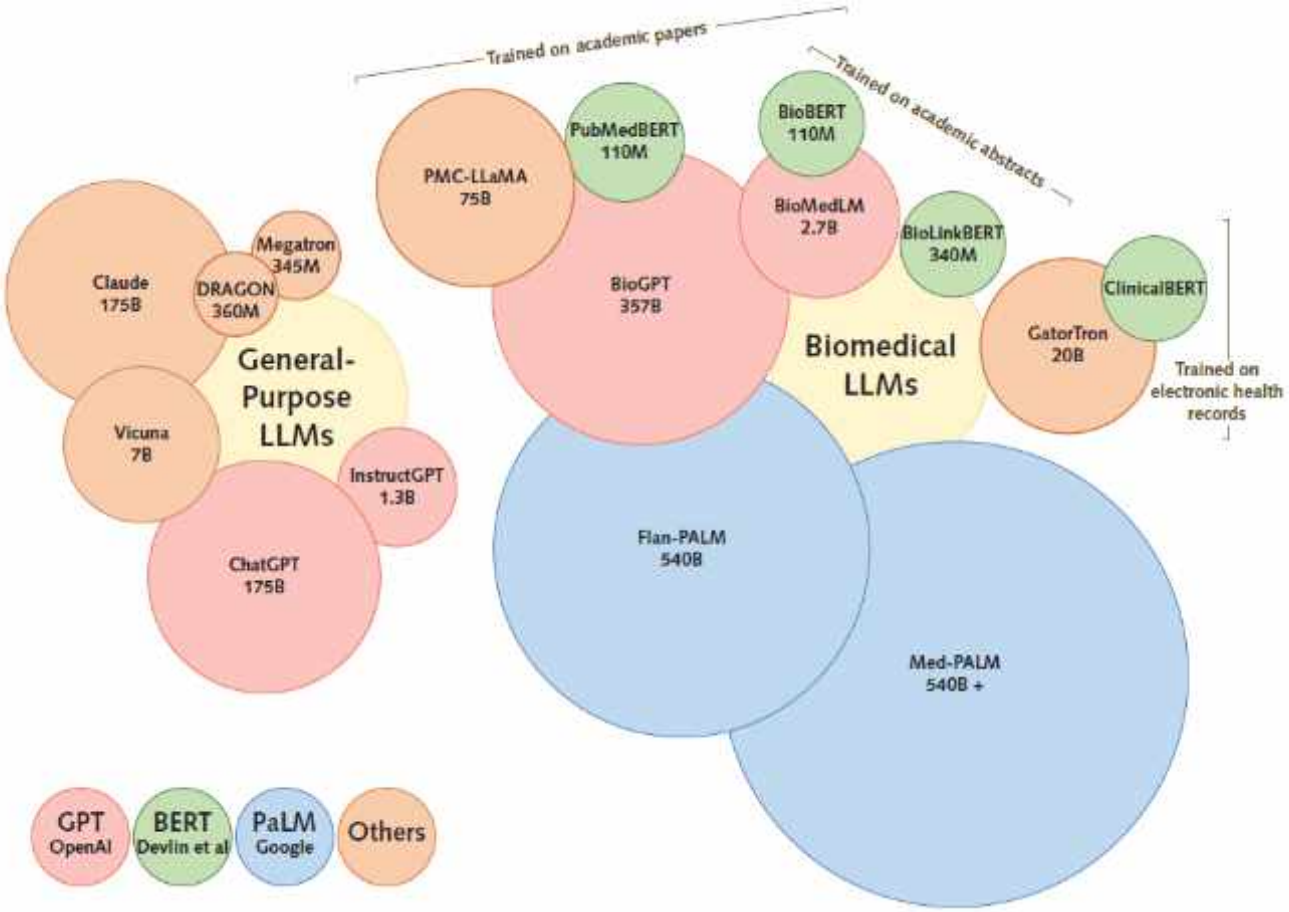




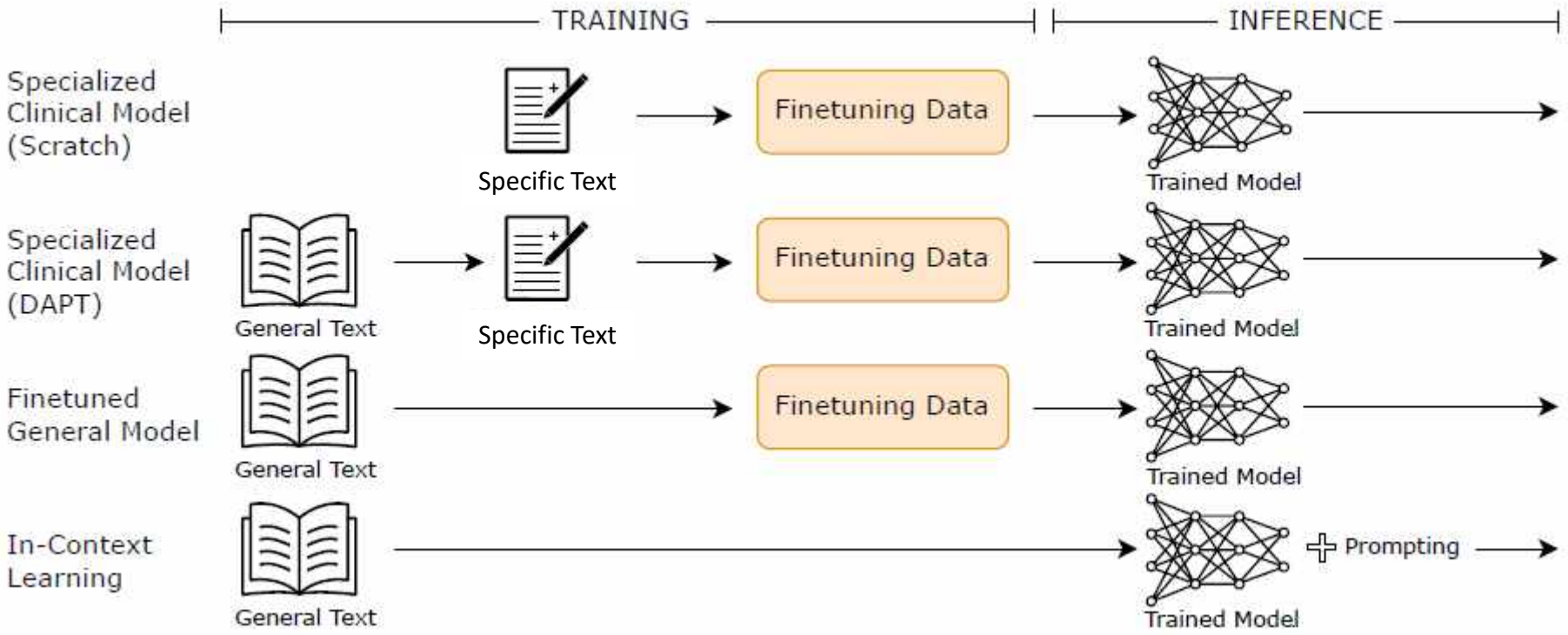
Basics & Background: How to Train a LLM[5]



Current Clinical Applications: LLMs in Medicine Today[5]



Current Clinical Applications: How to Apply an LLM[6]



Current Clinical Applications: LLMs in Medicine Today[5]

- **GPT-Lineage LLMs:**
  - Powerful, prevalent, most familiar
  - Trainable on specific data sets
- **PaLM-Lineage LLMs:**
  - Google-developed
  - Largest LLM by number of weights
  - Fine-tunable for clinical applications
- **Bi-directional Encoder (BERT):**
  - Non-generative; contextual word embedding model
  - Used in NLP applications

Current Clinical Applications: Capabilities of Chat-GPT/DALL·E

- **“Chat Generative Pre-Trained Transformer”**
- Developed by San Francisco based-Open AI on Microsoft Azure, Nvidia GPUs
- Free and Paid (Plus, about $20) tiers
- Features:
  - Can process code, pictures, files/PDFs (4)
  - Browses the internet (4)
  - API and Plug-In integration (4)
  - App store
  - iPhone app
  - Whisper

ChatGPT

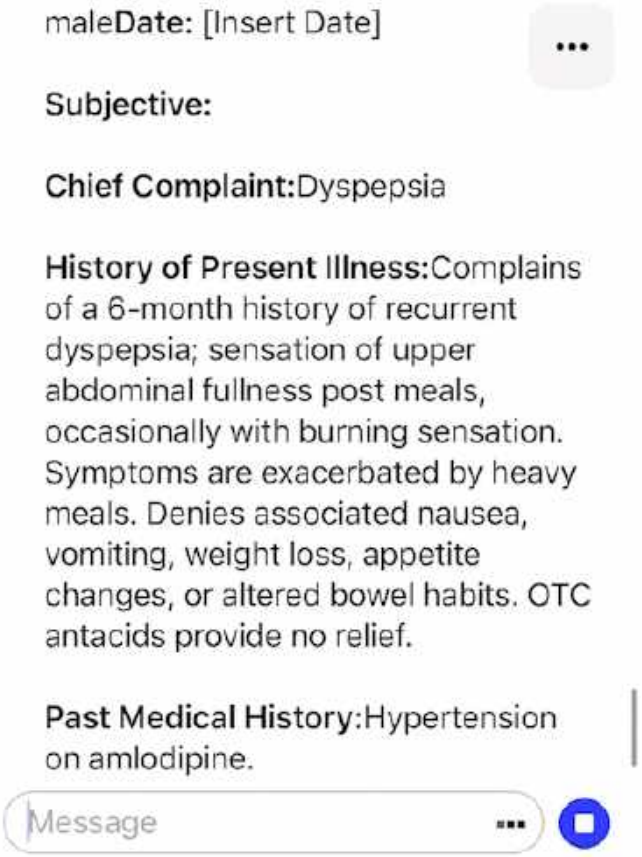
DALL·E 3

Current Clinical Applications: Use Cases

- **Practice Workflow:**
  - Medical Scribe
  - Diagnostic Assistant
  - Chart Reviewer
  - Point of Care Decision Resource
  - Creating patient resources
- **Administrative:**
  - Scanned medical record processing
  - Patient correspondence
  - Scheduling
  - Billing and Compliance
- **Medical Education:**
  - Question/Item Writing
  - Exam Analysis/Grading
  - Personal Tutor
  - Flashcard/material production
- **Research:**
  - Literature review
  - Document drafting
  - Data analysis

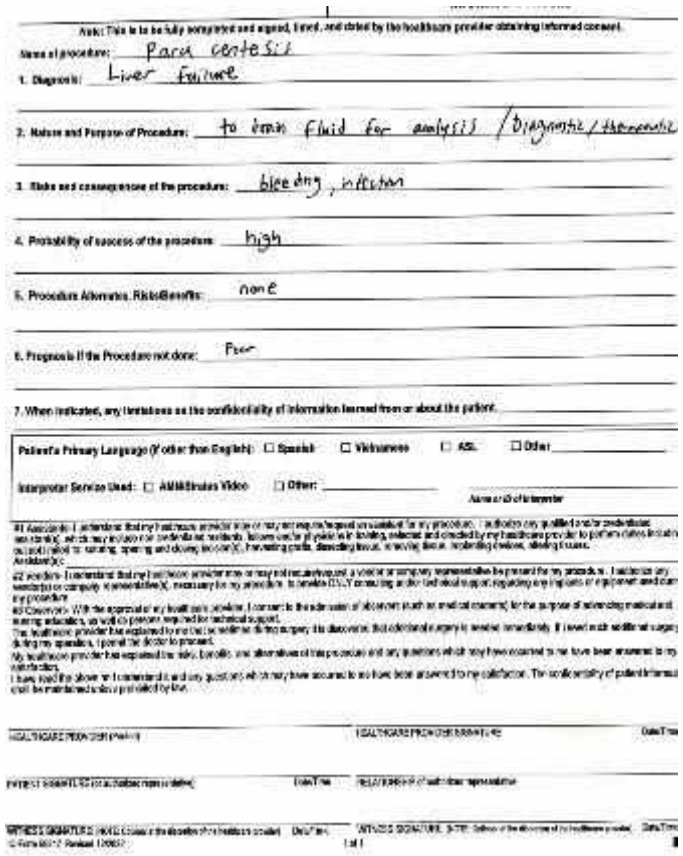
Selected Use Case: Medical Scribe

- Generative AI has the ability to both produce and analyze text through **natural language processing (NLP).**
- Trainable to your note writing style.
- When paired with an AI transcription tool (like Whisper), Chat GTP can become a fully autonomous medical scribe.
- With file upload, can reference prior medical records/notes.



Selected Use Case: Scanned Record Processing

- Can review PDF documents, Excel files, scanned images.
  - Upload directly or access via share link
- **Optical character recognition (OCR)**
- Analyze and document your handwritten or submitted questionnaires
- Simplifies medical record review and conversion of handwritten records



Note: This is to be fully completed and signed, dated, and dated by the healthcare provider obtaining informed consent.

Name of procedure: Para centesis

1. Diagnosis: Liver failure

2. Nature and Purpose of Procedure: to drain fluid for analysis / Diagnostic / therapeutic

3. Risks and consequences of the procedure: bleeding, infection

4. Probability of success of the procedure: high

5. Procedure Alternative, Risks/Benefits: none

6. Prognosis if the Procedure not done: Poor

7. When indicated, any limitations on the confidentiality of information learned from or about the patient:

Patient's Primary Language (if other than English): ☐ Spanish ☐ Vietnamese ☐ ASL ☐ Other

Interpreter Service Used: ☐ AMWBinaus Video ☐ Other:

Name of Interpreter

#1 Anesthesia: I understand that my healthcare provider or one or more physicians may be required as qualified for my procedure. I authorize any qualified and/or credentialed anesthesiologist, anesthetist, nurse anesthetist, or other qualified anesthesia personnel to perform such anesthesia as may be deemed necessary by my healthcare provider to perform such procedure, including but not limited to sedating, opening and closing veins or arteries, intubating, administering medicines, administering fluids, monitoring vitals, and other procedures.

Anesthesiologist

#2 Interpreter: I understand that my healthcare provider may not be able to speak or understand my language and may require the assistance of a translator or an interpreter to be present for my procedure. I authorize any translator or interpreter or company representative(s), necessary for my procedure, to translate (V.L.Y consulting and/or medical support regarding my rights of informed and consent for my procedure.

#3 Consent: With the approval of my healthcare provider, I consent to the audio use of videotape (such as medical cameras) for the purpose of advancing medical and nursing education, as well as personnel responsible for technical support.

The healthcare provider has explained to me that I may need to be sedated during surgery, the discovery that additional surgery is needed immediately. If I need such additional surgery during my operation, I permit the doctor to proceed.

My healthcare provider has explained the risks, benefits, and alternatives of the procedure and any questions which I may have concerned to me have been answered to my satisfaction.

I have read the above or I understand it and any questions which I may have concerned to me have been answered to my satisfaction. The confidentiality of patient information cannot be maintained unless provided by law.

HEALTHCARE PROVIDER (Print) | HEALTHCARE PROVIDER SIGNATURE | Date/Time

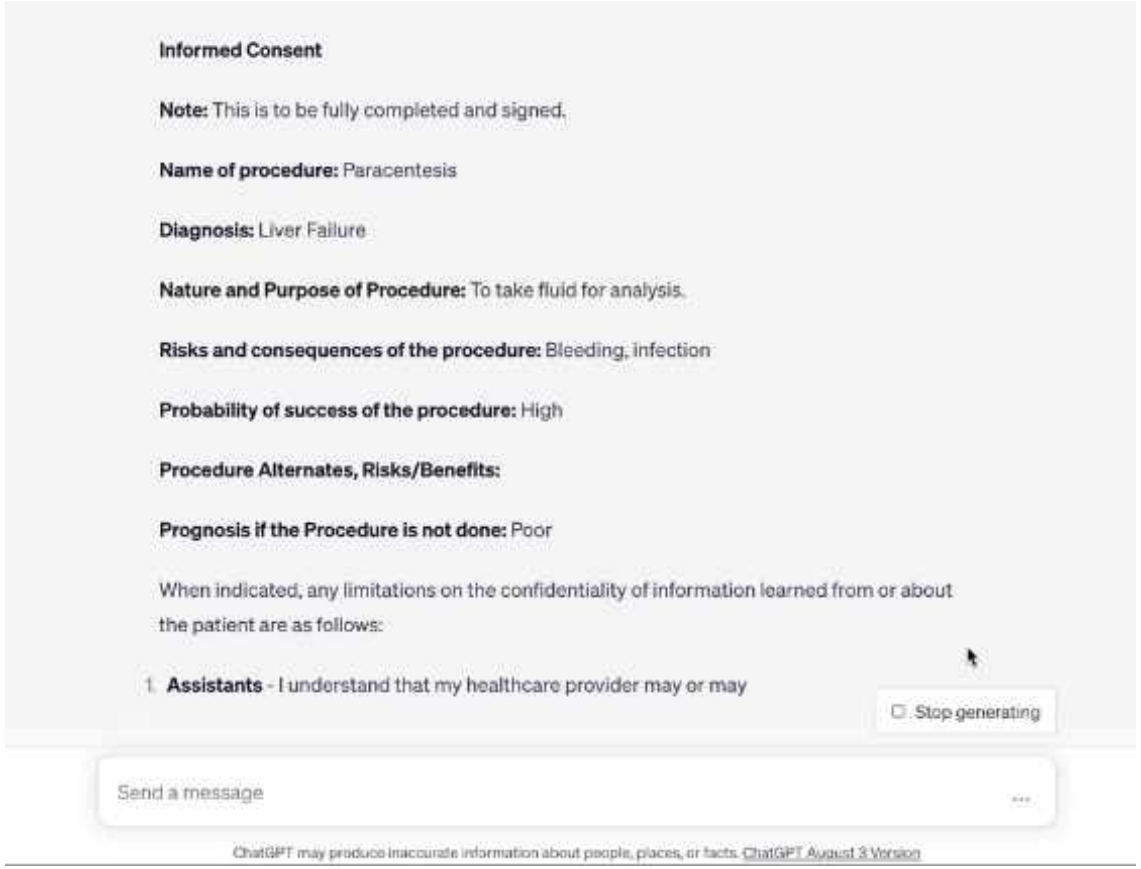
PATIENT SIGNATURE (Print) | Date/Time | RELATIONSHIP of authorized representative

WITNESS SIGNATURE (Print) Witness of the discussion of the healthcare provider | Date/Time | WITNESS SIGNATURE (Print) Witness of the discussion of the healthcare provider | Date/Time

© Form 6017-7 Revised 12/2003 | 1 of 1

Selected Use Case: Scanned Record Processing

- Can review PDF documents, Excel files, scanned images.
  - Upload directly or access via share link
- **Optical character recognition (OCR)**
- Analyze and document your handwritten or submitted questionnaires
- Simplifies medical record review and conversion of handwritten records



Informed Consent

Note: This is to be fully completed and signed.

Name of procedure: Paracentesis

Diagnosis: Liver Failure

Nature and Purpose of Procedure: To take fluid for analysis.

Risks and consequences of the procedure: Bleeding, infection

Probability of success of the procedure: High

Procedure Alternates, Risks/Benefits:

Prognosis if the Procedure is not done: Poor

When indicated, any limitations on the confidentiality of information learned from or about the patient are as follows:

1. **Assistants** - I understand that my healthcare provider may or may

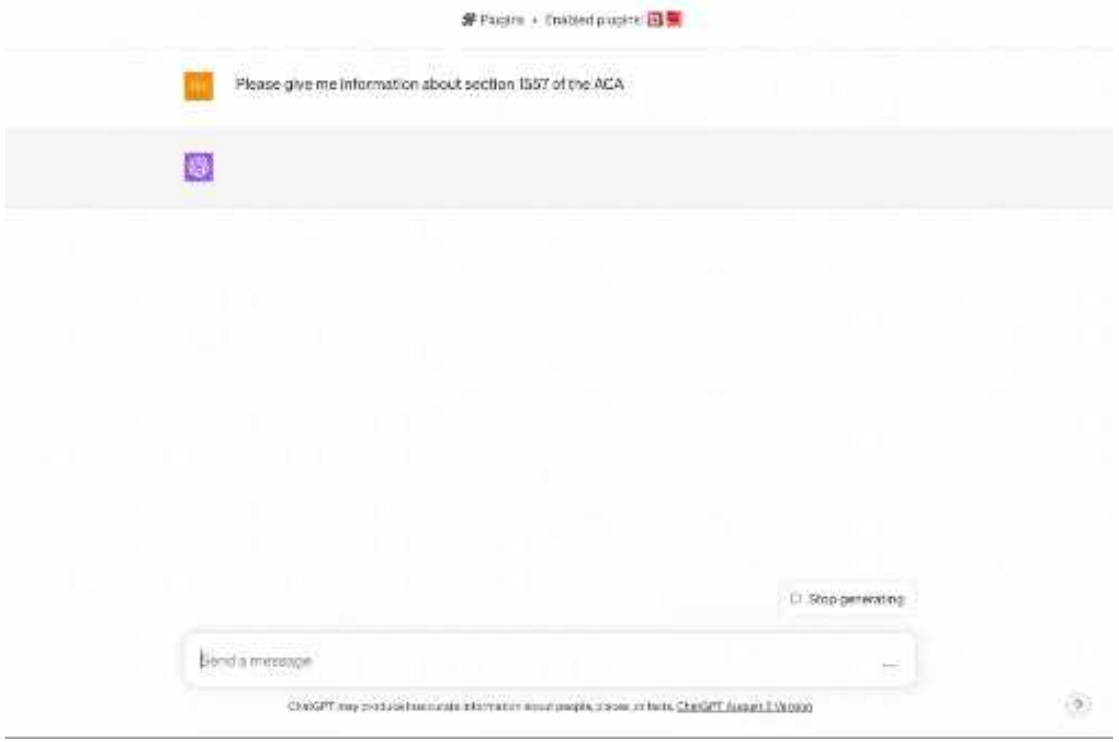
Stop generating

Send a message

ChatGPT may produce inaccurate information about people, places, or facts. ChatGPT August 3 Version

Selected Use Case: Research Assistant/Evidence Based Medicine

- With internet-enabled plug ins (Google Scholar/PubMed)
  - Reduced/eliminated hallucinations
  - Can produce, evaluate, categorize sources
- Scans for publicly available sources, governmental rules/regulations
- Can produce necessary guidelines and/or statutes for your research question.



Selected Use Case: Research Assistant/Evidence Based Medicine

OpenEvidence

TLDr API About Blog Ask OpenEvidence Login

When can you stop DAPT if a patient is having severe bleeding after PCI?

Showing answer for: When can you stop **dual antiplatelet therapy** if a patient is having severe bleeding after **percutaneous coronary intervention?**

In the context of severe bleeding after percutaneous coronary intervention (PCI), the decision to stop dual antiplatelet therapy (DAPT) must be individualized, balancing the risks of stent thrombosis against the risks of ongoing bleeding. The American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACC/AHA/SCAI) 2021 Guideline for Coronary Artery Revascularization suggests that a short duration of DAPT after PCI in patients with stable ischemic heart disease is reasonable to reduce the risk of bleeding events.[1-4] For patients at high bleeding risk, transitioning to P2Y12 inhibitor monotherapy and stopping aspirin after 1 to 3 months of DAPT may be considered.

The American College of Chest Physicians (ACCP) also provides guidance on perioperative management of antithrombotic therapy, suggesting that in patients with coronary stents placed within the last 6 to 12 weeks who are undergoing elective surgery, either continuation of both antiplatelet agents or stopping one antiplatelet agent within 7 to 10 days of surgery may be considered, depending on the bleeding risk associated with the surgery and the risk for acute coronary syndrome or coronary stent thrombosis if antiplatelet therapy is interrupted.[5-8]

References

1. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Circulation. 2022;145(3):e4-e17. doi:10.1161/CIR.0000000000001039.
   ☆ Top Journal
2. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Circulation. 2022;145(3):e18-e114. doi:10.1161/CIR.0000000000001038.
   ☆ Top Journal
3. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Journal of the American College of Cardiology. 2022;79(2):197-215. doi:10.1016/j.jacc.2021.09.005.
   ☆ Top Journal
4. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Journal of the American College of Cardiology. 2022;79(2):e21-e129. doi:10.1016/j.jacc.2021.09.006.
   ☆ Top Journal

Future and Potential Applications of AI:

- **Full Scope Medical Practice**
  - Diagnosis, management, and documentation at the level of a medical resident or mid-level.
- **Full Scope Personal Assistant**
  - Clinic manager, scheduler, human resources, biller/coder all rolled into one.
  - Correspond and triage patient messages.[7]
- **Pocket Curbside/Scalable Privilege**
  - Act with the aggregated expertise of tertiary level experts on demand.
  - Verified, vetted, standard of care.
  - Extends tertiary capabilities to under-served/rural areas.
- **Remote Patient Monitoring**
  - Manage certain patients to an inpatient standard in an outpatient or home setting.
- **Live Video Analysis**
  - Current gen AI are capable of watching and understanding video footage.[8]
  - Possibility of standardized real-time assessment.

Big Issues: Accuracy and Reliability

- “Hallucinations”
  - Error rate of producing real research citations when prompted = 20.6% for GPT-4 [9]
  - Examples of bad outcomes from false information in other disciplines [10]

Big Issues: Accuracy and Reliability

DO

Give me a hyperlink to the second source

Sure! Here's the hyperlink to the second source in PubMed Central:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249176/

Big Issues: Accuracy and Reliability

Cover photograph (Copyright © 2014, American Society for Microbiology. All Rights Reserved.) *Apis mellifera* nurse workers sealing a brood frame within a colony located in Austin, TX. The related article describes the mechanisms through which newly emerged worker bees acquire their core microbiota and the colonization patterns of these microbes in the bee gut. (See related article on page 7210.)

Appl Environ Microbiol. 2014 Dec; 80(23): Cover

Big Issues: Accuracy and Reliability

- Clinical Reasoning[11]
  - 39% accuracy in correctly diagnosing “challenging” cases
  - 64% accuracy in identifying correct diagnosis in the differential
- Source of data
  - Inability to control or even know the information general models were trained on
  - Unregulated, unverified information
- “WebMD” effect
  - Chatbot is NOT a doctor

Big Issues: Regulatory & Policy Challenges[12]

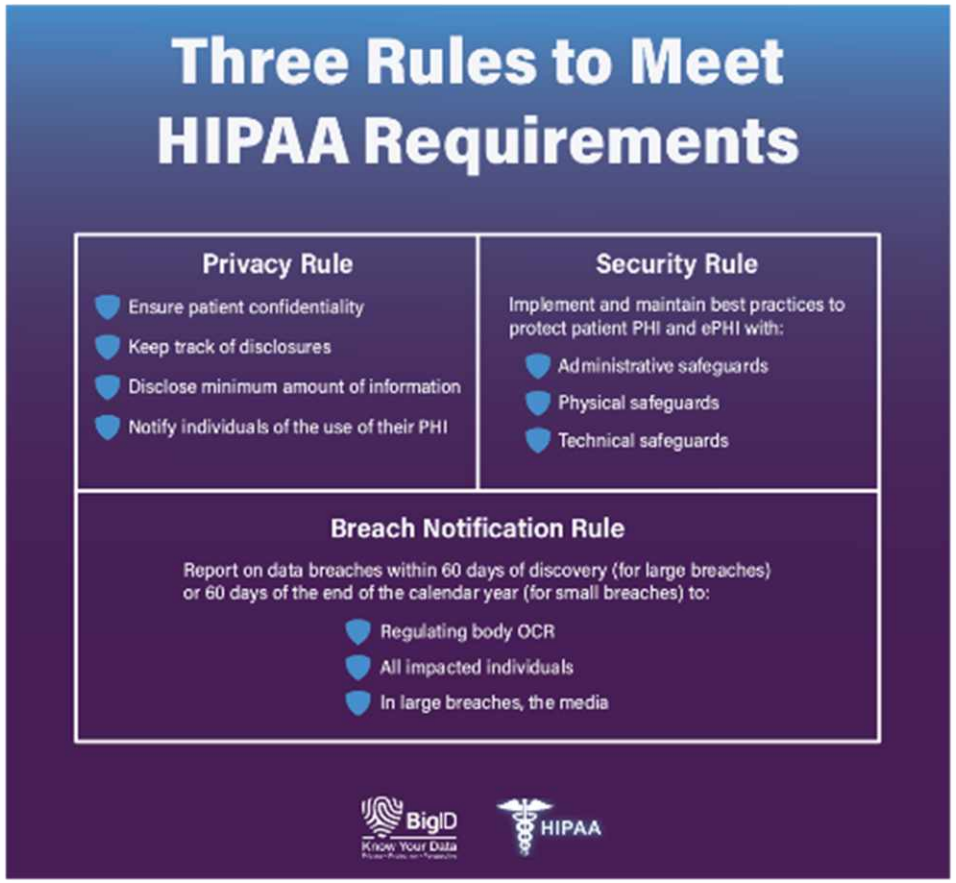
- Few regulations for LLM AI in clinical use
  - Jurisdiction is unclear (FDA? CMS? FTC? FCC?)
- AI developers largely (currently) unregulated at any level
  - Tendency away from oversight in A.I. community
  - “Regulation stifles innovation” mindset
- “Code of Conduct” enforceability
  - Not clear proposed A.I. expert guidance “has teeth”

Big Issues: Regulatory & Policy Challenges

- **Biden's Executive Order 14110** (Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence)
  - First nationwide AI policy with force of law.
  - Focuses on safety, privacy, data security, and reducing AI biases/civil rights
  - Directs HHS to establish a "safety program" to remedy harms of unsafe healthcare practices
- Food and Drug Administration (FDA) policy
  - **Section 520(o)(1)I(i)** of the Federal Food, Drug, and Cosmetic Act (FD&C Act)
  - Nonbinding recommendations for classifying clinical decision support (CDS) software as medical devices
  - Currently consider a CDS to be a "medical device" when it captures and processes images
- **EU AI Act**
  - Tiered "Risk System"
  - Possible model for future AI policy
  - European

Big Issues: HIPAA, Privacy, Data Security[13]

- HIPAA compliance?
  - Limits use of PII/PHI
- Privacy concerns
  - Data leaks
  - Developer access
- Server/Data Security
  - Limits CUI, government use



Big Issues: Malpractice Liability[14,15]

- Physicians (currently) 100% liable for bad outcomes
  - (**ACA Section 1557 §92.210**)
- Likely will be treated as 3rd party medical guidance
- "Learned Intermediary" Doctrine
  - Theoretical; Never litigated
  - No standard for "standard of care"
  - Developers and database curators currently not liable

Big Issues: Racism, Bias, Social Justice[16,17]

- Non-representative data set = non-representative output.
- Potential to reflect and amplify existing biases in healthcare.
- Performance variations may lead to misdiagnosis or inappropriate care for under-represented groups.

Call to Action:

- Osteopathic Medicine is the **most well-positioned profession in the world** to guide the development of AI in healthcare.
- Failure to contribute = **loss of input**
- This is our opportunity to **define, characterize,** and **protect** what is distinctly osteopathic when applying clinical AI and LLMs for **medical practice, education, examination,** and **research.**

The Future of AI is Osteopathic.

References:

1. Anyoha, Rockwell. The History of Artificial Intelligence, Harvard University. https://sitn.hms.harvard.edu/flash/2017/history-artificial-intelligence/
2. Elyoseph Z, Hadar-Shoval D, Asraf K, Lvovsky M. ChatGPT outperforms humans in emotional awareness evaluations. Front Psychol. 2023 May 26;14:1199058. doi: 10.3389/fpsyg.2023.1199058. PMID: 37303897; PMCID: PMC10254409.
3. Cutler DM. What Artificial Intelligence Means for Health Care. JAMA Health Forum. 2023;4(7):e232652. doi:10.1001/jamahealthforum.2023.2652
4. Wolfram, S. (2023) "What Is ChatGPT Doing…and Why Does It Work?", Book, Available at https://writings.stephenwolfram.com/2023/02/what-is-chatgpt-doing-and-why-does-it-work/
5. Jesutofunmi A. Omiye, Haiwen Gui, Shawheen J. Rezaei, et al. Large Language Models in Medicine: The Potentials and Pitfalls: A Narrative Review. Ann Intern Med. [Epub 30 January 2024]. doi:10.7326/M23-2772
6. Lehman E, Hernandez E, Mahajan D, et al. Do We Still Need Clinical Language Models? arXiv.org. doi:https://doi.org/10.48550/arXiv.2302.08091
7. Ayers JW, Poliak A, Dredze M, et al. Comparing Physician and Artificial Intelligence Chatbot Responses to Patient Questions Posted to a Public Social Media Forum. JAMA Intern Med. 2023;183(6):589–596. doi:10.1001/jamainternmed.2023.1838
8. NEC's generative AI video recognition solution. Accessed at: https://www.nec.com/en/press/202312/global_20231205_01.html 2/9/24
9. Chen A, Chen DO. Accuracy of Chatbots in Citing Journal Articles. JAMA Netw Open. 2023;6(8):e2327647. doi:10.1001/jamanetworkopen.2023.27647
10. Lawyers Cited for Bogus Case Law https://apnews.com/article/artificial-intelligence-chatgpt-courts-e15023d7e6fdf4f099aa122437dbb59b
11. Kanjee Z, Crowe B, Rodman A. Accuracy of a Generative Artificial Intelligence Model in a Complex Diagnostic Challenge. JAMA. 2023;330(1):78–80. doi:10.1001/jama.2023.8288
12. Minssen T, Vayena E, Cohen IG. The Challenges for Regulating Medical Use of ChatGPT and Other Large Language Models. JAMA. 2023;330(4):315–316. doi:10.1001/jama.2023.9651
13. Marks M, Haupt CE. AI Chatbots, Health Privacy, and Challenges to HIPAA Compliance. JAMA. 2023;330(4):309–310. doi:10.1001/jama.2023.9458
14. Price WN, Gerke S, Cohen IG. Potential Liability for Physicians Using Artificial Intelligence. JAMA. 2019;322(18):1765–1766. doi:10.1001/jama.2019.15064
15. Shumway, David O. and Hartman, Hayes J.. "Medical malpractice liability in large language model artificial intelligence: legal review and policy recommendations" Journal of Osteopathic Medicine, 2024. https://doi.org/10.1515/jom-2023-0229
16. Thomasian NM, Eickhoff C, Adashi EY. Advancing health equity with artificial intelligence. J Public Health Policy. 2021;42(4):602-611. doi:10.1057/s41271-021-00319-5
17. Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Dissecting racial bias in an algorithm used to manage the health of populations. Science. 2019;366(6464):447-453. doi:10.1126/science.aax2342

Open Discussion

AMERICAN OSTEOPATHIC ASSOCIATION

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Closing Remarks / Adjournment

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

AMERICAN
OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

2024 MIDYEAR STRATEGIC BREAKFAST DISCUSSION

JW Marriott Clearwater Beach Resort · Pallavi Ballroom

Virtual Participation: https://us06web.zoom.us/j/82862375322 | 312-626-6799,, #82862375322

Please remember to place yourself on mute if not speaking

Thursday, February 22, 2024 · 8 – 11 am ET

Time	Agenda Item	Presenter(s)
8 am	Networking Breakfast	
8:30 am	Opening Remarks	Ira P. Monka, DO, FACOCP, President
8:40 am	Strategic Discussion: Artificial Intelligence ▪ Description of AI ▪ Current AI Uses ▪ What can I do? ▪ AI Issues in Medicine ▪ Call to Action	David Shumway, DO, Capt, USAF
9:30 am	Open Discussion	
10:45 am	Closing Remarks	Ira P. Monka, DO, FACOCP, President
11 am	Adjournment	Ira P. Monka, DO, FACOCP, President

Midyear Strategic Breakfast Discussion

Thursday, February 22, 2024 · 8 – 11 am ET

JW Marriott Clearwater Beach Resort · Pallavi Ballroom

AMERICAN OSTEOPATHIC ASSOCIATION

Opening Comments

Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

Clinical Artificial Intelligence (AI) & Large Language Models (LLM)

David O. Shumway, DO, Capt, USAF

AMERICAN OSTEOPATHIC ASSOCIATION

About Me:

COI/Financial Disclosures:

- I have no financial connections to any AI or LLM products, companies, developers discussed in this presentation, and no relevant disclosures.

AI Use Disclosure:

- Chat-GPT (GPT-4) and Open Evidence (OE-2) were used in the creation of this presentation. Sources and generated text were reviewed, edited by me and content re-produced in my own words where necessary.

Presentation Outline:

- Basics & Background of AI/LLMs
- Current Clinical Applications of AI
- What CAN it do? Future Applications of AI
- Current AI “Big Issues” in Medicine
- Call to Action: The Future of AI is Osteopathic

Why This Matters: Why Are We Here?

- Artificial intelligence (AI) is already rapidly changing healthcare as we know it forever.
- AI is clinically relevant to you. If not now, it soon will be.
- Osteopathic medicine is the best situated profession in the world to guide the development of clinical AI.
- It is our duty as physicians to take an active part in the development of this technology.

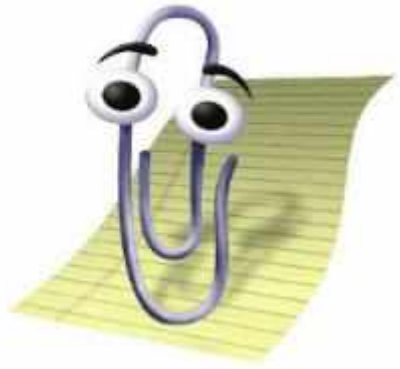
Voices:

- “When it comes to technology, I think doctors in general tend to be conservative because we’re dealing with caring for human lives. **In this situation, we can’t afford that conservatism.** We have to be proactive in shaping how these things enter the world of health care” — Nigam H. Shah, Chief Data Scientist, Stanford Health

- “In the end, **AI reflects the principles of the people who build it,** the people who **use it,** and the **data upon which it is built**” — Joe Biden, President, USA

Basics & Background of AI/LLMs:

- Artificial Intelligence = simulation of human intelligence in machines
  - Allows them to perform tasks that typically require human-like cognitive functions
  - Can learn, reason, problem-solve, perceive, understand and produce language.
- Highly integrated into modern life:
  - Voice assistants, facial recognition, predictive text, driverless cars, automated tele-receptionists, anthropomorphic paper-clips.



Basics & Background: A Brief History of AI[1]

- Early logical framework proposed by Alan Turing in 1950.
- First AI program “Logic Theorist” presented, and the term “AI” officially coined at DSRPAI in 1956.
- Further development through DARPA over the next 20 years, special focus on a speech recognition and language processing programs.
- Moore’s Law = limiting factor in A.I. advancement.
- “Big Data” and Large Language Models.

Basics & Background: A Brief History of AI in Medicine

- Use in EHR (1970-1990's)
  - MYCIN – computerized infectious disease consultation system (1977)
  - Decision support & drug interaction warnings
  - Quality metric tracking, billing and coding support
- Use in Imaging/Radiology (1990's)
  - Basic CAD applications/measurements (1990's)
  - Deep learning/CNN for pathology recognition (2008-2010)
- Use in Echocardiography (2010's)
  - Improved image acquisition/measurements, higher diagnostic accuracy
- Use in Endoscopy (2010's)
  - Automatic polyp detection improved performance over human endoscopist (2022)

Basics & Background: AI Terminology

- **Narrow vs General AI**
  - Narrow AI: current/historical technology; designed to perform specific tasks
  - General AI: emerging/future technology; human-like intelligence that can learn, interpret, and apply knowledge to any domain.
- **Machine Learning**
  - Deep Learning: utilizes neural networks to analyze and learn from large amounts of data, often without explicit human understanding (“Black Box”).
  - Reinforcement Learning: utilizes human influence to guide AI development by using rewards or penalties based on its performance.

Basics & Background: AI Terminology

- **Natural Language Processing (NLP)**
  - The process of a computer reading, understanding, and interpreting human language.
  - Also involves translation and production of language.
- **Optical Character Recognition (OCR)**
  - Involves the detection and recognition of printed or handwritten characters
  - Converts photos, scanned images, and un-editable formats into editable and searchable text that can be accessed by a word processor.
- **Ambient Dictation**
  - Emerging application of LLM NLP in healthcare and legal settings; “AI Scribe”
  - Pairs voice recognition with NLP and generative AI functionality.
- **Prompt**
  - The way a user inputs, queries, or communicates with a LLM AI.

Basics & Background: AI Terminology

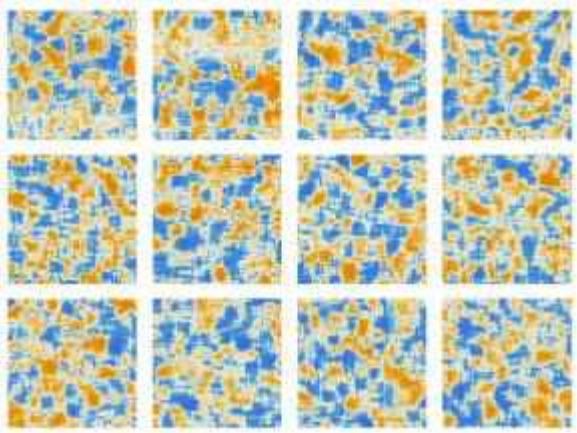
- **Large Language Models (LLM)**
  - Artificial intelligence algorithms based on neural networks designed to understand, generate, and manipulate human-like language.
  - Trained on vast amounts of data.
  - Complexity and capabilities of an LLM is directly related to size.
    - Number of “weights” (training parameters)
    - Amount of training data
  - Indistinguishable from humans[2,3]

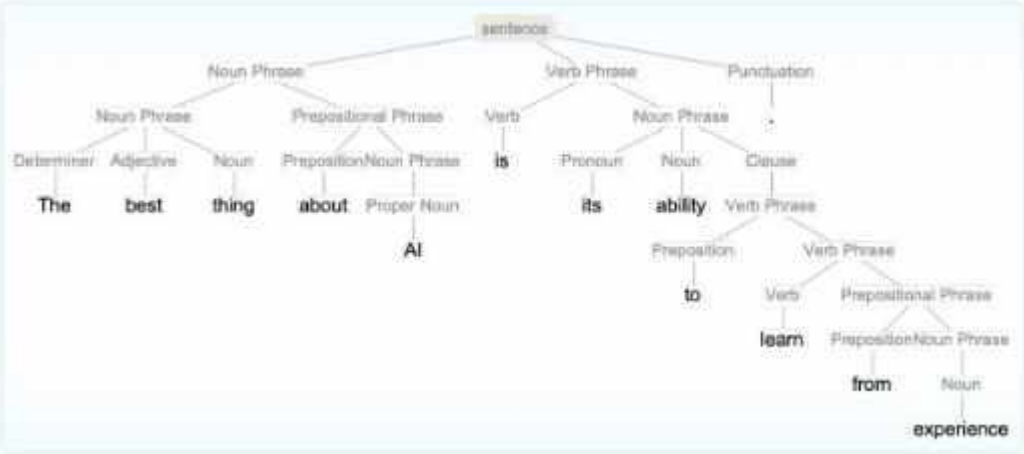
Basics & Background: How to Train a LLM[4]

- “Probabilities”
  - ‘tokens’
- “Temperature”
- Neural nets
  - ‘nodes’
  - ‘weights’
- Machine learning
- “Transformer”
  - Modularization
  - ‘Attention’

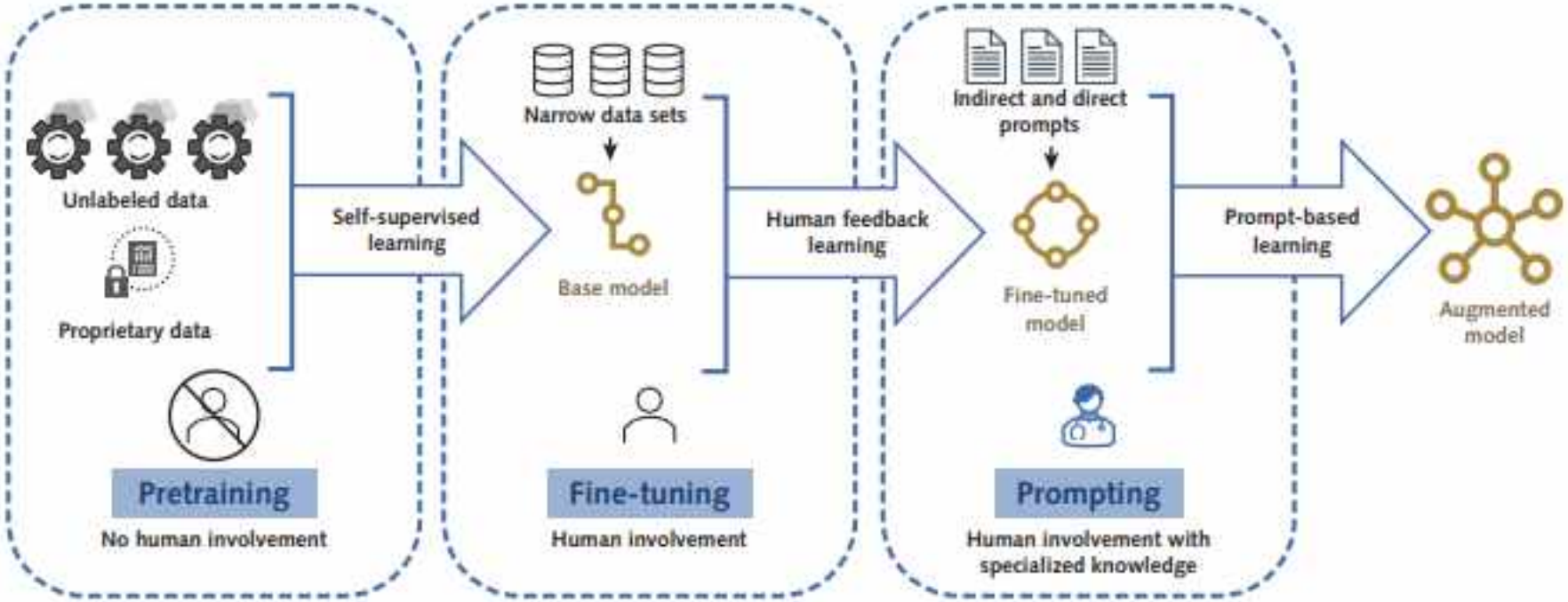
The best thing about AI is its ability to

learn	4.5%
predict	3.5%
make	3.2%
understand	3.1%
do	2.9%

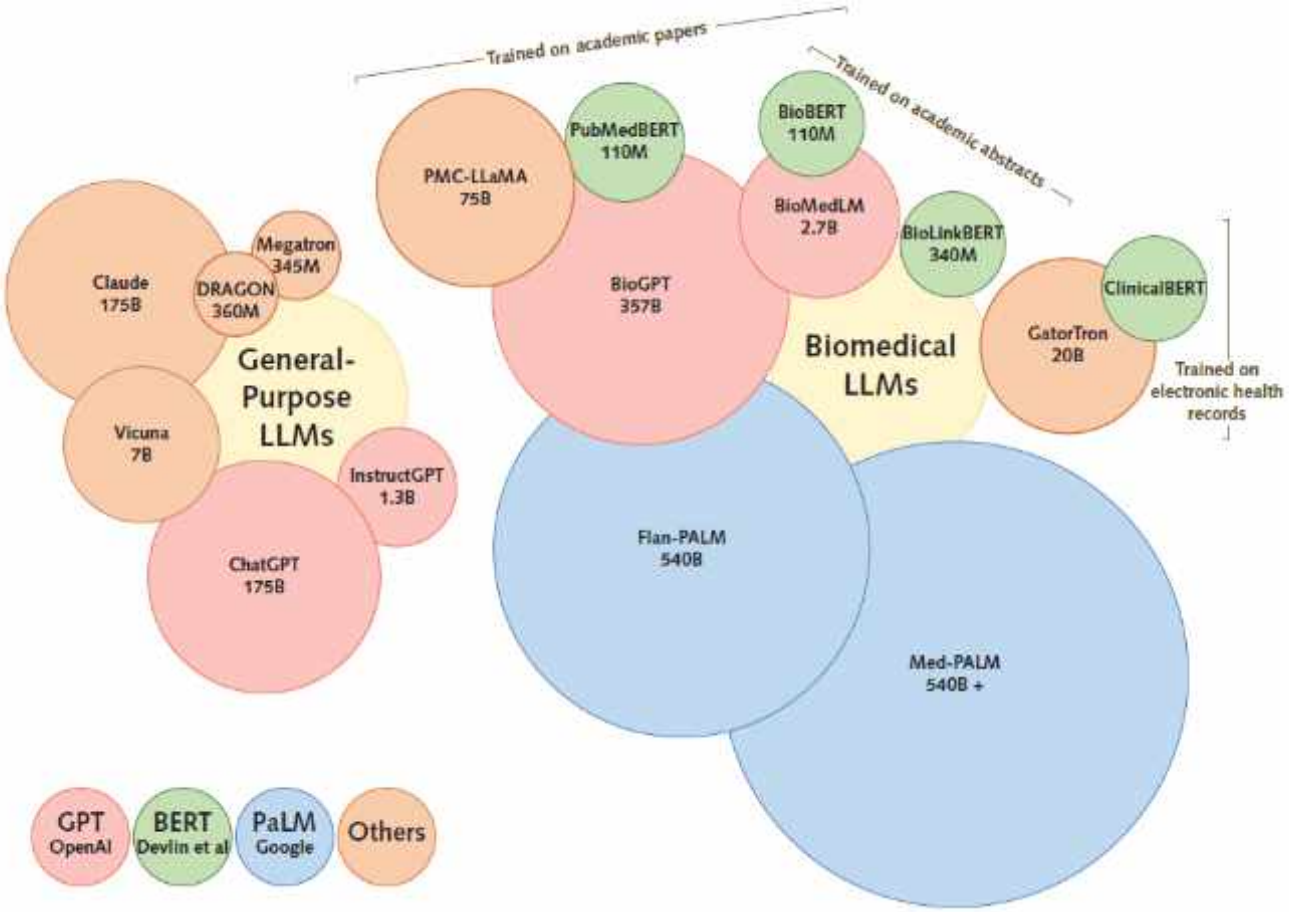




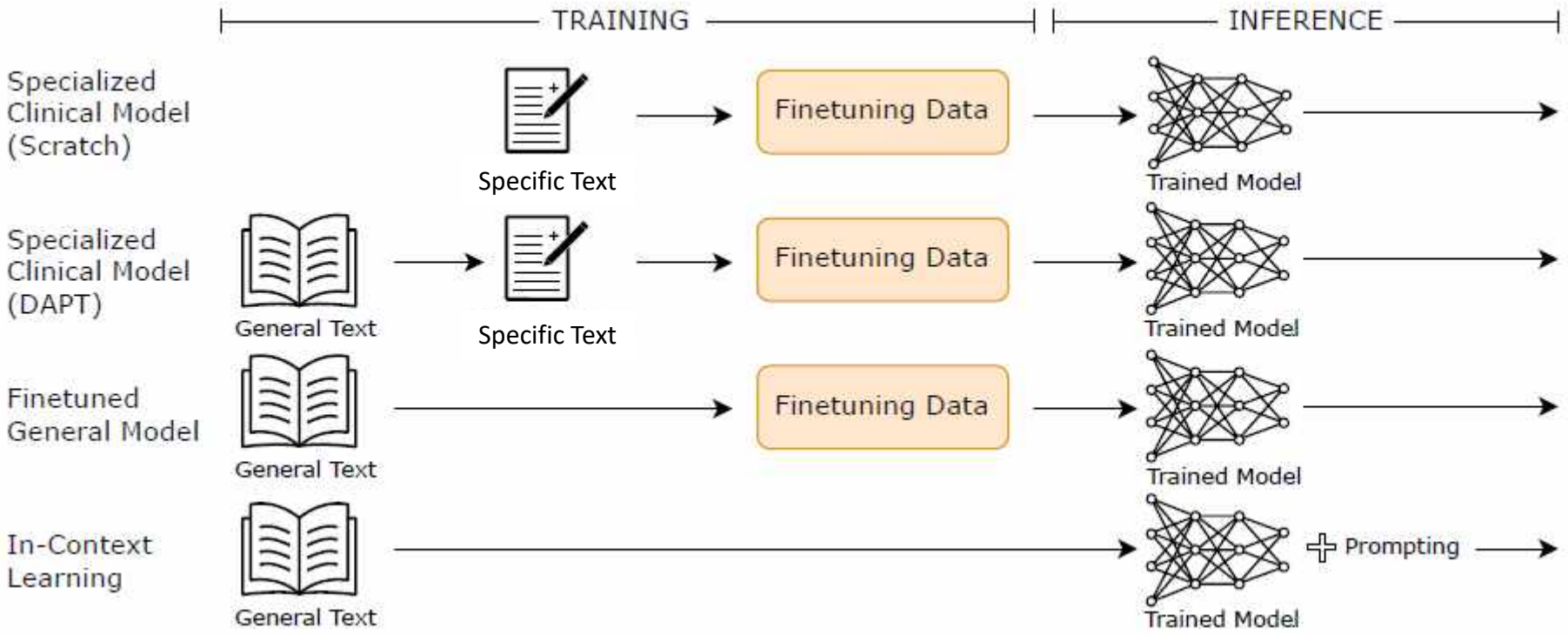
Basics & Background: How to Train a LLM[5]



Current Clinical Applications: LLMs in Medicine Today[5]



Current Clinical Applications: How to Apply an LLM[6]



Current Clinical Applications: LLMs in Medicine Today[5]

- **GPT-Lineage LLMs:**
  - Powerful, prevalent, most familiar
  - Trainable on specific data sets
- **PaLM-Lineage LLMs:**
  - Google-developed
  - Largest LLM by number of weights
  - Fine-tunable for clinical applications
- **Bi-directional Encoder (BERT):**
  - Non-generative; contextual word embedding model
  - Used in NLP applications

Current Clinical Applications: Capabilities of Chat-GPT/DALL·E

- **“Chat Generative Pre-Trained Transformer”**
- Developed by San Francisco based-Open AI on Microsoft Azure, Nvidia GPUs
- Free and Paid (Plus, about $20) tiers
- Features:
  - Can process code, pictures, files/PDFs (4)
  - Browses the internet (4)
  - API and Plug-In integration (4)
  - App store
  - iPhone app
  - Whisper

ChatGPT

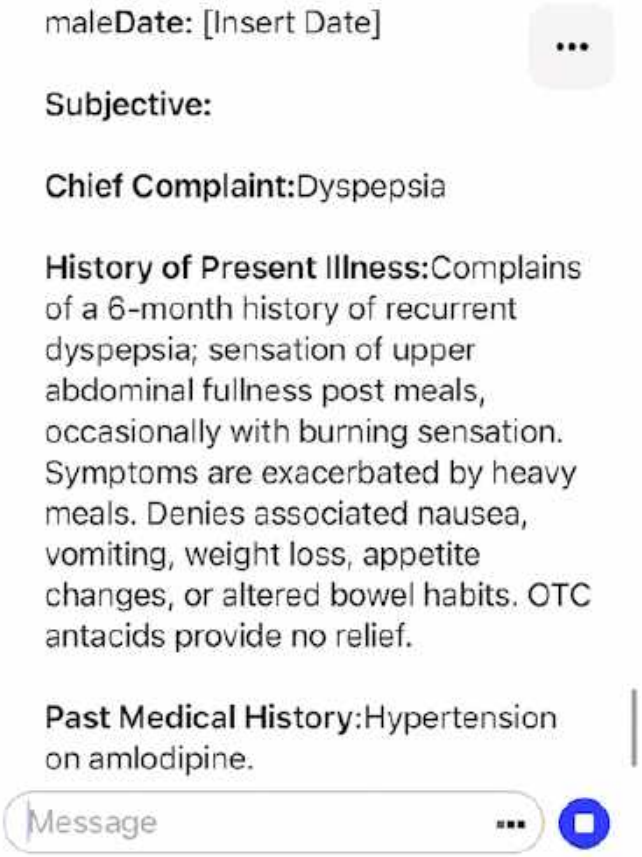
DALL·E 3

Current Clinical Applications: Use Cases

- **Practice Workflow:**
  - Medical Scribe
  - Diagnostic Assistant
  - Chart Reviewer
  - Point of Care Decision Resource
  - Creating patient resources
- **Administrative:**
  - Scanned medical record processing
  - Patient correspondence
  - Scheduling
  - Billing and Compliance
- **Medical Education:**
  - Question/Item Writing
  - Exam Analysis/Grading
  - Personal Tutor
  - Flashcard/material production
- **Research:**
  - Literature review
  - Document drafting
  - Data analysis

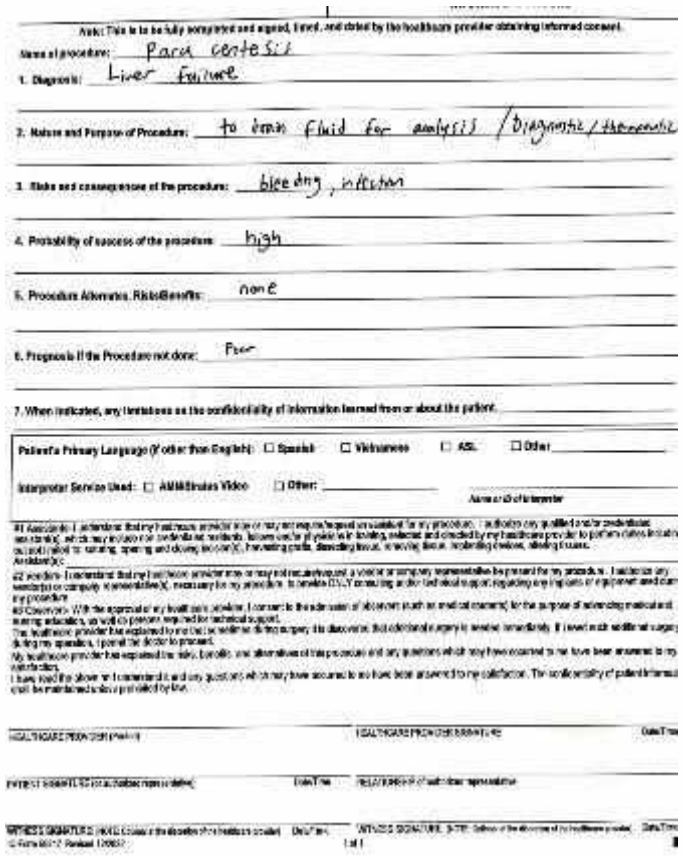
Selected Use Case: Medical Scribe

- Generative AI has the ability to both produce and analyze text through **natural language processing (NLP).**
- Trainable to your note writing style.
- When paired with an AI transcription tool (like Whisper), Chat GTP can become a fully autonomous medical scribe.
- With file upload, can reference prior medical records/notes.



Selected Use Case: Scanned Record Processing

- Can review PDF documents, Excel files, scanned images.
  - Upload directly or access via share link
- **Optical character recognition (OCR)**
- Analyze and document your handwritten or submitted questionnaires
- Simplifies medical record review and conversion of handwritten records



Note: This is to be fully completed and signed, dated, and dated by the healthcare provider obtaining informed consent.

Name of procedure: Para centesis

1. Diagnosis: Liver failure

2. Nature and Purpose of Procedure: to drain fluid for analysis / Diagnostic / therapeutic

3. Risks and consequences of the procedure: bleeding, infection

4. Probability of success of the procedure: high

5. Procedure Alternative, Risks/Benefits: none

6. Prognosis if the Procedure not done: Poor

7. When indicated, any limitations on the confidentiality of information learned from or about the patient:

Patient's Primary Language (if other than English): ☐ Spanish ☐ Vietnamese ☐ ASL ☐ Other

Interpreter Service Used: ☐ AMWBinaus Video ☐ Other:

Name of Interpreter

#1 Anesthesia: I understand that my healthcare provider or one or more physicians may be required as qualified for my procedure. I authorize any qualified and/or credentialed anesthesiologist, anesthetist, nurse anesthetist, or other qualified anesthesia personnel to perform such anesthesia as may be deemed necessary by my healthcare provider to perform such procedure, including but not limited to sedating, opening and closing veins or arteries, intubating, administering medicines, administering fluids, monitoring vitals, and other procedures.

Anesthesiologist

#2 Interpreter: I understand that my healthcare provider may not be able to speak or understand my language and may require the assistance of a translator or an interpreter to be present for my procedure. I authorize any translator or interpreter or company representative(s), necessary for my procedure, to translate (V.L.Y consulting and/or medical support regarding my rights of informed and consent for my procedure.

#3 Consent: With the approval of my healthcare provider, I consent to the audio use of videotape (such as medical cameras) for the purpose of advancing medical and nursing education, as well as personnel responsible for technical support.

The healthcare provider has explained to me that I may need to be sedated during surgery, the discovery that additional surgery is needed immediately. If I need such additional surgery during my operation, I permit the doctor to proceed.

My healthcare provider has explained the risks, benefits, and alternatives of the procedure and any questions which I may have concerned to me have been answered to my satisfaction.

I have read the above or I understand it and any questions which I may have concerned to me have been answered to my satisfaction. The confidentiality of patient information cannot be maintained unless provided by law.

HEALTHCARE PROVIDER (Print) | HEALTHCARE PROVIDER SIGNATURE | Date/Time

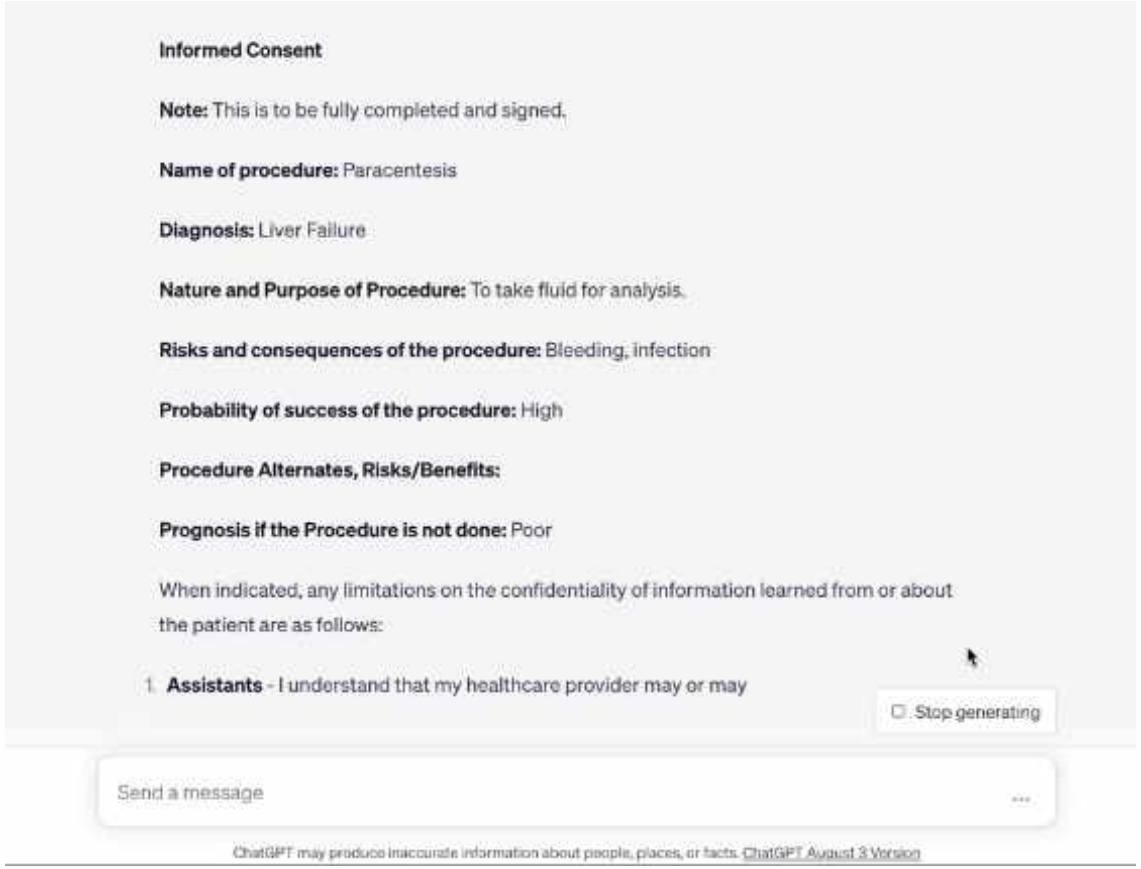
PATIENT SIGNATURE (Print) | Date/Time | RELATIONSHIP of authorized representative

WITNESS SIGNATURE (Print) Witness of the discussion of the healthcare provider | Date/Time | WITNESS SIGNATURE (Print) Witness of the discussion of the healthcare provider | Date/Time

© Form 6017-7 Revised 12/2003 | 1 of 1

Selected Use Case: Scanned Record Processing

- Can review PDF documents, Excel files, scanned images.
  - Upload directly or access via share link
- **Optical character recognition (OCR)**
- Analyze and document your handwritten or submitted questionnaires
- Simplifies medical record review and conversion of handwritten records



Informed Consent

Note: This is to be fully completed and signed.

Name of procedure: Paracentesis

Diagnosis: Liver Failure

Nature and Purpose of Procedure: To take fluid for analysis.

Risks and consequences of the procedure: Bleeding, infection

Probability of success of the procedure: High

Procedure Alternates, Risks/Benefits:

Prognosis if the Procedure is not done: Poor

When indicated, any limitations on the confidentiality of information learned from or about the patient are as follows:

1. **Assistants** - I understand that my healthcare provider may or may

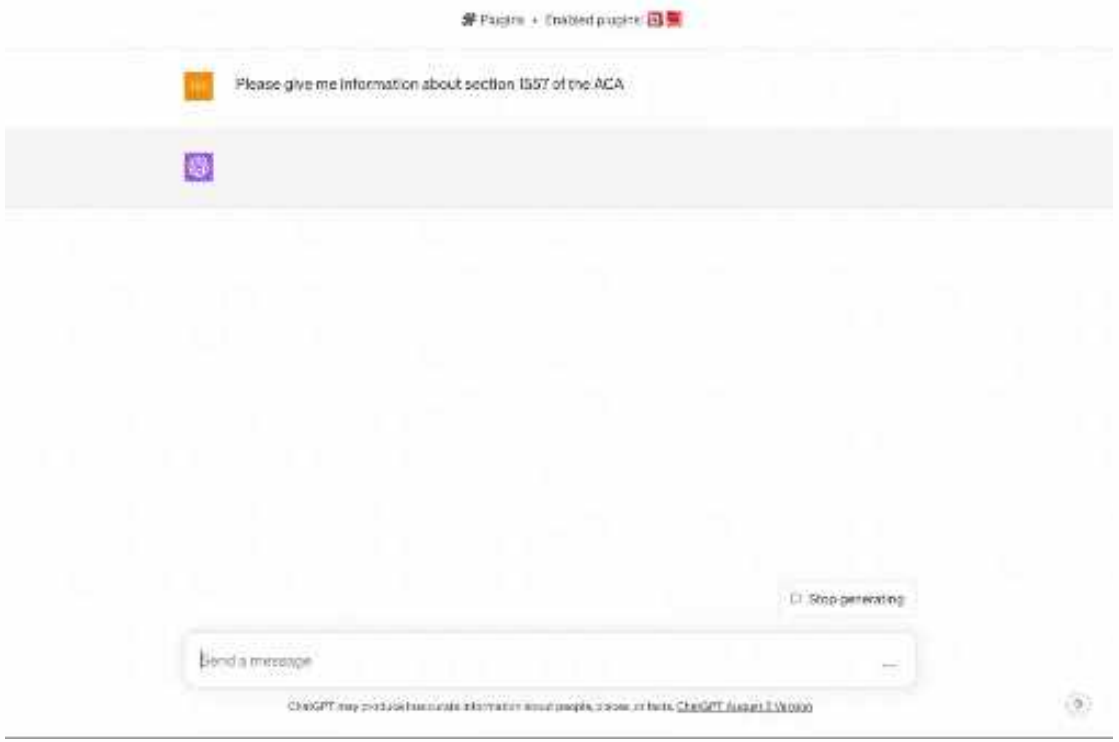
Stop generating

Send a message

ChatGPT may produce inaccurate information about people, places, or facts. ChatGPT August 3 Version

Selected Use Case: Research Assistant/Evidence Based Medicine

- With internet-enabled plug ins (Google Scholar/PubMed)
  - Reduced/eliminated hallucinations
  - Can produce, evaluate, categorize sources
- Scans for publicly available sources, governmental rules/regulations
- Can produce necessary guidelines and/or statutes for your research question.



Selected Use Case: Research Assistant/Evidence Based Medicine

OpenEvidence

TLDr API About Blog Ask OpenEvidence Login

When can you stop DAPT if a patient is having severe bleeding after PCI?

Showing answer for: When can you stop **dual antiplatelet therapy** if a patient is having severe bleeding after **percutaneous coronary intervention?**

In the context of severe bleeding after percutaneous coronary intervention (PCI), the decision to stop dual antiplatelet therapy (DAPT) must be individualized, balancing the risks of stent thrombosis against the risks of ongoing bleeding. The American College of Cardiology/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACC/AHA/SCAI) 2021 Guideline for Coronary Artery Revascularization suggests that a short duration of DAPT after PCI in patients with stable ischemic heart disease is reasonable to reduce the risk of bleeding events.[1-4] For patients at high bleeding risk, transitioning to P2Y12 inhibitor monotherapy and stopping aspirin after 1 to 3 months of DAPT may be considered.

The American College of Chest Physicians (ACCP) also provides guidance on perioperative management of antithrombotic therapy, suggesting that in patients with coronary stents placed within the last 6 to 12 weeks who are undergoing elective surgery, either continuation of both antiplatelet agents or stopping one antiplatelet agent within 7 to 10 days of surgery may be considered, depending on the bleeding risk associated with the surgery and the risk for acute coronary syndrome or coronary stent thrombosis if antiplatelet therapy is interrupted.[5-8]

References

1. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Circulation. 2022;145(3):e4-e17. doi:10.1161/CIR.0000000000001039.
   ☆ Top Journal
2. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Circulation. 2022;145(3):e18-e114. doi:10.1161/CIR.0000000000001038.
   ☆ Top Journal
3. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Journal of the American College of Cardiology. 2022;79(2):197-215. doi:10.1016/j.jacc.2021.09.005.
   ☆ Top Journal
4. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Show Details
   Lawton JS, Tamis-Holland JE, Bangalore S, et al.
   Journal of the American College of Cardiology. 2022;79(2):e21-e129. doi:10.1016/j.jacc.2021.09.006.
   ☆ Top Journal

Future and Potential Applications of AI:

- **Full Scope Medical Practice**
  - Diagnosis, management, and documentation at the level of a medical resident or mid-level.
- **Full Scope Personal Assistant**
  - Clinic manager, scheduler, human resources, biller/coder all rolled into one.
  - Correspond and triage patient messages.[7]
- **Pocket Curbside/Scalable Privilege**
  - Act with the aggregated expertise of tertiary level experts on demand.
  - Verified, vetted, standard of care.
  - Extends tertiary capabilities to under-served/rural areas.
- **Remote Patient Monitoring**
  - Manage certain patients to an inpatient standard in an outpatient or home setting.
- **Live Video Analysis**
  - Current gen AI are capable of watching and understanding video footage.[8]
  - Possibility of standardized real-time assessment.

Big Issues: Accuracy and Reliability

- “Hallucinations”
  - Error rate of producing real research citations when prompted = 20.6% for GPT-4 [9]
  - Examples of bad outcomes from false information in other disciplines [10]

Big Issues: Accuracy and Reliability

DO

Give me a hyperlink to the second source

Sure! Here's the hyperlink to the second source in PubMed Central:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249176/

Big Issues: Accuracy and Reliability

Cover photograph (Copyright © 2014, American Society for Microbiology. All Rights Reserved.) *Apis mellifera* nurse workers sealing a brood frame within a colony located in Austin, TX. The related article describes the mechanisms through which newly emerged worker bees acquire their core microbiota and the colonization patterns of these microbes in the bee gut. (See related article on page 7210.)

Appl Environ Microbiol. 2014 Dec; 80(23): Cover

Big Issues: Accuracy and Reliability

- Clinical Reasoning[11]
  - 39% accuracy in correctly diagnosing “challenging” cases
  - 64% accuracy in identifying correct diagnosis in the differential
- Source of data
  - Inability to control or even know the information general models were trained on
  - Unregulated, unverified information
- “WebMD” effect
  - Chatbot is NOT a doctor

Big Issues: Regulatory & Policy Challenges[12]

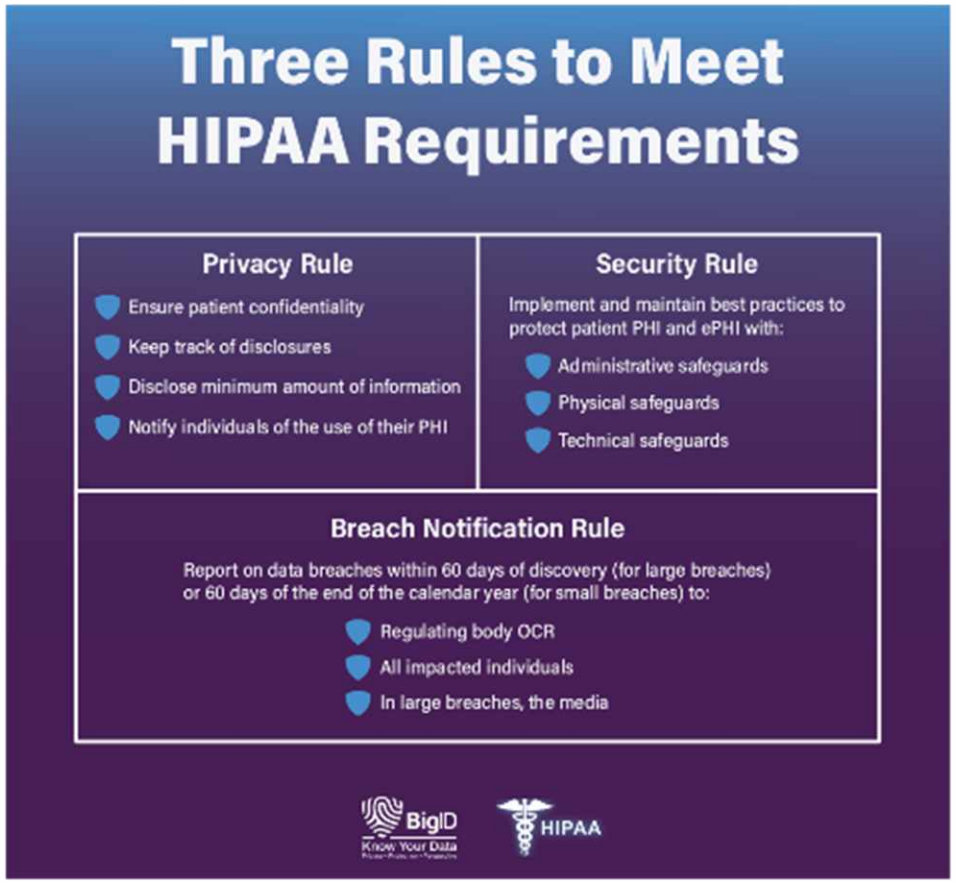
- Few regulations for LLM AI in clinical use
  - Jurisdiction is unclear (FDA? CMS? FTC? FCC?)
- AI developers largely (currently) unregulated at any level
  - Tendency away from oversight in A.I. community
  - “Regulation stifles innovation” mindset
- “Code of Conduct” enforceability
  - Not clear proposed A.I. expert guidance “has teeth”

Big Issues: Regulatory & Policy Challenges

- **Biden's Executive Order 14110** (Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence)
  - First nationwide AI policy with force of law.
  - Focuses on safety, privacy, data security, and reducing AI biases/civil rights
  - Directs HHS to establish a "safety program" to remedy harms of unsafe healthcare practices
- Food and Drug Administration (FDA) policy
  - **Section 520(o)(1)I(i)** of the Federal Food, Drug, and Cosmetic Act (FD&C Act)
  - Nonbinding recommendations for classifying clinical decision support (CDS) software as medical devices
  - Currently consider a CDS to be a "medical device" when it captures and processes images
- **EU AI Act**
  - Tiered "Risk System"
  - Possible model for future AI policy
  - European

Big Issues: HIPAA, Privacy, Data Security[13]

- HIPAA compliance?
  - Limits use of PII/PHI
- Privacy concerns
  - Data leaks
  - Developer access
- Server/Data Security
  - Limits CUI, government use



Big Issues: Malpractice Liability[14,15]

- Physicians (currently) 100% liable for bad outcomes
  - (**ACA Section 1557 §92.210**)
- Likely will be treated as 3rd party medical guidance
- "Learned Intermediary" Doctrine
  - Theoretical; Never litigated
  - No standard for "standard of care"
  - Developers and database curators currently not liable

Big Issues: Racism, Bias, Social Justice[16,17]

- Non-representative data set = non-representative output.
- Potential to reflect and amplify existing biases in healthcare.
- Performance variations may lead to misdiagnosis or inappropriate care for under-represented groups.

Call to Action:

- Osteopathic Medicine is the **most well-positioned profession in the world** to guide the development of AI in healthcare.
- Failure to contribute = **loss of input**
- This is our opportunity to **define, characterize,** and **protect** what is distinctly osteopathic when applying clinical AI and LLMs for **medical practice, education, examination,** and **research.**

The Future of AI is Osteopathic.

References:

1. Anyoha, Rockwell. The History of Artificial Intelligence, Harvard University. https://sitn.hms.harvard.edu/flash/2017/history-artificial-intelligence/
2. Elyoseph Z, Hadar-Shoval D, Asraf K, Lvovsky M. ChatGPT outperforms humans in emotional awareness evaluations. Front Psychol. 2023 May 26;14:1199058. doi: 10.3389/fpsyg.2023.1199058. PMID: 37303897; PMCID: PMC10254409.
3. Cutler DM. What Artificial Intelligence Means for Health Care. JAMA Health Forum. 2023;4(7):e232652. doi:10.1001/jamahealthforum.2023.2652
4. Wolfram, S. (2023) "What Is ChatGPT Doing…and Why Does It Work?", Book, Available at https://writings.stephenwolfram.com/2023/02/what-is-chatgpt-doing-and-why-does-it-work/
5. Jesutofunmi A. Omiye, Haiwen Gui, Shawheen J. Rezaei, et al. Large Language Models in Medicine: The Potentials and Pitfalls: A Narrative Review. Ann Intern Med. [Epub 30 January 2024]. doi:10.7326/M23-2772
6. Lehman E, Hernandez E, Mahajan D, et al. Do We Still Need Clinical Language Models? arXiv.org. doi:https://doi.org/10.48550/arXiv.2302.08091
7. Ayers JW, Poliak A, Dredze M, et al. Comparing Physician and Artificial Intelligence Chatbot Responses to Patient Questions Posted to a Public Social Media Forum. JAMA Intern Med. 2023;183(6):589–596. doi:10.1001/jamainternmed.2023.1838
8. NEC's generative AI video recognition solution. Accessed at: https://www.nec.com/en/press/202312/global_20231205_01.html 2/9/24
9. Chen A, Chen DO. Accuracy of Chatbots in Citing Journal Articles. JAMA Netw Open. 2023;6(8):e2327647. doi:10.1001/jamanetworkopen.2023.27647
10. Lawyers Cited for Bogus Case Law https://apnews.com/article/artificial-intelligence-chatgpt-courts-e15023d7e6fdf4f099aa122437dbb59b
11. Kanjee Z, Crowe B, Rodman A. Accuracy of a Generative Artificial Intelligence Model in a Complex Diagnostic Challenge. JAMA. 2023;330(1):78–80. doi:10.1001/jama.2023.8288
12. Minssen T, Vayena E, Cohen IG. The Challenges for Regulating Medical Use of ChatGPT and Other Large Language Models. JAMA. 2023;330(4):315–316. doi:10.1001/jama.2023.9651
13. Marks M, Haupt CE. AI Chatbots, Health Privacy, and Challenges to HIPAA Compliance. JAMA. 2023;330(4):309–310. doi:10.1001/jama.2023.9458
14. Price WN, Gerke S, Cohen IG. Potential Liability for Physicians Using Artificial Intelligence. JAMA. 2019;322(18):1765–1766. doi:10.1001/jama.2019.15064
15. Shumway, David O. and Hartman, Hayes J.. "Medical malpractice liability in large language model artificial intelligence: legal review and policy recommendations" Journal of Osteopathic Medicine, 2024. https://doi.org/10.1515/jom-2023-0229
16. Thomasian NM, Eickhoff C, Adashi EY. Advancing health equity with artificial intelligence. J Public Health Policy. 2021;42(4):602-611. doi:10.1057/s41271-021-00319-5
17. Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Dissecting racial bias in an algorithm used to manage the health of populations. Science. 2019;366(6464):447-453. doi:10.1126/science.aax2342

Open Discussion

AMERICAN OSTEOPATHIC ASSOCIATION

Thank You

AMERICAN
OSTEOPATHIC
ASSOCIATION

Closing Remarks / Adjournment

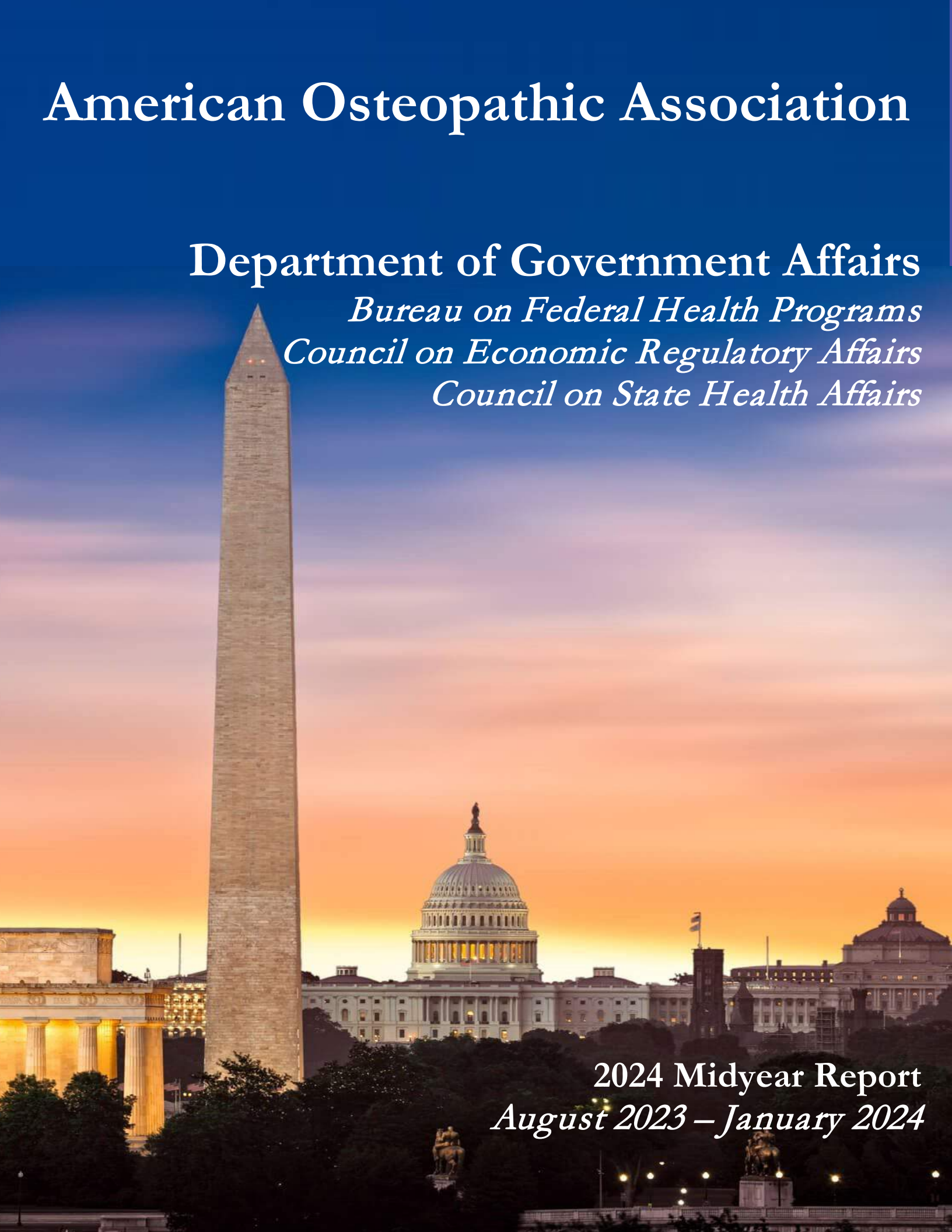
Ira P. Monka, DO, FACOFP, President

AMERICAN OSTEOPATHIC ASSOCIATION

American Osteopathic Association

Department of Government Affairs

Bureau on Federal Health Programs
Council on Economic Regulatory Affairs
Council on State Health Affairs



2024 Midyear Report
August 2023 – January 2024

Table of Contents

Federal Priorities – 118th Congress 6
State Priorities – 118th Congress 7

Advocacy Report 8

Supporting Physicians and Their Ability to Care for Patients

AOA Supports – *Saving Access to Laboratory Services Act (SALSA)* 10
This legislation would provide critical updates to Medicare's payment system for laboratory services and prevent a 15% payment cut to laboratory services scheduled to take effect January 1, 2024.

AOA Responds – Ways and Means Committee Request for Information (RFI) 11
AOA comment focused on issues impacting the rural health care landscape: geographic payment differences, sustainable provider financing, aligning sites of service, implementing innovative models, and improving the healthcare workforce.

AOA and Regulatory Relief Coalition (RRC) Responds – House Budget Committee Health Care Task Force RFI: *Actions Congress Could Take to Improve Health Care Outcomes* 15
Comments focused on the urgency of passing the *Improving Seniors' Timely Access to Care Act* and reducing the costs and burden associated with prior authorization.

AOA and 40 Affiliates Support – *Preserving Seniors' Access to Physicians Act* 22
The legislation would prevent payment cuts to the Medicare Physician Fee Schedule (MPFS).

AOA and 40 Affiliates Urge Congress to Reverse Physician Payment Cuts 24
The letter to Leaders Schumer and McConnell, Speaker Johnson, and Leader Jeffries urged Congress to pass legislation to reverse the 3.37% Medicare physician payment cuts that went into effect on January 1, 2024.

Strengthening the Physician Workforce Where it is Needed Most

AOA and MOS (MA) Oppose – *An Act Improving Healthcare Delivery for Underserved Residents of the Commonwealth* 26
The legislation would create a new, unproven pathway to licensure for international medical graduates (IMGs) licensed in "any country," disregarding established licensure requirements for IMGs that are in place to protect patient safety.

AOA Supports – *Lower Costs, More Transparency Act* 29
The legislation, among other things, includes funding for a 7-year reauthorization of the Teaching Health Center Graduate Medical Education (THCGME) program along with an increased in funding to help provide stability in training and grow the number of medical residents/programs.

AOA and G5 Support – Strengthening and Diversifying the Physician Workforce 30
The AOA, AAFP, AAP, ACOG, ACP, and APA (G6) endorsed enactment of: *Conrad State 30 and Physician Access Reauthorization Act*; *Doctors of Community Act*; *Resident Physician Shortage Reduction Act*; *Mental Health Professional Workforce Shortage Loan Repayment Act*; *Resident Education Deferred Interest (REDI) Act*; and the *Rural Physician Workforce Production Act*.

G6 Op-Ed – STAT News: *Policymakers Must Take Action on the Physician Shortage* 33
The G6 article highlighted the current landscape of the health care workforce and the challenges it brings and offered potential solutions.

AOA and AOCA (Anesthesiology) Support – *Protect Lifesaving Anesthesia Care for Veterans* ….. 37

The legislation would ensure physician anesthesiologists are appropriately involved in the provision of anesthesia care to our veterans and prohibits the Secretary of the Department of Veterans Affairs (VA) from replacing physician anesthesiologists with nurse anesthetists.

AOA and AKOMA (AK) Support – *Resident Education Deferred Interest (REDI) Act* …….. 39

Thank you letter to Senator Lisa Murkowski for cosponsoring the legislation.

AOA and MOMS (MN) Support – *Resident Education Deferred Interest (REDI) Act* …… 40

Thank you letter to Representative Angie Craig for cosponsoring the legislation.

AOA Statement for the Record – Senate Finance Committee Hearing: Legislation to Expand the Mental Health Care Workforce and Services, Reduce Prescription Drug Costs, and Extend Certain Expiring Provision under Medicare and Medicaid …… 41

AOA statement focused on support for the *Strengthening Medicare for Patients and Providers Act*, the inclusion of budget neutrality waivers for Behavioral Health Integration codes, and support for the *Provider Reimbursement Stability Act*.

AOA and WOMA (WA) Oppose – *An Act Increasing the Scope of Practice of Naturopathic Physicians & Sunrise Review* ……..…… 45

The legislation & related sunrise review would reauthorize and expand the scope of practice of naturopaths to allow them to prescribe Schedule II drugs.

AOA and WOMA (WA) Oppose – *An Act Authorizing the Prescriptive Authority of Psychologists* . 47

The legislation would expand the scope of practice of psychologists to allow them to prescribe Schedule II drugs.

AOA and AOAAM Support – *Substance Use Disorder Workforce Act* …… 50

The legislation would add an additional 1,000 Medicare GME supported residency positions in addiction medicine, addiction psychiatry, or pain medicine over five years.

Access and Affordability

AOA Supports – *Primary Care Enhancement Act* …… 52

The legislation would allow individuals to use their Health Savings Accounts to pay for medical services furnished under a Direct Primary Care model.

AOA Statement for the Record – Subcommittee on Health of the Committee on Energy and Commerce Hearing: Examining Medicare Proposals to Improve Patient Access to Care and Minimize Red Tape for Doctors …… 53

AOA statement focused on patient access to care issues such as preventing the 15% laboratory services payment cut and reforming prior authorization; independent practice sustainability issues such as addressing practice consolidation, comprehensive reform of the Quality Payment Program to support value-based payment for all practice settings, the reauthorization of the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program, extending the 1.0 work GPCI floor, and adjustments to the Medicare Physician Fee Schedule; and workforce issues such as student loan reform, and increasing Medicare residency slots.

AOA Supports – *Chronic Disease Flexible Coverage Act* …….…… 58

The legislation would support care affordability for patients managing chronic conditions by allowing health savings account (HSA)-eligible high deductible health plans (HDHPs) to cover low-cost preventive care and services that manage chronic conditions on a pre-deductible basis.

Regulatory Reform

AOA Comments – Federal Trade Commission 59

Health Breach Notification Proposed Rule – The AOA commented in support of FTC's proposal to ensure patient data, housed in platforms that are not subject to HIPAA, is protected from unauthorized disclosures.

AOA Comments – Centers for Medicare & Medicaid Services 63

CY2024 Medicare Physician Fee Schedule (MPFS) Proposed Rule – The AOA submitted detailed comments on the CY2024 physician fee schedule addressing changes related to payment rates for existing services, creation of newly billable codes, and changes to requirements under the Quality Payment Program.

AOA Comments – U.S. Department of Veterans Affairs 75

Supremacy Project Listening Session – The AOA submitted comments opposing the development of national standards of practice for CRNAs, PAs, and optometrists that would circumvent state licensure laws to expand scope of practice for these clinicians in VA facilities.

AOA and G5 Comments – Department of Homeland Security 79

G6 submitted comments regarding the proposed rule to modify the H1-B visa program.

AOA Comments – Centers for Medicare & Medicaid Services 82

CY25 MA and Part D Proposed Rule – The AOA commented in support of changes that would strengthen oversight of plan prior authorization practices, supported changes to strengthen network adequacy requirements for behavioral health services, and opposed provisions for certain formulary substitutions of biosimilar products.

AOA Comments – National Committee on Vital Health Statistics (NCVHS) 89

International Classification of Disease (ICD) – 11 Request for Information – The AOA urged the NCVHS to work with the relevant federal agencies to ensure ICD-11 has sufficient granularity to document somatic dysfunction when implemented in the US. The ICD-11, as published by the World Health Organization, collapses the current somatic dysfunction codes to a single code. AOA also addressed the needs of small and independent practices to ensure a smooth transition to ICD-11.

AOA Leadership – White House Domestic Policy Council

AOA leadership met with President Biden's Administration to make recommendations on key issues, including promoting access to quality care, ensuring physician wellness, and supporting workplace safety.

Public Health

AOA and DSOMS (DE) Support – *Dillon's Law* 93

Thank you letter to Representative Lisa Blunt Rochester for cosponsoring the legislation.

AOA and ACOP Support – *Access to Donor Milk Act* 94

The legislation would allow states to use WIC funding to promote viability and access to donor milk programs, and funding for emergency capacity to mitigate shortages during a major disaster.

AOA Supports – *Hospitals as Naloxone Distribution Sites (HANDS) Act* 95

The legislation would support hospital-based dispensing of naloxone with no cost sharing.

Public Policy Publication

CY2024 MPFS and Quality Payment Program Final Rule – Initial Summary …… 97

CY2024 MPFS and Quality Payment Program Final Rule – Key Takeaways …… 99

AOA and AOAAM Partner on Addiction Medicine Policy Webinar

AOA joined AOAAM at OMED to present on regulatory changes that will impact the practice of addiction medicine in 2023 and discussed current legislative proposals.

Nominations/Appointments

National Committee on Foreign Medical Accreditation – Brian Kessler, DO, FACOFP

AOA nominee and current Commission on Osteopathic College Accreditation commissioner, Brian Kessler, DO, was appointed to the Department of Education's NCFMEA in October. The NCFMEA is charged with assessing the quality of foreign medical education accreditation bodies, to ensure that they adhere to similarly high standards to the COCA and the US Liaison Committee on Medical Education.

Current Procedural Terminology Editorial Panel – J. Mark Bailey, DO, Ph D

AOA nominee and current AOA Advisor to the CPT Editorial Panel, J. Mark Bailey, DO, was appointed by the AMA to the CPT Editorial Panel with his term beginning in February 2024. The CPT Editorial Panel is charged with maintaining the current procedural terminology code set and is responsible for revising, updating, and modifying CPT codes, descriptors, rules, and guidelines.

Council on Graduate Medical Education – Martin Levine, DO, MPH

The AOA nominated Martin Levine, DO, to serve on the Health Resources and Services Administration's Council on Graduate Medical Education (COGME). The COGME provides advice and recommendations to the Secretary of the Department of Health and Human Services (Secretary), the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Energy and Commerce on matters concerning policy, program development, and other matters of significance related to physician training and workforce development.

2024 FEDERAL PRIORITIES

AMERICAN OSTEOPATHIC ASSOCIATION

SUPPORTING PHYSICIANS AND THEIR ABILITY TO CARE FOR PATIENTS

Support enactment of legislation and regulatory reforms that promote physician wellness and safety in workplaces.

Support enactment of legislation that strengthens the financial stability of independent physician practices.

Support enactment of legislation and regulatory reforms that promote osteopathic manipulative treatment (OMT).

STRENGTHENING THE PHYSICIAN WORKFORCE WHERE IT IS NEEDED MOST

Support enactment of legislation that increases the physician workforce; and provides an equitable distribution of graduate medical education resources to practice types and communities where it is needed most.

Support enactment of legislation that reforms student loan repayment programs.

Educate Congress on the importance of physician-led care in all communities, and how programs that improve physician shortages in underserved rural and urban communities are better for patients, and more effective and efficient than scope of practice expansion.

ACCESS AND AFFORDABILITY

Support enactment of legislation that alleviates arbitrary burdens in step therapy and prior authorization to improve patients' access to prescription drugs and physician services.

Support legislative and regulatory reforms that ensure continued and improved coverage and payment for telehealth services.

Support enactment of legislation and regulatory reform that expands access to medical services and prescription drugs that treat and manage chronic conditions.

REGULATORY REFORM

Support policies that address systemic issues and improve payment adequacy for medical services, reduce administrative burdens, eliminate barriers to coverage and care, and strengthen the patient-physician relationship.

Support value-based arrangements that provide adequate payment and greater flexibility in service delivery.

Support health information technology (HIT) policies that reduce physician burden through greater interoperability and make care delivery more efficient and seamless across the healthcare spectrum.

PUBLIC HEALTH

Promote policies that reduce health disparities across ethnic, racial, geographic, socioeconomic, and other underserved populations.

Support policies that increase utilization of evidence-based vaccine guidelines, address vaccine hesitancy, expand patient and physician education, and ensure adequate payment for vaccine administration.

FEDERAL FUNDING

Support funding that enhances research opportunities for osteopathic physician-researchers and osteopathic institutions.

Support funding that advances an infrastructure that promotes the provision of primary care to advance health and wellness for patients.

Support funding for the Centers for Disease Control and Prevention and National Institutes of Health for research on reducing firearm violence.

511 2nd Street, NE, Washington, DC 20002 • 202.349.8750 • osteopathic.org

2024 STATE PRIORITIES

AMERICAN OSTEOPATHIC ASSOCIATION

SCOPE OF PRACTICE & NEW LICENSURE TYPES

Support the physician-led, team-based model of care and uniform, evidence-based licensure pathways for all clinicians based upon scope of practice.

OSTEOPATHIC EQUIVALENCY AND RECOGNITION

Ensure that the osteopathic profession and credentials are recognized as equivalent to their allopathic counterparts. Educate legislators about current osteopathic terminology, and the distinctive philosophy and practice of osteopathic medicine. Support DO licensure and regulation by osteopathic medical boards in dual board states.

TRUTH IN ADVERTISING

Support legislation that requires all health care providers to affirmatively communicate their degrees and licensure types to patients, restricts "-ologist" titles to physicians, and requires entities offering physician board certification to possess legitimate training and testing requirements.

PUBLIC HEALTH

Work to increase public awareness and implement evidence-based recommendations and best practices related to public health issues. Support funding to strengthen our public health care infrastructure and workforce, address health care disparities and social determinants of health, and establish a robust national strategy to combat future public health emergencies.

PHYSICIAN WORKFORCE

Support legislation that expands the physician workforce by increasing funding for graduate medical education, especially in high-need specialties and locations, and expanding financial incentives to facilitate care for the underserved.

TELEMEDICINE

Support the delivery of appropriate health care services, including the prescription of controlled substances, through telemedicine and other communications-based technologies. Advocate for coverage and payment parity between these services and similar services delivered in-person.

PRESCRIPTION DRUG MISUSE, ABUSE AND DIVERSION

Support evidence-based approaches that balance the need to curb prescription drug misuse with ensuring access to appropriate, timely health care. Support legislation that promotes non-pharmacological pain management modalities, such as osteopathic manipulative treatment.

ACCESS AND AFFORDABILITY

Support access to timely, affordable, high-quality care for all patients. This includes:

- Supporting network adequacy and transparency standards for insurers.
- Supporting stabilization of state health insurance exchanges and expanding Medicaid.
- Supporting access to affordable prescription drugs, including by regulating Pharmacy Benefit Managers.
- Supporting the removal of arbitrary burdens in step therapy and prior authorization.
- Supporting physician self-regulation by protecting the authority and autonomy of state medical boards, and opposing legislation that interferes with professional self-regulation, the physician-patient relationship, or physicians' ability to provide evidence-based information and care to their patients.

INTERSTATE MEDICAL LICENSURE COMPACT

Support enactment of the Compact, which enhances physician license portability and increases patient access to care.

511 2nd Street, NE, Washington, DC 20002 • 202.349.8750 • osteopathic.org

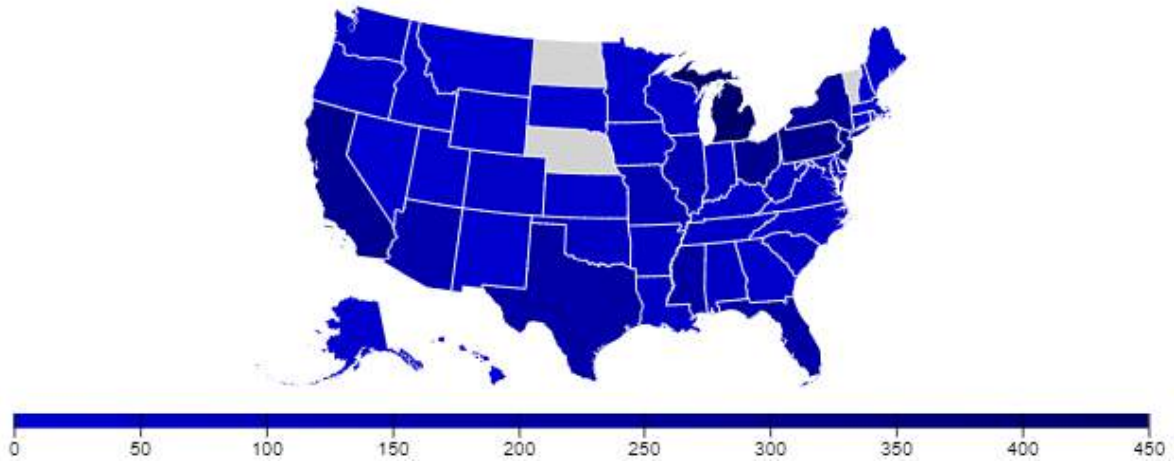
ADVOCACY REPORT
AUGUST 2023 – JANUARY 2024

FEDERAL ADVOCACY INITIATIVES AND ENGAGEMENT

From August 1, 2023, to January 31, 2024, AOA advocates sent 3,264 unique advocacy actions (email, social media posts, video, and stories) to their members of Congress. Below are the ongoing AOA advocacy campaigns, along with a heatmap depicting engagement from each state.

- Preserving Seniors' Access to Physicians Act (H.R. 6683)
  - Collaborative effort with Congressman Greg Murphy, MD (R-NC-3) for floor time discussion (Video)
  - AOA and 40 Affiliates Urge Congress to Stop the Cut to Medicare Physician Payment (Article & Letter)
- AOA Leadership Met with the U.S. Administration to Discuss Issues that Impact the Osteopathic Profession
- National Physician Practice Expense Survey Participation
- Advancing Safe Medications for Moms and Babies Act of 2023 (H.R. 1117)
  - Collaborative article in The DO by Alexis Cates, DO
- Teaching Health Center Graduate Medical Education (THCGME) Reauthorization
- Resident Education Deferred Interest Act (REDI Act - H.R. 1202/S. 704)
- Dillon's Law (H.R. 3910)
- Tell Your Story: Prior Authorization Requirements
- Strengthening Medicare for Patients and Provide (H.R. 2474)
  - Collaborative article in The DO about physician payment
  - October Advocacy by Alexis Cates, DO
- Ira P. Monka, DO, Calls on Physicians to Protect Patient Access to Care
- August Recess Outreach Campaign – Direct Constituent Engagement

FEDERAL ADVOCACY HEATMAP



The Department of Public Policy continues to increase the visibility of our work to support our members by including information about the department's activities on the AOA homepage. Our work can be found here, under the public policy filter. The summary of the physician fee schedule email had our highest open and click-through rate. The email had a 40% open rate (more than 26,500 individuals) with a 26% click-through rate (more than 17,000 individuals). To put this in perspective, our second-highest click-through rate for a mass email was 5.84% (more than 3,700 individuals).

Congress continues to recognize AOA's public policy efforts on physician payment.

- Subcommittee on Health of the Committee Energy and Commerce
  - Video of hearing where AOA is recognized
- Patient Access and Red Tape Burdens Hearing
  - Video of hearing where AOA is recognized

The AOA Department of Public Policy also continues to keep members engaged in advocacy through the growing Osteopathic Advocacy Network (OAN). The first Wednesday of each month, the AOA hosts virtual public policy roundtables with members of the OAN to discuss the latest Congressional and state activity and how to be engaged.

DO DAY ON CAPITOL HILL

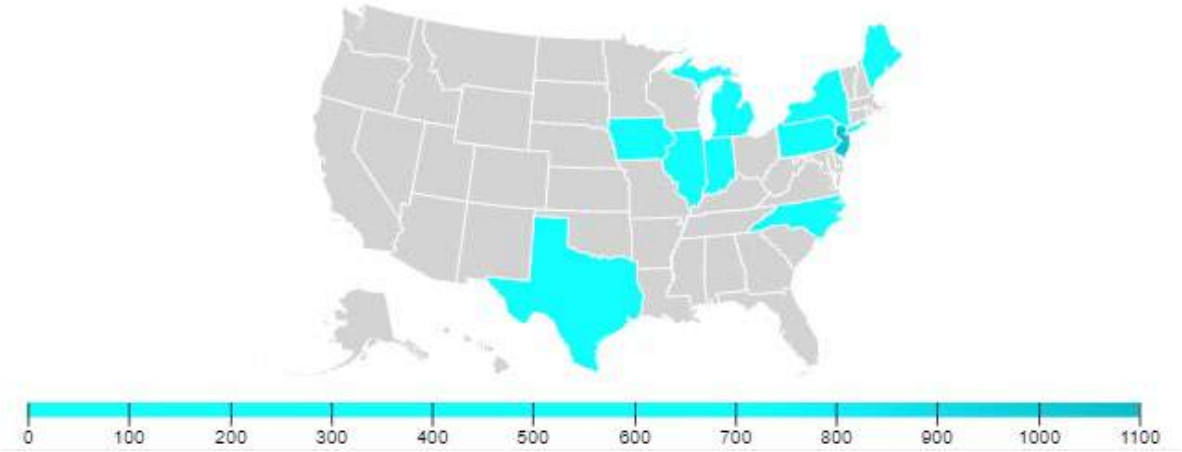
- To help capture the pulse of the osteopathic profession, for the first time, the AOA launched a call for speakers and presentations campaign. More information can be found here.
- The AOA solicited nominations for several awards designed to recognize excellence in public policy and professional advocacy on behalf of the osteopathic profession. More information can be found here.
- The Bureau of Emerging Leaders DO Day Scholarship, which provides opportunities for osteopathic residents, fellows, and new physicians in practice to attend DO Day on Capitol Hill. More information can be found here.
- Affiliate sponsorship for DO Day has been reviewed by the AOA board. The proposal can be found here.

STATE ADVOCACY INITIATIVES AND ENGAGEMENT

From August 1, 2023, to January 31, 2024, AOA advocates sent 1,559 unique advocacy actions (email, social media posts, video, and stories) to their state lawmakers. Below are the campaigns:

- Virginia: Scope of Practice Expansion (S.B. 351)
- Washington: Scope of Practice Expansion (H.B. 1041)
- Arizona: Supporting Truth in Advertising in Healthcare
- Maine: Medical Liability (LD 549)
- New York: Malpractice Legislation (A. 6698/S 6636)
- Texas: Consolidation Legislation (HB 2414)
- New Jersey: Scope of Practice (A 2286/S 1522)

STATE ADVOCACY HEATMAP



STRETEGIC PARTNERSHIPS

The Department of Public Policy has also attended numerous osteopathic affiliate meetings and collaborated by providing advocacy, political, and legislative updates, and custom advocacy materials. Such partnerships include:

- Montana Osteopathic Medical Association
- Oklahoma Osteopathic Association and the Osteopathic Founders Foundation
- Student Osteopathic Medical Association
- Omega Beta Iota
- Delaware State Osteopathic Medical Association
- Iowa Osteopathic Medical Association
- Maine Osteopathic Association
- Indiana Osteopathic Association
- Illinois Osteopathic Medical Society

The Department of Public Policy has also provided many osteopathic affiliates their own advocacy action center for their website at no cost to further promote advocacy engagement to their members.

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

September 5, 2023

The Honorable Chuck Schumer
United States Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Mitch McConnell
United States Senate
317 Russell Senate Office Building
Washington, DC 20510

The Honorable Kevin McCarthy
United States House of Representatives
2468 Rayburn House Office Building
Washington, DC 20515

The Honorable Hakeem Jeffries
United States House of Representatives
2433 Rayburn House Office Building
Washington, DC 20515

Dear Leader Schumer, Leader McConnell, Speaker McCarthy, and Leader Jeffries:

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we urge you to include the *Saving Access to Laboratory Services Act (SALSA)* in must-pass legislation this year. *SALSA* is an essential bipartisan, bicameral legislation, which provides critical updates to Medicare's payment system for laboratory services. These updates would ensure stability and access for patients while making payment predictable and sustainable for providers.

Between 2017-2022, payment for common tests for diseases such as diabetes, cancer, and heart disease were cut by 27 percent. An additional 15 percent cut, for nearly 800 common laboratory tests, is scheduled to take effect January 1, 2024. These drastic payment cuts jeopardize access to many clinical laboratory tests that are used to diagnose, monitor, prevent, and manage common diseases impacting Medicare beneficiaries. The impact of these cuts will be felt hardest by small independent physician practices. In addition to cuts to the laboratory services, physicians are also facing a payment reduction in the proposed CY24 Medicare Physician Fee Schedule, as the cost of maintaining an independent practice and providing care soars. The closure of these practices as a result of additional and compounding payment cuts would most significantly impact rural and underserved communities already facing difficulties accessing care.

A strong, national laboratory infrastructure is essential for the rapid development and distribution of tests, particularly for common diseases and new pathogens. The enactment of *SALSA* would address years of Medicare payment cuts to clinical laboratory services and provide a payment system that is stable and sustainable – supporting earlier disease detection and improved patient care.

Thank you for your thoughtful consideration on this essential issue. The AOA and our members stand ready to assist you in securing its enactment. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Public Policy, John-Michael Villarama, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

October 17, 2023

The Honorable Jason Smith
United States House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith,

On behalf of the American Osteopathic Association (AOA) and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to thank you for the opportunity to respond to the Ways and Means Committee's Request for Information on issues impacting the rural health care landscape. This is a particularly important opportunity to provide insight on matters impacting physicians and our patients. Key topics such as geographic payment differences, sustainable provider financing, aligning sites of service, implementing innovative models, and improving the healthcare workforce are uniquely important for the AOA. DOs represent nearly 11%[1] of physicians in the United States but comprise nearly 40% of physicians serving rural and underserved communities.[2] In fact, many osteopathic schools are in rural areas, allowing students to establish connections with these communities at an early stage in their medical education.

Our policy proposals would provide stability in the delivery of high-quality care in rural communities and would provide lasting solutions to problems that have long plagued both patients and physicians across rural America.

Geographic Payment Differences:

The Ways and Means Committee has said it will review inequities resulting from the area wage index and the geographic practice cost index (GPCI), which is an excellent starting point for review of unique disparities long impacting rural communities. **We highly encourage the committee to extend the 1.0 work GPCI floor and permanently extend certain adjustments for cost of practice before it expires at the beginning of 2024.** According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI values raised by the floor to the national average. Without congressional action, the expiration of GPCI floor, established by Congress, will greatly impact rural communities that tend to have more patients in medically underserved areas.[3]

In testimony to the Ways & Means Committee in 2002, Urban Institute economists argued that the GPCI should account for more than just cost of living in order to promote adequate supply of physicians in both urban and rural areas.[4] Economists recognized at the time that a decision to not include secondary factors impacting the economic feasibility of rural physician practices could damage the sustainability of the rural physician workforce. Equalization of real compensation has not happened in the ensuing 21 years, and rural areas face increasingly severe physician shortages.

---

[1] American Osteopathic Association. "2023 OMP Report." 2023.
[2] Senator Martin Heinrich. "Heinrich, Wicker, Lee Lead Bipartisan, Bicameral Call for Increased Access to Osteopathic Medical Research That Benefits Rural, Underserved Communities." 2022.
[3] Government Accountability Office. "Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort." 2022
[4] Urban Institute. "Just Why Do We Adjust Medicare Physician Fees for Geographic Practice Cost Differences?" 2002.

To address the economic disparities across geographic areas, Congress must implement sustainable adjustments to the Medicare Physician Fee Schedule (MPFS) such as tie-ins to the Medicare Economic Index (MEI), which was a recommendation to Congress by the Medicare Payment Advisory Commission (MedPAC) for 2024.[5]

Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update. This change would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R.2474), and **the AOA strongly urges the Ways & Means Committee to consider this legislation further.** AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians.

Additionally, the Committee should evaluate proposals such as the bipartisan *Rural Physician Workforce Production Act* (H.R.834), which would allow certain hospitals to receive additional payments from Medicare for employing resident physicians in rural areas. This would increase the number of physicians practicing in rural communities and would provide financial support to make these residencies more feasible.

Sustainable Provider and Facility Financing:

As costs rise and payments decline, it is increasingly unsustainable to open, operate, or improve rural health facilities particularly standalone physician offices. Mitigation – and reversal – of cuts to the Medicare Physician Fee Schedule is the single most important factor to improving the sustainability of rural physician practices. The Physician Fee Schedule is the only part of the Medicare payment ecosystem that does not currently receive any form of annual inflationary adjustment or consideration. This has led to two decades of cuts to physician payment when considering the net impact of payment adjustments against cost increases due to inflation.

Furthermore, Medicare's current budget neutrality obligations within the physician payment schedule exacerbate the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS due to upward payments or new procedures in one category that increase costs by $20 million or more must be offset by cuts in other areas of the fee schedule. This issue is reflected in the implementation of a new care complexity add-on code (G2211). Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of payment reductions in other specialties that would limit the benefits the new code provides.

Additionally, cuts to payments for laboratory services present a unique challenge for rural physicians, as patients will lose access to critical tests if the cuts scheduled to go into effect January 1, 2024, are not addressed. Between 2017 and 2022, payment for common tests for diseases such as diabetes, cancer, and heart disease were cut by 27 percent, and an additional 15 percent cut, for nearly 800 common laboratory tests, will go into effect in the beginning of 2024 without Congressional intervention. These payment cuts will be felt hardest by small, independent physician practices. **We strongly urge the Committee to include the *Saving Access to Laboratory Services Act* (H.R.2377) in a must-pass legislative package before the payment cuts go into effect at the beginning of 2024.**

Aligning Sites of Service:

Differences in payment predicated upon the site of service create fundamental inequities in the care delivery landscape, and the MPFS cuts due to go into effect January 1, 2024, would exacerbate existing site of service differences for services that are demonstrably similar. **AOA supports policies which would require that**

[5] MedPAC. "March 2023 Report to the Congress: Medicare Payment Policy." 2023.

payments to physicians reflect the resources necessary to provide high-quality patient care in each setting.

The inequities in the current payment model allows for Hospital Outpatient Departments (HOPDs) to net higher payments for certain services, driving up costs to both Medicare and patients, while driving consolidation and reducing competition in the care delivery ecosystem. As the Committee considers policies that will align payments for various sites of service, it should prioritize payment models that account for costs incurred to the provider while also taking into account the nature of the patient population being served. Payment policies should also include factors such as the provision of care coordination, after-hours care, emergency care, quality-based payments, and other costs.

MedPAC recommended Congress implement site-neutral payment policies in its July 2023 report, and the AOA strongly echoes that recommendation.[6]

Health Care Workforce:

The AOA is grateful for the Committee's work to tackle physician workforce shortages across the country. The osteopathic profession disproportionately serves rural communities, and osteopathic physicians will play an integral role in addressing patients' access to care in these communities.

Substantial student loan debt and year over year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. Grants and low-interest or interest-free loans for small, rural practices could improve access to the necessary capital to add facilities, rather than contributing to physician consolidation. **AOA strongly urges the Committee to consider the *Resident Education Deferred Interest (REDI) Act* (H.R.1202).** The REDI Act would allow resident physicians to defer student loan interest from medical school until the completion of their residency. Medical school graduates must undertake several years of residency with a modest salary[7] and are often unable to begin repaying student debt immediately. While these medical residents are eligible to have payments halted during residency, the debt still accrues interest, causing ballooning balances for many borrowers. The REDI Act would reduce student debt burden without direct forgiveness or reducing the borrower's original balance. Reducing total debt burden for physicians completing residencies would enable physicians to have more flexibility in where they choose to practice and would allow physicians to make a choice to open their own practices or join an existing physician group in the communities that need them most.

AOA strongly urges Congress to advance the *Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization Act* (H.R.4079). This bill would provide loan repayment for individuals working directly with patients experiencing substance use disorder in Mental Health Professional Shortage Areas. This program is integral to ensuring there is an adequate physician workforce to combat substance use disorder impacting communities.

Beyond these measures, AOA has multiple recommendations to educate, attract, and retain physicians in rural and underserved areas. First, the implementation of an incentive or benefit program for recruiting and retaining physicians in rural and underserved communities. This could be achieved through residency program incentives for physicians who remain in rural and underserved communities following completion of a residency program. Beyond individual incentives for physicians, medical schools and residency programs should be incentivized to support rural health education and training tracks. Similarly, Congress could provide funding increases for Area Health Education Centers. These federally funded, nonprofit programs were created to recruit, train, and retain health professionals in underserved communities, and work regionally to improve quality and access to care.

Innovative Models and Technology:

[6] MedPAC. "Health Care Spending and the Medicare Program: July 2023 Data Book." 2023.
[7] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits

Both rural patients and physicians have been well served by technological advancements and payment flexibilities for care delivery. The expansion of telehealth coverage has allowed physicians to see more patients, and for patients to have better access to the care they need when they need it. Congress can improve access to care by making the availability of telehealth services permanent. Further, the AOA supports the bipartisan *Telehealth Expansion Act (H.R.1843),* which would improve patient access to telehealth services by allowing first-dollar coverage for beneficiaries with Health Savings Accounts (HSA) and enrolled in a High Deductible Health Plan, which Committee recently passed. Evidence shows that physicians are able to deliver clinically equivalent care via telehealth for many conditions, increasing the number of patients physicians can see in a given day, and reducing potential access burdens for patients.[8] Additionally, demand for telemedicine remains high post-COVID-19 PHE, especially for mental health services.[9]

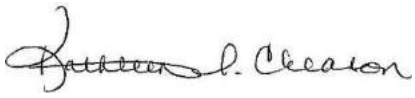
Further, the Committee should consider additional funding for the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program. This program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access while lowering costs. Most small and rural providers do not have access to the technical or administrative staff necessary to ensure proper participation in the Merit-based Incentive Payment System (MIPS), which currently disadvantages small and independent physician practices. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.[10] Physician-owned practices deliver high-quality and cost-effective care regardless of health system affiliation, and this research demonstrates the technical and administrative disadvantage small and independent physician practices are currently facing. Ensuring rural physicians can participate in Alternative Payment Models (APMs) that incentivize high-quality, cost-effective care is integral to improving the rural health ecosystem.

Conclusion

Again, thank you for the opportunity to comment on this important Request for Information. The AOA and our members stand ready to assist you as you consider new policies and legislation to improve rural healthcare. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Congressional Affairs and Public Policy, John-Michael Villarama, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA



Kathleen S. Creason, MBA
Chief Executive Officer, AOA

[8] Baughman DJ, Jabbarpour Y, Westfall JM, et al. Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System. *JAMA Netw Open.* 2022;5(9):e2233267

[9] Kaiser Family Foundation. "Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic." 2022

[10] Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open. 2020;324(10):984-992*

RRC

Regulatory Relief Coalition

Protecting Patients' Timely Access To Care

October 18, 2023

The Honorable Michael Burgess, Chair
Health Care Task Force
House Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Via: hbcr.health@mail.house.gov

Dear Congressman Burgess:

The Regulatory Relief Coalition is pleased to have the opportunity to respond to the Budget Committee Health Care Task Force's August 25, 2023, Request for Information (RFI), soliciting input on actions Congress could take to improve health care outcomes while reducing spending. The RRC is a coalition of national physician specialty organizations seeking to reduce regulatory burdens that interfere with patient care. Our recent activities focus on ensuring that utilization review policies are not a barrier to timely and equitable access to care for the patients we serve.

In responding to your RFI, we will address the following areas posed:

1) Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending;
2) Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes; and
3) Congressional Budget Office's (CBO) modeling capabilities on health care policies, including limitations or improvements to such analyses and processes.

Removing regulatory barriers to improve patient outcomes and lower costs

The RRC strongly supports enacting the *Improving Seniors' Timely Access to Care Act*[1] (*"Seniors Act"*), which unanimously passed the House of Representatives last year. Enactment of this legislation would modernize and streamline the prior authorization (PA) process for the nearly 32 million Americans currently enrolled in Medicare Advantage (MA) plans. Along with the RRC, more than 500 organizations representing patients, health care physicians and other clinicians, the medical technology and biopharmaceutical industry, health plans and other organizations have endorsed this legislation.

[1] H.R. 3173 in the 117th Congress. Most recently, the provisions in the Seniors Act were included in the House Ways and Means Committee-passed Health Care Transparency Act of 2023 (H.R.4822).

Enacting the *Seniors Act* has the potential to significantly improve health care outcomes while saving costs. Research clearly demonstrates that the delays and denials resulting from onerous PA requirements are harming patients. For example, one recent national physician survey[2] found the following:

- 89% of physicians reported that PA has a negative impact on clinical outcomes;
- 80% of respondents reported that PA can at least sometimes lead to treatment abandonment;
- 33% of physicians reported that PA has resulted in serious adverse events;
- 25% of physicians reported that PA has led to a patient's hospitalization;
- 19% of physicians reported that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage; and
- 9% of physicians reported that PA has led to a patient's disability/permanent bodily damage, congenital anomaly/birth defect or death.

Delays in care not only have a negative impact on patient outcomes but they also increase health care costs. A number of examples illustrating the adverse impact of PA on patient outcomes and health care costs are attached.

Additionally, the most recent (2022) Annual Report issued by the Council for Affordable Quality Health Care (CAQH)[3] indicates that increased use of electronic prior authorization would result in $449 million in cost savings for the medical industry annually, including $139 million/year for health plans and $310 million/ year for providers.

RECOMMENDATION: Since a more judicious and cost-effective use of PA falls squarely within the goals of the Budget Committee's Health Care Task Force, the RRC recommends that Congress swiftly enact the *Seniors Act*.

CBO Modeling

Since CBO modeling of the costs of legislation has the potential to derail legislation that is strongly supported by legislators on both sides of the aisle — or to accelerate its adoption — the RRC very much appreciates the Health Care Task Force's interest in examining potential improvements to CBO modeling processes and analyses.

The RRC believes that CBO cost modeling processes and analyses require significant reform to improve transparency, accuracy, consistency, and timeliness. While the CBO does publish some limited information purporting to explain the basis for its cost estimates, this information is skeletal, providing virtually no insight into the CBO's rationale for its projections. The information CBO analysts currently make available to Congress and the public often fails to

[2] See https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[3] See https://www.caqh.org/sites/default/files/2022-caqh-index-report%20FINAL%20SPREAD%20VERSION.pdf

detail the assumptions upon which its projections are based, the empirical basis or other data supporting these assumptions, or the CBO's basis for dismissing data that does not support its assumptions. Moreover, CBO's failure to provide or update cost estimates on a timely basis may interfere with legislative progress, particularly for bills that may have significant budgetary implications, thus disrupting the legislative process.

The deficiencies in CBO processes and analyses are especially evident in the case of cost estimates related to preventive health services. For example, CBO's June 15, 2020 report, entitled *How CBO Analyzes Approaches to Improve Health Through Disease Prevention*[4] makes it clear that CBO's modeling does not take into account the cost implications of long-term improvements in health status and resulting cost savings. The legislation that you introduced along with Diana DeGette (D-Colo.), which was likewise introduced in the Senate by Senators Ben Cardin (D-Md.), Mike Crapo (R-Idaho), Angus King (I-Maine) and Kevin Cramer (R-N.D.)== the *Preventive Health Savings Act* (H.R. 766 /S. 114)-- seeks to address this deficiency.

We agree with this dynamic scoring approach and believe if CBO had evaluated the costs of the *Seniors Act* through this lens, the score of this bill would have been significantly lower since unwarranted delays in diagnosis and treatment attributable to the misuse of PA likewise result in negative long term health consequences that result in increased health care expenditures over a period that exceeds the 10-year CBO budget window.

The CBO's cost estimate for the *Seniors Act* also illustrates the deficiencies of the current process. The primary provisions of the *Seniors Act* increase the transparency of the PA processes used by MA plans while also requiring MA plans to institute real-time electronic PA for frequently approved items and services. The bill does not preclude or otherwise limit MA plans' ability to utilize PA for any item or service, nor does it mandate coverage of any item or service that is not already required to be covered under existing legal authorities. Yet, on July 26, 2022, the CBO published an estimate indicating that enacting the *Seniors Act* would increase Medicare expenditures by over $16 billion over 10 years. This cost estimate defies common sense and illustrates the pressing need to improve the transparency, accuracy and timeliness of CBO cost estimates. Consider the following:

- Transparency: The CBO's rationale for its cost estimate is cursory and conclusory, leaving Hill sponsors and proponents of the legislation at a loss regarding CBO's reasoning. In explaining its estimate, the CBO states that by placing "additional requirements" on plans that use PA, it expects the legislation to result in "greater use of services" and, therefore, higher bids by MA plans. Since the bill does not restrict MA plans' use of PA, it is difficult to understand how it would result in "greater use of services." Nor is it clear how CBO determined that the projected increase in the use of services would be of sufficient magnitude to impact MA plans' bids or how CBO projected the amount of the projected bid increases. The rationale is not supported by data, nor does it appear to take into account existing and published data on the financial impact of PA for both plans and

[4] https://www.cbo.gov/publication/56345.

providers that suggests that modernization of PA processes would actually result in cost savings for both plans and providers.

- Accuracy: The CBO estimate is inconsistent with a highly detailed analysis of proposed regulatory provisions that essentially mirror the critical provisions of the *Seniors Act.* Specifically, the Centers for Medicare & Medicaid Services determined that regulatory provisions that largely parallel the *Seniors Act* provisions for a broader range of health plans would ***save*** an estimated $16 billion over 10 years and would not appreciably increase health plan costs.[5] Nor does the CBO estimate consider CAQH data indicating that health plans' implementation of electronic PA would actually result in appreciable health plan savings, estimated at $139 million/ year.

- Consistency: The CBO's *Seniors Act* cost estimate is inconsistent with cost estimates produced by CBO for several other PA-related legislation.[6] In other contexts, CBO has also acknowledged considerable uncertainty about whether and to what extent MA plans can be expected to change their bids — upward or downward — in response to legislative or regulatory changes.[7] These issues are not addressed or considered in the CBO *Seniors Act* score.

- Timeliness: Since CBO's initial *Seniors Act* cost estimate, CMS has proposed and/or finalized several regulations that address various aspects of PA. While the RRC has received information suggesting that regulatory action has impacted the budget score, the score has not been formally updated.

RECOMMENDATION: Based on our experience with the CBO's cost estimation process, we urge the Budget Committee's Health Care Task Force to consider reforms that address each of these problem areas:

- Transparency: The CBO should be required to do the following to improve transparency:

    - Provide a written, plain language explanation of the methodology used to produce cost estimates for proposed legislation;

---

[5] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[6] For example, the CBO cost estimate for the mental health parity bill which includes a provision relating to PA and step therapy, was less than a million dollars; H.R. 7539 (cbo.gov). The CBO did found no cost for H.R. 4841, Standardizing Electronic Prior Authorization for Safe Prescribing Act of 2018 | Congressional Budget Office (cbo.gov) or for electronic PA for H.R. 5773, Preventing Addiction for Susceptible Seniors Act of 2018 | Congressional Budget Office (cbo.gov).

[7] See Options for Reducing the Deficit, 2023 to 2032--Volume I: Larger Reductions. Reduce Medicare Advantage Benchmarks. https://www.cbo.gov/budget-options/58626.

- Identify the primary economic, behavioral or other assumptions made in the cost model; and
- Identify the data supporting the model's primary assumptions.

In addition, the CBO analysis should identify any available published data relevant to the cost projection and explain why existing data sources were (or were not) considered.

- Accuracy: CBO should be required to consult with knowledgeable sources to obtain the data used in its cost models and should be required to detail in writing the sources consulted. The rationale for all assumptions not supported by data should be explained.

- Consistency: CBO should be required to establish a binding internal process to ensure that the assumptions and methodologies used in producing budget scores are consistent across all legislation for which budget scores are made. In addition, CBO should be encouraged to publish reports — such as the report published on the methods used to analyze the cost implications of preventive services legislation — for other economic modeling issues commonly raised by proposed health care legislation (e.g., how to account for the costs of commonly accepted practices, how to estimate the impact of increased administrative costs in MA plans, how to estimate utilization changes attributable to cost reductions for a particular service, etc.).

- Timeliness: Guidelines for completing (and updating) preliminary and final scores for proposed legislation should be established.

We appreciate the opportunity to comment on these critical issues and look forward to working with the Budget Committee Health Care Task Force on this and future initiatives.

Respectfully,

American Academy of Dermatology Association
American Academy of Ophthalmology
American Association of Orthopaedic Surgeons
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American College of Cardiology
American College of Surgeons
American Gastroenterological Association
American Osteopathic Association
Association for Clinical Oncology
Congress of Neurological Surgeons
Medical Group Management Association
National Association of Spine Specialists (NASS)

Illustrations of the Adverse Impact of PA on Health Care Outcomes and Costs

- The patient is a 51-year-old AA male who presented in the fall of 2021 with SOB (shortness of breath) and cough. He was treated with abx (antibiotics) and steroids and improved but after the holidays noted increasing SOB especially when lying flat. He was admitted with a large mediastinal mass and after several biopsies was dx (diagnosed) with Hodgkin's Lymphoma. Because of the policy that PET (scan) cannot be done in the hospital, he received steroids with some relief and was seen by me the next week. At the time, consent for chemotherapy was obtained and orders written to begin urgently. PA (prior authorization) was required prior to the PET and treatment. Ten days after the orders were written, he developed increasing SOB and went to the ED and was re-admitted to the hospital. His PET had been scheduled the morning of admission, but his treatment was still not yet scheduled awaiting PA. His breathing deteriorated and he was intubated and taken to the MICU. The physician visited him in the ICU the morning after admission and helped orchestrate emergent chemotherapy with AVD Br (arterial vascular disease/bronchitis?). His course was complicated by bacterial hospital acquired pneumonia, and he remained in the ICU for 10 days when he was weaned from the vent and transferred to the Hem/Onc service. He was discharged to receive his treatment in the outpatient setting. Brentuximab was denied by his insurance until "peer to peer," which took several days to arrange. None of this needed to happen had he received timely therapy.

- The patient is a 32-year-old AA female who presented to the ED with SOB, chest pain and a large anterior chest mass growing into the anterior soft tissues. A bx (biopsy) was done in interventional radiology (IR) and the physician was called about the patient while she was in radiology. The physician added her to the next clinic, and because of her sx (symptoms), she was admitted to receive her first dose of ABVD (chemotherapy combination used to treat Hodgkin lymphoma). A randomized trial has shown that AVD-Br is superior, but the Br requires approval and her situation required urgent treatment. After receiving her C1D1 treatment, she was to receive C1D15 in the clinic. The orders were written but the infusion center refused to schedule her because they had yet to receive PA. After multiple communications including texts, phone calls, and "peer to peer" the patient was scheduled for treatment 5 days late. For her second cycle, her payor finally approved brentuximab after more back and forth with insurance.

- Following cataract surgery, an ophthalmology patient travels to have an exam and needs a YAG laser capsulotomy. This procedure addresses post-cataract surgery vision issues by using a laser to rupture a membrane holding the lens implant in place that can become cloudy and reduce vision. The ophthalmologist cannot do the procedure immediately because of PA requirements by the patient's insurance company. This requires the patient to again travel to the ophthalmologist's office for a common procedure on a later date. It also requires the practice to make adjustments to their already overbooked schedule to accommodate the patient's additional visit. This practice is a regional referral center for many rural areas in northwest Georgia and northeast Alabama. In this case, PA results in increased cost an inconvenience for the patient for a procedure that could have been provided during a previously scheduled visit.

- In Florida, a third-party administrator manages Aetna Medicare Advantage beneficiaries' ophthalmology services. The administrator is now asking for Manifest Refractions to be within 90

days of cataract surgery scheduled for the patient's second eye. Although a Manifest Refraction was done for both eyes prior to the first eye surgery that clearly showed the patient's vision could not be improved, the administrator is requiring the practice to repeat the patient's Manifest Refraction if more than 90 days have passed since the patient's first eye surgery. The passage of 90 or more days sometimes occurs with the elderly population, as other health issues arise between the procedures for the first and second eye. Repetition of the Manifes Refraction results in a waste or time and resources. This ophthalmology practice has also had PA denied for not specifically indicating that "The patient would like to have cataract surgery". This has unnecessarily delayed patients' timely access to needed eye care and added additional administrative burden for the practice's staff.

January 8, 2024

The Honorable Greg Murphy
United States House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable Danny Davis
United States House of Representatives
2159 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
United States House of Representatives
2335 Rayburn House Office Building
Washington, DC 20515

The Honorable Jimmy Panetta
United States House of Representatives
304 Cannon House Office Building
Washington, DC 20515

The Honorable Michael Burgess
United States House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Larry Bucshon
United States House of Representatives
2313 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Murphy, Davis, Wenstrup, Panetta, Burgees, and Bucshon,

On behalf of the American Osteopathic Association (AOA), alongside the 40 undersigned osteopathic specialty and state associations collectively representing more than 186,000 osteopathic physicians (DOs) and osteopathic medical students, we write to express our support for the *Preserving Seniors' Access to Physicians Act* (H.R.6683). This bipartisan legislation would fully prevent the pending cuts to the Medicare Physician Fee Schedule (MPFS) due to take effect on January 1, 2024. Enactment of this legislation would prevent further harm to the financial stability of physician practices and would allow them to continue providing essential care to Medicare beneficiaries, ensuring patients can maintain access to timely and high-quality care.

Physicians nationwide are currently facing a 3.37% payment cut for seeing Medicare beneficiaries, continuing the year over year payment cuts that threaten to fundamentally alter the care delivery landscape in the United States. While the annual payment cuts and uncertainty impact all physicians, it disproportionately affects DOs and the patients we serve. Despite being 11% of physicians in the United States, DOs comprise 40% of physicians practicing in medically underserved areas. Moreover, the sustainability of independent physician practices is foundational to ensuring adequate patient access to primary care services in rural and underserved communities. Analysis of Medicare Trustees data found that inflation-adjusted Medicare payments to clinicians have decreased by 26% from 2001-2022, and the impact will only become more severe as payment cuts are compounded by CMS' estimated 4.6% increase in practice costs for next year.[1]

As physicians continue to struggle with rising practice costs, workforce shortages, and other economic factors, any payment reduction jeopardizes the viability of physicians' practices and patients' ability to access care. Year over year payment reductions underscore the need for Congress to work towards comprehensive physician payment reform that takes the true cost of practice administration into account. While comprehensive reform is important in the long term, legislation to avoid the looming MPFS cut presents an existential need in the short term. The *Preserving Seniors' Access to Physicians Act* would provide essential stability and clarity to physicians while ensuring continued access to the care our senior citizens need.

[1] Analysis of Medicare Trustees and CBO Reports: Medicare Updates Compared to Inflation.

Again, the AOA and our affiliates stand ready to assist you in securing the enactment of this important legislation. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org or (202) 349-8748.

Sincerely,

American Osteopathic Association
American Academy of Osteopathy
American College of Osteopathic Emergency Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Neurologists and Psychiatrists
American College of Osteopathic Pediatricians
American College of Osteopathic Surgeons
American Osteopathic Academy of Orthopedics
American Osteopathic Academy of Sports Medicine
American Osteopathic College of Anesthesiologists
American Osteopathic College of Occupational and Preventive Medicine
American Osteopathic College of Physical Medicine & Rehabilitation
American Osteopathic College of Radiology
American Osteopathic Colleges of Ophthalmology & Otolaryngology – Head and Neck Surgery

Delaware State Osteopathic Medical Society
Florida Osteopathic Medical Association
Georgia Osteopathic Medical Association
Idaho Osteopathic Physicians Association
Illinois Osteopathic Medical Society
Iowa Osteopathic Medical Association
Kansas Association of Osteopathic Medicine
Louisiana Osteopathic Medical Association
Maine Osteopathic Association
Michigan Osteopathic Association
Missouri Association of Osteopathic Physicians and Surgeons
New Jersey Association of Osteopathic Physicians and Surgeons
New Mexico Osteopathic Medical Association
New York State Osteopathic Medical Society
New Hampshire Osteopathic Association
North Carolina Osteopathic Medical Association
Oklahoma Osteopathic Association
Osteopathic Physicians & Surgeons of California
Osteopathic Physicians and Surgeons of Oregon
Pennsylvania Osteopathic Medical Associations
Tennessee Osteopathic Medical Association
Texas Osteopathic Medical Association
Utah Osteopathic Medical Association
Virginia Osteopathic Medical Association
Washington Osteopathic Medical Association
West Virginia Osteopathic Medical Association

January 11, 2024

The Honorable Chuck Schumer
United States Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Mitch McConnell
United States Senate
317 Russell Senate Office Building
Washington, DC 20510

The Honorable Mike Johnson
United States House of Representatives
418 Cannon House Office Building
Washington, DC 20515

The Honorable Hakeem Jeffries
United States House of Representatives
2433 Rayburn House Office Building
Washington, DC 20515

Dear Leaders Schumer and McConnell, Speaker Johnson, and Leader Jeffries,

On behalf of the American Osteopathic Association (AOA), alongside the 40 undersigned osteopathic specialty and state associations collectively representing more than 186,000 osteopathic physicians (DOs) and osteopathic medical students, we write to urge Congress to pass legislation to reverse the 3.37% Medicare physician payment cuts that went into effect on January 1, 2024.

Failure to reverse these cuts threatens the viability of physician practices and their ability to care for patients, with the risk of fundamentally altering the care delivery landscape in the United States. While the annual payment cuts and uncertainty impact all physicians, it disproportionately affects DOs and the patients we serve. Despite being 11% of physicians in the United States, DOs comprise 40% of physicians practicing in medically underserved areas. Moreover, the sustainability of independent physician practices is foundational to ensuring adequate patient access to primary care services in rural and underserved communities. Analysis of Medicare Trustees data found that inflation-adjusted Medicare payments to clinicians have decreased by 26% from 2001-2022, and the impact will only become more severe as payment cuts are compounded by CMS' estimated 4.6% increase in practice costs for 2024.[1]

Physicians are the only Medicare providers that received a payment cut for 2024. In fact, every other provider in the Medicare payment ecosystem receives annual inflationary payment updates. The FY2024 National Defense Authorization Act included an extension to the Medicare sequester that will add $2.2 billion to the Medicare Improvement Fund - a sum that is more than enough to offset the reversal of physician payment cuts without adding to the federal deficit and would constitute a significant improvement to physicians' ability to deliver care to their patients.

Efforts by members of Congress to address this issue, including a Dear Colleague letter signed by over 200 members in December, demonstrate that this is a bipartisan, bicameral issue that must be addressed. We urge Congress to work in a bipartisan manner, to quickly pass legislation reversing the entire 2024 Medicare physician payment cuts, to ensure our nation's physicians and seniors continue to provide and have access to care when and where it is needed.

Sincerely,

American Osteopathic Association
American Academy of Osteopathy
American College of Osteopathic Emergency Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Internists

[1] Analysis of Medicare Trustees and CBO Reports: Medicare Updates Compared to Inflation.

American College of Osteopathic Neurologists and Psychiatrists
American College of Osteopathic Pediatricians
American College of Osteopathic Surgeons
American Osteopathic Academy of Orthopedics
American Osteopathic Academy of Sports Medicine
American Osteopathic College of Anesthesiologists
American Osteopathic College of Occupational and Preventive Medicine
American Osteopathic College of Physical Medicine & Rehabilitation
American Osteopathic College of Radiology
American Osteopathic Colleges of Ophthalmology & Otolaryngology – Head and Neck Surgery

Delaware State Osteopathic Medical Society
Florida Osteopathic Medical Association
Georgia Osteopathic Medical Association
Idaho Osteopathic Physicians Association
Illinois Osteopathic Medical Society
Iowa Osteopathic Medical Association
Kansas Association of Osteopathic Medicine
Louisiana Osteopathic Medical Association
Maine Osteopathic Association
Michigan Osteopathic Association
Missouri Association of Osteopathic Physicians and Surgeons
New Jersey Association of Osteopathic Physicians and Surgeons
New Mexico Osteopathic Medical Association
New York State Osteopathic Medical Society
New Hampshire Osteopathic Association
North Carolina Osteopathic Medical Association
Oklahoma Osteopathic Association
Osteopathic Physicians & Surgeons of California
Osteopathic Physicians and Surgeons of Oregon
Pennsylvania Osteopathic Medical Associations
Tennessee Osteopathic Medical Association
Texas Osteopathic Medical Association
Utah Osteopathic Medical Association
Virginia Osteopathic Medical Association
Washington Osteopathic Medical Association
West Virginia Osteopathic Medical Association

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member Senate Finance Committee
The Honorable Jason Smith, Chair, House Committee on Ways and Means
The Honorable Richard Neal, Ranking Member, House Committee on Ways and Means

AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

MASSACHUSETTS OSTEOPATHIC SOCIETY

Maintaining a difference to make a difference.

TO: Members of the Massachusetts Joint Committee on Public Health

FROM: American Osteopathic Association
Massachusetts Osteopathic Society

DATE: September 20, 2023

SUBJECT: S 1402 / H 2224

The American Osteopathic Association (AOA) and the Massachusetts Osteopathic Society (MOS) are writing to express our strong opposition to S 1402 / H 2224.

The AOA represents more than 186,000 osteopathic physicians (DOs) and medical students (OMSs) nationwide. The AOA promotes public health, encourages scientific research, serves as the primary certifying body for DOs and is the accrediting agency for osteopathic medical schools. More information on the AOA can be found at www.osteopathic.org. The MOS is a professional medical organization that represents more than 1,000 DOs providing patient care in Massachusetts.

The AOA and the MOS are concerned that S 1402 / H 2224 create a new, unproven pathway to licensure for international medical graduates (IMGs) licensed in "any country," disregarding established licensure requirements for IMGs that are in place to protect patient safety.

The requirements for licensure as a DO or an allopathic physician (MD) in the United States are substantially similar, and include:

- **Four years of medical school,** which includes **two years of didactic study** totaling upwards of 750 lecture/practice learning hours just within the first two years, **plus two more years of clinical rotations** done in community hospitals, major medical centers and doctors' offices.
- A **comprehensive, three-part licensing examination** series designed to test their knowledge and ability to safely deliver care to patients before they are granted a license to independently practice medicine.
- **12,000 to 16,000 hours of supervised postgraduate medical education** ("residencies") completed over the course of **three to seven years,** during which DO and MD physicians develop advanced knowledge and clinical skills relating to a wide variety of patient conditions.

By contrast, the education and training requirements that IMGs must meet vary widely from country to country. For example, the length of residency training that a physician is required to complete varies among specialties within a single country, as well as within the same specialty across countries.[1] The residency training and assessments that IMGs undergo also vary according to the patient population and disease prevalences that they are most likely to see in a given country, and available technology may also vary.

---

[1] *See* O'Brien et al., A Global View of Structures and Trends in Medical Education, Understanding Medical Education: Evidence, Theory, and Practice, The Association for the Study of Medical Education (2019).

In addition, the requirements for unlimited practice in a given country can range from attainment of an MD degree, to one year of specialty training, to completion of specialty training and fellowship.[2] In addition to differences in the structure of foreign medical education, the terminology also differs, making it difficult to compare curricula and safety outcomes *even if* the bills required it, which they currently do not.

For these reasons, in order to practice in the United States, IMGs have traditionally been required to complete a U.S.-based residency program and undergo the same evaluations that US.-licensed MDs and DOs undergo, in order to ensure that all physicians providing care to U.S. patients are held to the same high level of care.

This bill would disregard these patient safety requirements and require the Massachusetts Board of Registration in Medicine (Board) to license IMGs from any foreign country, who comply with the following requirements:

- **"A degree of doctor of medicine or its equivalent** from a legally chartered medical school outside the United States recognized by the World Health Organization;"
- **"Licensed or otherwise authorized to practice medicine in a country other than the United States;"** and
- **Practiced for one year** in their home country**.**

The AOA and the MOS share the legislature's goals of increasing access to care; however, we oppose disregarding the evidence-based pathway that currently exists to ensure that IMGs are qualified to safely practice in the United States.

The AOA and the MOS believe that all patients deserve access to high-quality medical care provided by a rigorously trained and fully licensed physician. Granting practice authority to IMGs who practiced for one year in *any* foreign country creates the risk of licensing physicians who may lack the comprehensive medical education and training required of all other U.S. physicians in order to protect patient safety. Further, the bill delegates the "develop[ment], assess[ment] and evaluat[ion]" of these IMGs' performance to individual healthcare facilities in the state, rather than the Board, without providing them with any guidelines or resources, which could result in substandard implementation and variable standards across facilities.

For these reasons, the AOA and the MOS urge you to **oppose S 1402 / H 2224** to ensure that all physicians providing care to Massachusetts patients complete the same, evidence-based requirements that are designed to protect patient safety. Should you need any additional information, contact Raine Richards, JD, AOA Vice President of State and International Affairs at rrichards@osteopathic.org or (202) 349-8720.

Sincerely,

Ira P. Monka, DO
President, AOA

Yasir Saleem, DO
President, MOS

[2] Id.

CC: Teresa A. Hubka, DO, President-elect, AOA
Shannon C. Scott, DO, Chair, Department of Governmental Affairs, AOA
Thomas Dardarian, DO, Chair, Council on State Health Affairs, AOA
Kathleen Creason, MBA, Chief Executive Officer, AOA
Raine Richards, JD, Vice President, State and International Affairs, AOA
Bre Schmidt, MPH, Associate Director, State Government Affairs, AOA
Samyuktha Neeraja, MPH, CAE, Executive Director, MOS

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

September 19, 2023

The Honorable Kevin McCarthy
United States House of Representatives
2468 Rayburn House Office Building
Washington, DC 20515

The Honorable Hakeem Jeffries
United States House of Representatives
2433 Rayburn House Office Building
Washington, DC 20515

Dear Speaker McCarthy and Leader Jeffries:

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we urge the House of Representatives to pass the *Lower Costs, More Transparency Act (*H.R. 5378) before the end of the fiscal year. This bipartisan legislation includes funding for a 7-year reauthorization of the Teaching Health Centers Graduate Medical Education (THCGME) program along with funding that will help provide stability in training an increased number of medical residents.

The Health Resources and Services Administration's (HRSA) National Center for Health Workforce Analysis projects a shortage of 35,260 primary care physicians by 2035, creating potentially life-threatening gaps in care for those in rural and underserved areas. To combat this projected shortage, THCGME programs currently train over 1,000 residents in sought after primary care fields including family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and dentistry. These medical residencies are located in 81 community-based teaching health centers across 24 states, providing stability in access to medical care in underserved rural and urban communities.

Residents who train in THC programs are far more likely to practice primary care and remain in the communities in which they have trained. According to HRSA, of the 266 residents who completed their program last year, 64% continue to practice in a primary care setting in a medically underserved community or rural area. THC programs not only play a vital role in training our next generation of primary care physicians, but also help to bridge our nation's physician shortfall. In addition, THC programs tackle the issue of physician maldistribution by attracting and retaining physicians in rural areas and medically underserved communities.

Approximately 57% of osteopathic physicians (DOs) practice in primary care. Osteopathic medical education has a long history of establishing educational programs for medical students and residents that target the health care needs of rural and underserved populations. Given this strong presence in primary care, osteopathic medicine aligns naturally with the mission and goals of the THCGME program that has proven successful in helping address the existing gaps in our nation's primary care workforce.

Thank you for your thoughtful consideration. The AOA and our members stand ready to assist you in securing the reauthorization of the THCGME program. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Public Policy, John-Michael Villarama, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

September 6, 2023

The Honorable Kevin McCarthy
Speaker of the House
U.S House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Hakeem Jefferies
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

Dear Speaker McCarthy and Leaders Jeffries, McConnell, and Schumer:

On behalf of the nearly 600,000 physicians our organizations represent, we greatly appreciate your commitment to support physicians and patient access to affordable, high quality health care. As we move into the final months of 2023, we believe it is critical for Congress to advance policies aimed at strengthening and diversifying the physician workforce.

The shortage and maldistribution of adult and pediatric primary care, psychiatric, and other high-need specialties limit patient access to cost-effective, preventive care, and these problems will become even more acute in the coming years if no action is taken. According to the Association of American Medical Colleges, the United States faces a projected physician shortage of up to 124,000 physicians by 2034. Further, the Health Resources and Services Administration (HRSA) estimates that by 2025, there will be a shortage of over 250,000 mental health professionals, including psychiatrists.

As Congress returns from the August recess work period, we urge you to focus on:

- **Conrad State 30 and Physician Access Reauthorization Act (S. 665).** This legislation would extend for three years the Conrad State 30 program, which allows states to request J-1 visa waivers for 30 foreign physicians per state, per year to work in federally designated shortage areas. The bill would also increase state allocations to 35 physicians

per year and provide flexibility to expand the number of waivers in states where demand exceeds that limit. This program is due for reauthorization on September 30, 2023.

- **Long-term reauthorization of the Teaching Health Center Graduate Medical Education (THCGME) program or the Doctors of Community (DOC) Act (H.R. 2569).** The THCGME program helps to attract and retain physicians in rural and medically underserved communities, while also addressing the issue of physician maldistribution. The THCGME program is the only federal program that invests in the training of physicians in a community setting. The program expires in FY24, and we urge Congress to move beyond the uncertainty caused by short-term reauthorizations of the program and toward permanent authorization and robust funding. This program is due for reauthorization on September 30, 2023.

Looking beyond the fiscal year deadline, there are additional pieces of legislation that our organizations urge Congress to pursue to address challenges facing the physician workforce. These include:

- **Resident Physician Shortage Reduction Act of 2023 (H.R. 2389/S. 1302),** which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years.
- **Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023 (S.462),** which would make mental health practitioners eligible for the loan repayment program passed in the SUPPORT Act five years ago. That program provides loan forgiveness for substance use disorder treatment providers who practice in shortage areas.
- **Resident Education Deferred Interest (REDI) Act (H.R. 1202/S. 704),** which would allow borrowers to qualify for interest-free deferment on their student loans while in a medical or dental internship or residency program.
- **Rural Physician Workforce Production Act (S. 230/H.R. 834),** which would lift the current cap on Medicare reimbursement payments to rural hospitals that cover the cost of taking on residents, in order to alleviate the disadvantage that rural hospitals face when recruiting new medical professionals.

Further, as Congress presses forward with the FY2024 appropriations proceedings, we urge the House and Senate to join forces and provide discretionary funding based on the Senate 302(b) allocation levels. These funding levels will ensure programs linked to health care quality, outcomes, research, and workforce are well-positioned going into the new fiscal year.

We appreciate your consideration of these important health care issues. If you have any questions, please feel free to contact David Tully at dtully@aafp.org.

Sincerely,

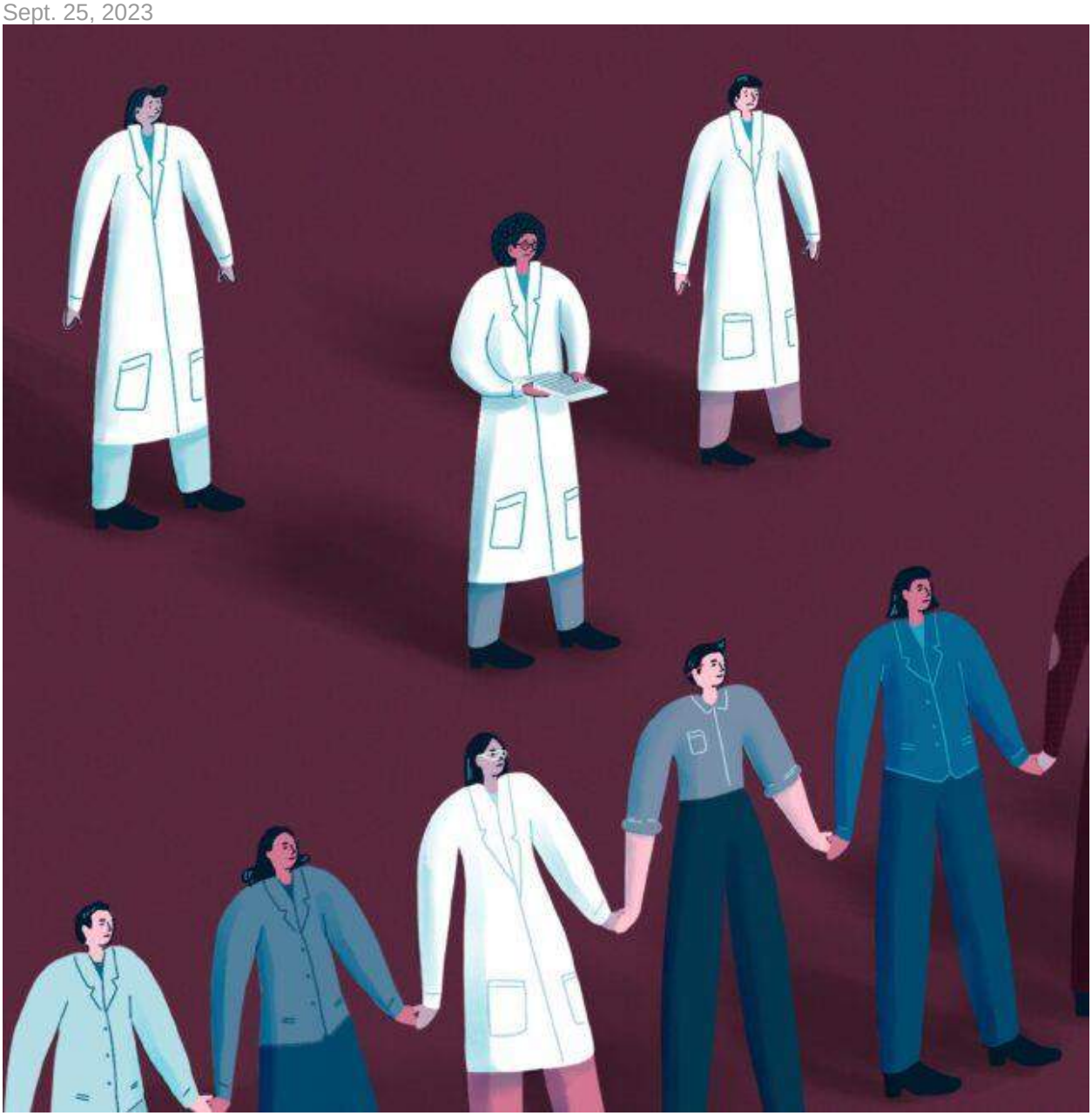
American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Osteopathic Association
American Psychiatric Association

FIRST OPINION

Policymakers must take action on the physician shortage

By Tochi Iroku-Malize, Sandy Chung, Verda Hicks, Omar T. Atiq, Ira P. Monka and Petros Levounis

Sept. 25, 2023



The pressures of the last three and a half years have affected every corner of the health care landscape, but nowhere is the effect more evident than the country's physician workforce. Burnout, staffing shortages, financial challenges, administrative burden, and two U.S. Supreme Court decisions that stand to stifle diversity and representation in medicine have hamstrung physicians across specialties and settings — in rural and urban communities, in hospitals, clinics, and independent practices. These workforce challenges are compounded by the fact that America — both physicians and our patient population — is also aging, and the number of available doctors is shrinking. Nearly 334,000 health care professionals left the workforce in 2021. Further, the Health Resources and Services Administration estimates that by 2025, there will be a shortage of more than 250,000 mental health professionals, including psychiatrists.

Our patients also experience side effects of this crisis in the form of lengthy wait times, difficulty finding physicians, and even care delays — all which can have negative health consequences. The nation faces a jarring reality: We need more physicians, and we need them practicing in communities that lack adequate access to care. But there are several legal and political barriers to make this a reality.

Our organizations — the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Osteopathic Association, and the American Psychiatric Association — represent nearly 600,000 physicians, residents, and medical students across the country. We treat infants, children, adolescents, adults, and seniors. We provide primary care, behavioral health care, reproductive health care, and a variety of essential health services patients seek every day. We form strong relationships with our patients and their families that cement our position as trusted sources of information and leaders in our communities. Because of our unique roles, we are well-positioned to advocate for policy solutions that will ensure we have a robust physician workforce equipped to meet all our patients' needs.

The road to becoming a doctor in the U.S. is no easy feat. As a first step, we must tackle the steep medical student loan debt that makes a career in medicine unviable for many, and that pushes medical students away from lower-paying specialties, including those who most frequently provide primary care. Medical student debt can significantly affect underrepresented and low-income students and restrict their representation in the physician workforce. This is a trend we cannot allow to continue given that the entire physician workforce significantly lags behind the racial and ethnic diversity of the U.S.

population. Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11% of physicians.

Congress can help us ensure a diverse physician workforce and one that is not laden with the burden of medical student debt by enacting policies that provide student debt relief for physicians serving in high-need roles. We also support legislation like the Resident Education Deferred Interest Act, which allows medical residents to defer their federal student loan interest during their residency. That would save them a significant amount of money in interest they would otherwise accrue and pay back during a time in their careers when their pay is quite low.

Workforce efforts shouldn't end with graduation — we must make sure physicians are practicing in geographic areas where patients need them the most. We need help in communities where patients must travel far distances to access care, including specialty care. We need help in areas where the physicians are retiring or leaving their practices and where there is not a new doctor ready to take their place. We also need help to ensure that training and payment is sufficient to manage the mental health crisis that is overwhelming our practices.

Policymakers can support and expand programs that have been proven to help address physician shortages and maldistribution in medically underserved and rural areas. This includes funding for the National Health Service Corps and Teaching Health Centers, as well as expanding Medicare Graduate Medical Education slots, which can target specific hospitals and programs in areas and specialties.

Additionally, Congress must support policies like the Conrad State 30 and Physician Access Reauthorization Act, which allows foreign doctors studying in the U.S. to remain following their residency in exchange for practicing in medically underserved areas. This closes equity gaps while filling a critical need for quality care in these communities. While expanding these programs won't entirely fix our workforce shortage, they can strengthen and sustain our nation's health care workforce.

We have a timely opportunity to reaffirm support and investment in the physician community — the very one that provides preventive and emergency care, takes care of children and families, and helps us respond to emerging and devastating health threats. To Congress and our nation's health care leaders: We implore you to act now to secure the future of our nation's health.

Tochi Iroku-Malize, M.D., MPH, FAAFP, is president of the American Academy of Family Physicians. Sandy Chung, M.D., FAAP, is president of the American Academy of Pediatrics. Verda Hicks, M.D., FACOG, president of the American College of Obstetricians and Gynecologists. Omar

T. Atiq, M.D., FACP, is president of the American College of Physicians. Ira P. Monka, D.O., MHA, FACOFP, is president of the American Osteopathic Association. Petros Levounis, M.D., M.A., DFAPA, is president of the American Psychiatric Association.

About the Authors

Tochi Iroku-Malize
@aafp

Sandy Chung
@AmerAcadPeds

Verda Hicks
@acog

Omar T. Atiq
@ACPIMPhysicians

Ira P. Monka
@AOAforDOs

Petros Levounis
@APAPsychiatric

Tags

AMERICAN OSTEOPATHIC ASSOCIATION

October 2, 2023

The Honorable Maria Cantwell
United States Senate
511 Hart Senate Office Building
Washington, DC 20515

The Honorable Bill Cassidy, M.D.
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20515

Dear Senators Cantwell and Cassidy:

The American Osteopathic Association (AOA) and American Osteopathic College of Anesthesiology (AOCA), on behalf of the more than 186,000 osteopathic physicians (DOs) and medical students we represent, write to offer our support for the *Protect Lifesaving Anesthesia Care for Veterans Act of 2023,* (S. 2070). This important bipartisan legislation will ensure that physician anesthesiologists are appropriately involved in the provision of anesthesia care to our veterans and prohibits the Secretary of the Department of Veterans Affairs (VA) from replacing physician anesthesiologists with nurse anesthetists. We firmly believe that this legislation will help protect the health and safety of those who so courageously volunteered to serve our country.

The AOA and AOCA strongly support a physician-led, team-based approach to medical care. While we value the important role of every health care professional, a nurse anesthetist's training is not equivalent to that of a physician anesthesiologist. Physicians are required to complete four years of medical school, followed by 12,000-16,000 hours of clinical training over the course of a three-to-seven-year residency program, and a three-step licensing exam series, before they are eligible to practice medicine independently. By contrast, nurse anesthetists complete only 2-3 years of graduate-level education that includes only 2,500 hours of clinical training. The training difference between a physician anesthesiologist and a nurse anesthetist is vast, and their respective roles are not interchangeable without jeopardizing the high quality of care that our veterans deserve.

Indeed, a recent Stanford study comparing the productivity of nurse practitioners (NPs), who complete a similar amount of training to nurse anesthetists, and physicians in VA emergency departments concluded that NPs practicing without physician involvement raised the 30-day preventable hospitalization rate by 20% and increased length of stay by 11%.[1] The study also concluded that their higher resource use and worse outcomes made NPs less productive, on average, than physicians, and that these productivity differences were so significant that it is more costly to employ NPs than physicians, even accounting for differences in salary.[2]

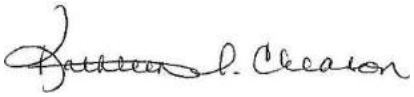
[1] Chan, D. and Chen, Y. *The Productivity of Professions: Evidence from the Emergency Department.* June 2023. Available at: http://web.stanford.edu/~chand04/papers/np_md_paper.pdf
[2] *Ibid.*

Our organizations are grateful that your legislation recognizes the critical importance of physician-led anesthesia care, and that attempting to replace physicians with nurse anesthetists could seriously jeopardize patient safety. We thank you for your leadership in ensuring that the physician-led, team-based model of anesthesia care remains intact, and for your efforts in maintaining the high standards of care that our veterans deserve. The AOA, AOCA, and our members stand ready to assist you in securing the enactment of this important legislation. If you have any questions, or if the AOA can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO
President, AOA

Jennifer Hargrave, DO, FAOCA
President, AOCA



Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

November 9, 2023

The Honorable Senator Lisa Murkowski
United States Senate
522 Hart Senate Office Building
Washington, DC 20515

Dear Senator Murkowski,

On behalf of the American Osteopathic Association (AOA) and the more than 186,000 osteopathic physicians (DOs) and medical students, and the Alaska Osteopathic Medical Association (AKOMA), which represents the interests of nearly 500 DOs throughout the state of Alaska, we write to express our sincere appreciation of your co-sponsorship of the *Resident Education Deferred Interest (REDI) Act,* S.704. The financial cost of medical education is a significant barrier to medical students and a burden on young physicians. This legislation will help address these issues and help alleviate our physician shortage and improve access to care.

As you may know, DOs comprise one of the most rapidly growing segments of the U.S. physician workforce, with one in four medical students in the United States attending a college of osteopathic medicine. Today, more than 65 percent of all DOs are under the age of 45, and if current trends continue, DOs are projected to represent more than 20 percent of the U.S. physician workforce by 2030.

The *REDI Act* is an important part of student loan repayment reform and will be extremely impactful for medical residents. A large portion of osteopathic medical schools and residency programs are in underserved rural and urban communities. A benefit of training in these communities is that young physicians choose to stay following completion of their graduate medical education and practice medicine in proximity to where they train. However, post-graduate training is often a difficult time to begin repaying student loans. Although many DO and MD residents qualify to have payments halted during residency through deferment or forbearance processes, their student loans continue to accrue interest. By not having to navigate the burden of additional interest accruing during residency, physicians will have less pressure to make decisions about where they practice based on their level of student debt, providing additional incentive to practice in rural and underserved communities where they are so greatly needed.

Again, we thank you for your support in cosponsoring this incredibly important legislation, and for your work in reducing the student loan burden for medical residents across the country. The AOA, AKOMA, and our members stand ready to assist in securing the enactment of this legislation. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact AOA Vice President of Congressional Affairs and Public Policy, John-Michael Villarama, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Joyce Restad, DO
President, AKOMA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

Minnesota Osteopathic Medical Society

November 15, 2023

The Honorable Angie Craig
United States House of Representatives
2442 Rayburn House Office Building
Washington, DC 20515

Dear Representative Craig:

On behalf of the American Osteopathic Association (AOA) and the more than 186,000 osteopathic physicians (DOs) and medical students, and the Minnesota Osteopathic Medical Society (MOMS), which represents the interests of nearly 220 DOs throughout your district, we write to express our sincere appreciation of your co-sponsorship of the *Resident Education Deferred Interest (REDI) Act,* H.R. 1202. The financial cost of medical education is a significant barrier to medical students and a burden on young physicians. This legislation will help address these issues and help alleviate our physician shortage and improve access to care.

As you may know, DOs comprise one of the most rapidly growing segments of the U.S. physician workforce, with one in four medical students in the United States attending a college of osteopathic medicine. Today, more than 65 percent of all DOs are under the age of 45, and if current trends continue, DOs are projected to represent more than 20 percent of the U.S. physician workforce by 2030.

The *REDI Act* is an important part of student loan repayment reform and will be extremely impactful for medical residents. A large portion of osteopathic medical schools and residency programs are in underserved rural and urban communities. A benefit of training in these communities is that young physicians choose to stay following completion of their graduate medical education and practice medicine in proximity to where they train. However, post-graduate training is often a difficult time to begin repaying student loans. Although many DO and MD residents qualify to have payments halted during residency through deferment or forbearance processes, their student loans continue to accrue interest. By not having to navigate the burden of additional interest accruing during residency, physicians will have less pressure to make decisions about where they practice based on their level of student debt, providing additional incentive to practice in rural and underserved communities where they are so greatly needed.

Again, we thank you for your support in cosponsoring this incredibly important legislation, and for your work in reducing the student loan burden for medical residents across the country. The AOA, MOMS, and our members stand ready to assist in securing the enactment of this legislation. If you have any questions or if the AOA can be of assistance in any way, please contact AOA Vice President of Congressional Affairs and Public Policy, John-Michael Villarama, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Sonbol Shahid-Salles, DO
President, MOMS

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

Statement for the Record

Senate Finance Committee Hearing on Legislation to Expand the Mental Health Care Workforce and Services, Reduce Prescription Drug Costs, and Extend Certain Expiring Provisions under Medicare and Medicaid

November 8, 2023

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the Committee's interest in improving patient access to care, and making meaningful strides toward addressing physician payment instability that threatens the future of the health care workforce.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and high-quality care when and where they need it. As such, the AOA unequivocally believes that the primary focus of any potential policy or legislative change should be to expand, or at minimum, maintain access to comprehensive high-quality care at the appropriate time and setting. It is with these sentiments that we respond to the Committee's discussion draft legislation.

Medicare Payment

Physicians across the country face ongoing uncertainty regarding the payment they will receive for services rendered year after year. This year, in the Medicare Physician Fee Schedule CMS finalized a 3.37% cut to Medicare's physician payments. This cut coincides with ongoing increases in costs to practice Medicine – which CMS acknowledges, as the projected increase in the Medicare Economic Index (MEI) for 2024 will be 4.6%. The Committee's discussion draft works to mitigate the impact of payment cut through a 1.25% increase to the payment rate for 2024. Should the Finance Committee's legislation be enacted into law, payment for 2024 would still decline 2.12%, as the adjustment does not account for the budget neutrality adjustments made by CMS in the CY2024 Physician Fee Schedule final rule. **While the Committee's legislation is a valuable and important step toward fairer physician payment for 2024, it does not address long-term stability and predictability that physicians desperately need.**

Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update. This change would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R.2474), and **the AOA strongly urges the Senate Finance Committee to consider this legislation further.** AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians. Without predictable inflationary

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

payment updates and additional incentives for rural and underserved areas, the physician workforce in these communities is likely to decline.

Furthermore, Medicare's current budget neutrality obligations within the physician payment schedule exacerbate the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS due to upward payments or new procedures in one category that increase costs by $20 million or more must be offset by cuts in other areas of the fee schedule. The widespread impact of the current budget neutrality threshold is reflected in the implementation of a new care complexity add-on code (G2211). The required conversion factor adjustments needed to implement the G2211 code accounts for approximately 2% of the total 3.37% cut to physician payment finalized by CMS. The budget neutrality requirements for this code yielded cuts across most specialties, except those that are office-based and rely heavily on E/M services. However, the net-positive estimated allowed charges for these office-based specialties rely on an assumption of high G2211 utilization that we believe is unattainable in 2024. The assumed level of utilization is highly unlikely given the required amount of physician education required to yield full utilization of the code. Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of across-the-board payment reductions to all services.

While the draft legislation does not address certain payment issues arising from budget neutrality and implementation of certain codes, the **AOA would like to convey our support for the inclusion of budget neutrality waivers for Behavioral Health Integration codes** that will result in payment increases to primary care practices successfully delivering integrated behavioral health. Beyond the budget neutrality waivers, the temporary boosts to the physician fee schedule payment to help support adoption of integrated care will alleviate the significant startup costs associated with a fully integrated, collaborative care model. Implementation of these policies would make important strides towards ensuring parity between medical and mental health benefits for patients. Further, these policies will help reduce the cost of care in the long run, as research has shown that improved access to primary care and behavioral health care reduces overall health care costs.[1]

The AOA would also like to convey our support for the *Provider Reimbursement Stability Act*, which would make the following changes to the Medicare Physician Fee Schedule (MPFS) with the goal of promoting sustainability in reimbursement and ensuring continued access to high quality healthcare: (1) increasing the threshold for applying budget neutrality from $20 million to $53 million to reflect the increase in the Medicare Economic Index (MEI) since the threshold was last updated, (2) require CMS to reconcile any overestimates and underestimates of pricing adjustment and make corresponding payment, and (3) updating prices for direct expenses related to budget neutrality adjustments with the goal of more frequently and accurately updating the costs used to calculate the Relative Value Units (RVUs) that are used to calculate the reimbursement formula for physician services.

The Chairman's Mark also provides a 5% increase to Medicare's bonus payments for physicians practicing in health professional shortage areas (HPSAs) when the physician is furnishing services to a patient with a mental health or substance use disorder condition. **The AOA would like to convey its strong support for this proposal but would**

[1] Jabbarpour Y, Greiner A, et al. PCPCC. Investing in Primary Care: A State-Level Analysis. 2019.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

also recommend broader policy that supplements support for all rural physicians. Provision of clear and demonstrable incentives for physicians to practice in rural communities and partner with underserved populations including those with mental health disorders and/or SUD is essential for the preservation and expansion of the rural health care workforce.

Patient Access to Care

The AOA strongly supports the Committee's decision to include provisions from the *Saving Access to Laboratory Services Act (SALSA),* that would revise the phase-in of Medicare's clinical laboratory test payment changes and avoid cuts to laboratory services for an additional year. ***SALSA* is an essential bipartisan, bicameral legislation, which provides critical updates to Medicare's payment system for laboratory services – supporting earlier disease detection and improved patient care.**

A strong, national laboratory infrastructure is essential for the rapid development and distribution of tests, particularly for common diseases and new pathogens. The full enactment of *SALSA* would address years of Medicare payment cuts to clinical laboratory services and provide a payment system that is stable and sustainable.

Program Extensions

The Senate Finance Committee's inclusion of an extension to the geographic practice cost index (GPCI) floor is an incredibly important step for rural physicians, and is an excellent starting point in reviewing the unique disparities long impacting rural communities. **We commend the Committee's decision to extend the 1.0 work GPCI floor for an additional year, and encourage the Committee to consider a permanent extension.**

The AOA is appreciative of the Committee's inclusion of a 1-year extension to the Alternative Payment Model participation bonuses. Unfortunately, physicians face technical and cost challenges in the transition to APMs, and the 1-year extension at 1.75% may not provide long-term stability or sufficient incentive needed to drive physicians from Fee-for-Service to more value-based models given the additional challenges involved. As a result, we believe an extension of the 3.5% bonus is needed. Further, the Committee should consider reauthorizing the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program. This program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access while lowering costs. Most small and rural providers do not have access to the technical or administrative staff necessary to ensure proper participation in the Merit-based Incentive Payment System (MIPS), which currently disadvantages small and independent physician practices. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.[2] Physician-owned practices deliver high-quality and cost-effective care regardless of health system affiliation, and this research demonstrates the technical and administrative disadvantage small and independent physician practices are currently facing. Ensuring rural physicians can participate in Alternative Payment Models (APMs) that incentivize high-quality, cost-effective care is integral to improving the rural health ecosystem.

[2] Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open. 2020;324(10):984-992*

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

Conclusion

Again, thank you for the opportunity to submit comments for the record. The Committee's draft legislation includes essential adjustments and reauthorizations that will support the stability of both the physician workforce and patient access to affordable, high-quality care. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Congressional Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.

AMERICAN
OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
312.202.8000

osteopathic.org

TO: The Honorable Umair Shah, MD, MPH
Washington State Secretary of Health
Washington State Department of Health
PO Box 47890
Olympia, WA 98504-7890

FROM: American Osteopathic Association

DATE: November 16, 2023

SUBJECT: Sunrise Review: Naturopathic physician scope of practice / Senate Bill (SB) 5411 (2023)

The American Osteopathic Association (AOA) is writing to express our strong opposition to a sunrise review of Naturopathic physician scope of practice and SB 5411.

We extend our sincere gratitude to the Washington State Department of Health for providing the opportunity to share our concerns and insights through public comments on the Naturopathic physician scope of practice and Senate Bill (SB) 5411.

The AOA represents more than 186,000 osteopathic physicians (DOs) and medical students (OMSs) nationwide. The AOA promotes public health, encourages scientific research, and serves as the primary certifying body for DOs. More information on the AOA can be found at www.osteopathic.org.

SB 5411 seeks to expand naturopathic physicians' ability to prescribe federally controlled substances, namely, to prescribe Schedule II drugs. Compared to those physicians in Washington State with M.D. or D.O. degrees, Naturopathic physicians do not have the same level of training and education in pharmacology, nor the same level of clinical training.

The requirements for licensure as a DO or an allopathic physician (MD) in the United States are substantially similar, and include:

- **Four years of medical school,** which includes **two years of didactic study** totaling upwards of 750 lecture/practice learning hours just within the first two years, **plus two more years of clinical rotations** done in community hospitals, major medical centers and doctors' offices.
- A **comprehensive, three-part licensing examination** series designed to test their knowledge and ability to safely deliver care to patients before they are granted a license to independently practice medicine.
- **12,000 to 16,000 hours of supervised postgraduate medical education** ("residencies") completed over the course of **three to seven years,** during which DO and MD physicians develop advanced knowledge and clinical skills relating to a wide variety of patient conditions.

Naturopathic education:

- **Varies by school.** There are seven naturopathic schools accredited by the Council on Naturopathic Medical Education (CNME) in the United States.
- Traditionally **focuses on holistic and nontoxic approaches** to therapy with a **strong emphasis on disease prevention and optimizing wellness.**
- **May not include any residency training.** While opportunities for one- to two-year residencies exist, this training is still optional and standard residency curriculum, rotations or experiences do not exist.

There is no universal postgraduate training requirement for Naturopathic physicians. In fact, many Naturopaths begin practicing medicine with a full license immediately after finishing their four-year medical school programs. M.D.s and D.O.s are not granted their full medical licenses until they have completed their post-graduate training programs and thus have more training and perhaps more importantly practical experience on the job in medicine, including pharmacology, than their Naturopath counterparts.

As we collectively work to reduce the burden of opiate dependency and addiction with your constituents in Washington State, we should ensure that only those with the highest level of education and practical experience are licensed to prescribe federally controlled substances. If our Naturopathic colleagues wish to prescribe these substances, then they should, *at minimum*, receive the same education and experience prior to licensure.

We hope you can appreciate the gravity of this issue and will join us in ensuring we continue the fight against opioid addiction and protect your constituents and their children for generations to come from the dangerous effects of this disease. Naturopaths **have not completed** similar education and training physicians, which allows them to safely deliver the services described in this bill. For these reasons, the AOA urges you to **not approve the scope of practice expansion for Naturopathic physicians.** Should you need any additional information, contact Raine Richards, JD, AOA Vice President of State and International Affairs at rrichards@osteopathic.org or (202) 349-8720.

Sincerely,

Ira P. Monka, DO
President, AOA

CC: Teresa A. Hubka, DO, President-elect, AOA
Shannon C. Scott, DO, Chair, Department of Governmental Affairs, AOA
Thomas Dardarian, DO, Chair, Council on State Health Affairs, AOA
Kathleen Creason, MBA, Chief Executive Officer, AOA
Raine Richards, JD, Vice President, State and International Affairs, AOA
Bre Schmidt, MPH, Associate Director, State Government Affairs, AOA

TO: Members of the Washington State House Committee on Health Care & Wellness

FROM: American Osteopathic Association
Washington Osteopathic Medical Association
American College of Osteopathic Neurologists and Psychiatrists

DATE: January 12, 2024

SUBJECT: OPPOSITION to H.B. 1041: Authorizing the Prescriptive Authority of Psychologists

The American Osteopathic Association (AOA), the Washington Osteopathic Association (WOMA), and the American College of Osteopathic Neurologists and Psychiatrists (ACONP) are writing in opposition to H.B. 1041: Authorizing the Prescriptive Authority of Psychologists. This bill greatly expands the scope of practice for psychologists by allowing psychologists to prescribe, administer, discontinue, and distribute psychotropic medications – including controlled substances – for various psychiatric and mental health disorders. Additionally, this authority extends to ordering and obtaining necessary laboratory tests, procedures, and diagnostic examinations related to the treatment of these conditions. The AOA, WOMA, and ACONP are very concerned that such a large increase in scope of practice for psychologists, without commensurate increases in education, training and competency demonstration requirements, could put the health and safety of Washington patients at risk.

The AOA represents more than 186,000 osteopathic physicians (DOs) and medical students (OMSs) nationwide. The AOA promotes public health, encourages scientific research, serves as the primary certifying body for DOs and is the accrediting agency for osteopathic medical schools, including the Pacific Northwest University of Health Sciences College of Osteopathic Medicine in Yakima, WA. The WOMA is a professional medical organization that represents over 2,800 DOs and OMSs providing patient care in Washington. The ACONP is a medical specialty society that represents over 5,000 osteopathic neurologists, psychiatrists, and students nationwide.

The AOA, WOMA, ACONP support the "team" approach to medical care because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care. While we value the contributions of all health care providers to the health care delivery system, we believe that psychologists' education and training lacks the comprehensive and robust requirements needed to properly evaluate the risks and benefits of psychotropic medications and safely treat patients with complex medical conditions such as drug addiction and mental illness. Further, authorizing controlled substance prescribing by another class of providers who receive less education and training than physicians runs contrary to nationwide efforts to reign in widespread opioid abuse, misuse and diversion.

Background:

- Psychology and psychiatry share similar subject matter, but are significantly different. A **psychologist holds a doctorate degree and a license to practice psychology**, while a **psychiatrist is a specialized physician with a DO or MD degree and a license to practice medicine.**

- Historically, **only physicians have been permitted to prescribe medications** due to the risk that **poor prescribing practices will harm patients**.
- **Psychotropic medications present a heightened risk of patient harm** because they are among the **most powerful drugs** available to modern medicine. These medications **affect the entire body, not just the brain**.
- Without adequate medical training, **psychologists may not recognize underlying medical conditions** that can mimic mental illnesses **or drug interactions that can have adverse effects on the patient.**

Psychiatrists (DOs and MDs) complete:

- **Four years of medical school**, which includes **two years of didactic study** totaling upwards of 750 lecture/practice learning hours just within the first two years, **plus two more years of clinical rotations** done in community hospitals, major medical centers and doctors' offices.
- **12,000 to 16,000 hours of supervised postgraduate medical education** ("residency") over the course of four years where they develop advanced knowledge and clinical skills relating to a wide variety of patient conditions.
- Washington-licensed osteopathic psychiatrists complete **150 continuing education hours every three years.**[1]

Psychologists authorized to prescribe under this bill complete:

- **A four-year doctoral program** in psychology.
- **A 500-hour clinical prescribing fellowship supervised by a "qualified prescriber,"** who may be **another psychologist**.
- **"Satisfactory evidence"** of **continuing education relevant to prescriptive authority every three years** for certificate renewal.
- Additionally, the board may also **issue prescriptive authority certificates by endorsement** to psychologists **with unrestricted licenses** and **similar certifications from other states**.

Psychologists do not have the extensive medical education and training that physicians receive that prepares them to understand medical treatment of disease, complex case management and safe prescribing practices. Allowing them to prescribe potentially dangerous medications independent of physician involvement may put the health and safety of Washington patients at risk. **We urge you to protect the safety of Washington's patients by <u>opposing H.B. 1041</u>**. Should you need any additional information, please contact Bre Schmidt, MPH, Associate Director of State Government Affairs at bschmidt@osteopathic.org.

Sincerely,

Ira P. Monka, DO
President, AOA

Scott Fannin, DO
President, WOMA

Sue Wesserling, MBA
Executive Director, ACONP

[1] *See* https://app.leg.wa.gov/WAC/default.aspx?cite=246-853-080&pdf=true

CC: Teresa A. Hubka, DO, President-elect, AOA
Shannon C. Scott, DO, Chair, Department of Governmental Affairs, AOA
Thomas Dardarian, DO, Chair, Council on State Health Affairs, AOA
Kathleen Creason, MBA, Chief Executive Officer, AOA
Raine Richards, JD, Vice President, State and International Affairs, AOA
Bre Schmidt, MPH, Associate Director, State Government Affairs, AOA
Roseanne Anderson, Executive Director WOMA
G. Theodore Harris, D.O., FACN, President, ACONP

January 29, 2024

The Honorable Brad Schneider
United States House of Representatives
300 Cannon House Office Building
Washington, DC 20515

The Honorable Annie Kuster
United States House of Representatives
137 Cannon House Office Building
Washington, DC 20515

The Honorable David Valadao
United States House of Representatives
2565 Rayburn House Office Building
Washington, DC 20515

The Honorable Mike Carey
United States House of Representatives
1433 Longworth Office Building
Washington, DC 20515

The Honorable Mike Kelly
United States House of Representatives
2565 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Schneider, Kuster, Valadao, Carey, and Kelly,

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students across the country that we represent, alongside the American Osteopathic Academy of Addiction Medicine (AOAAM), we write to express our support for the *Substance Use Disorder Workforce Act* (H.R.7050). This bipartisan legislation would create 1,000 new Medicare-supported residency positions over the next five years, for hospitals with programs in addiction medicine, addiction psychiatry, or pain medicine. These additional residency slots would improve patient access to addiction specialists and strengthen the workforce best trained to address substance use disorders (SUD) in our country.

In 2022, nearly 110,000 Americans died from drug overdoses, with the number of overdose deaths continuing to increase year over year.[1] Medical schools, teaching health systems, and hospitals across the country are actively working to train physicians to treat addiction and create a more comprehensive response to substance use disorders, but the workforce lags behind the significant demand for these specialized clinicians. The *Substance Use Disorder Workforce Act* would strengthen the ability of our health care system to treat patients more effectively with SUD and mitigate risk factors.

As physician workforce shortages continue to increase, we will also continue to struggle to successfully engage with patients experiencing SUD. To address this epidemic, additional residency positions to train specialists who can best address this crisis are essential. The osteopathic profession believes strongly in a comprehensive, team-based approach to care. Increasing the number of residents able to train in these complex specialties is necessary to ensure patients' access to high quality and effective care.

[1] NIH. "Drug Overdose Death Rates." June 30, 2023.

Again, the AOA and AOAAM would like to strongly offer our support for this important legislation. The AOA, AOAAM, and our members stand ready to assist you in securing the enactment of this legislation. If you have any questions or if the AOA or AOAAM can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

John Lepley, DO, FAOAAM
President, AOAAM

Kathleen S. Creason MBA
Chief Executive Officer, AOA

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

September 25, 2023

The Honorable Lloyd Smucker
U.S. House of Representatives
302 Cannon House Office Building
Washington, DC 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

The Honorable Claudia Tenney
U.S. House of Representatives
2349 Rayburn House Office Building
Washington, DC 20515

The Honorable Bradley Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, DC 20515

Dear Representatives Smucker, Blumenauer, Tenney, and Schneider:

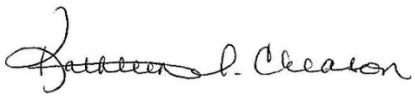
On behalf of the American Osteopathic Association (AOA) and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to thank you for introducing the "*Primary Care Enhancement Act of 2023*" (H.R. 3029). Your legislation would allow individuals with Health Savings Accounts (HSAs) to use their tax-exempt savings to pay for medical services furnished by primary care providers.

The AOA strongly supports policies that make health care costs more affordable and increases access to care. The *Primary Care Enhancement Act of 2023* would allow patients with Health Savings Accounts (HSAs) to use their tax-preferred savings to pay for their medical care using a subscription-based model in which they pay a monthly, quarterly, or annual fee to their primary care provider. In addition, it provides crucial inflationary-based adjustments based on the cost-of-living amount of a calendar year to high-deductible health plans and health savings accounts. This bill also provides important clarification that direct primary care services are not health insurance.

The AOA deeply appreciates your efforts to ensure that our patients have access to a variety of models of care, such as direct primary care, that best fit their needs. The AOA and our members stand ready to assist you in securing the enactment of this important legislation. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org, or (202) 349-8748 to support your efforts.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA



Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

Statement for the Record

Subcommittee on Health of the Committee on Energy and Commerce
Examining Medicare Proposals to Improve Patient Access to Care and Minimize Red Tape for Doctors

October 19, 2023

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the subcommittee's interest in improving patient access to care, minimizing red tape for physicians, and to convey our staunch support for several pieces of legislation before the subcommittee.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and high-quality care when and where they need it. As such, the AOA unequivocally believes that the primary focus of any potential policy or legislative change should be to expand, or at minimum, maintain access to comprehensive high-quality care at the appropriate time and setting. It is with these sentiments that we express our support for the following legislations.

Patient Access to Care

The ***Saving Access to Laboratory Services Act (SALSA)*** **is an essential bipartisan, bicameral legislation, which provides critical updates to Medicare's payment system for laboratory services – supporting earlier disease detection and improved patient care.**

Between 2017-2022, payment for common tests for diseases such as diabetes, cancer, and heart disease were cut by 27 percent. An additional 15 percent cut, for nearly 800 common laboratory tests, is scheduled to take effect January 1, 2024. These drastic payment cuts jeopardize access to many clinical laboratory tests that are used to diagnose, monitor, prevent, and manage common diseases impacting Medicare beneficiaries. The impact of these cuts will be felt hardest by small independent physician practices that offer in-house laboratory services but may no longer be able to sustain such services following further payment cuts. In addition to cuts to the laboratory services, physicians are also facing a payment reduction in the proposed CY24 Medicare Physician Fee Schedule, as the cost of maintaining an independent practice and providing care soars. The closure of these practices because of additional and compounding payment cuts would most significantly impact rural and underserved communities already facing difficulties accessing care.

A strong, national laboratory infrastructure is essential for the rapid development and distribution of tests, particularly for common diseases and new pathogens. The enactment of *SALSA* would address years of Medicare payment cuts to clinical laboratory services and provide a payment system that is stable and sustainable.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

We are also grateful for the subcommittee's continued efforts to reform prior authorization in the Medicare Advantage (MA) program. The *Improving Seniors Timely Access to Care Act* would help address many of the problems patients and physicians are experiencing in the prior authorization process.

Any change to improve prior authorization should be designed with the end goal of reducing patients' wait times for treatment, reducing physician administrative burden, and allowing physicians to spend more time with patients. We, therefore, greatly appreciate the Subcommittee's continued efforts to ensure MA policies are not a barrier to timely and equitable access to care for the patients our members serve. Congress can protect our nation's seniors from wrongfully delayed or denied care by requiring proper transparency and oversight of prior authorization in the MA program. If adopted, **the *Improving Seniors Timely Access to Care Act* will reduce barriers to care, decrease provider burden, and help ensure Medicare beneficiaries enrolled in MA plans have the same access to Medicare-covered items and services as beneficiaries who opt for traditional Medicare.**

Independent Practice Sustainability

The healthcare system is experiencing unprecedented consolidation, amongst both hospitals and physician practices – contributing to the workforce shortage, and driving up costs, without improving quality of care for patients. For example, in 2020, the Medicare Payment Advisory Commission, or MedPAC, released a report[1] concluding that "the preponderance of evidence suggests that hospital consolidation leads to higher prices." In addition, a study conducted by the University of Chicago Law School[2] found that physicians in the most concentrated markets throughout the country charged patients 14% to 30% more than practices in the least concentrated markets. Another study that examined Medicare beneficiaries' patterns of health care utilization found that acquisition of primary care practices by larger hospitals and health systems led to increased utilization and a 5% increase in enrollee spending without considerable changes in quality.[3] Simply put, consolidation does not improve quality of care and drives up costs for patients. It is essential that action is taken to support small and independent practices, and that physicians are able to provide patients with the high-quality care they are trained to deliver, regardless of their practice setting or employment model. In the long-term, comprehensive reform of the Quality Payment Program is necessary to support value-based payment and ensure that providers across settings are treated equitably. However, several short-term actions can provide more immediate, necessary support to physician practices.

The AOA urges the subcommittee to support the passage of the *SURS Extension Act*. The Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access to care while lowering costs. Most small and rural physician practices do not have access to the technical or administrative staff or funding necessary to ensure proper participation in the Merit-based Incentive Payment System (MIPS), which currently disadvantages small and independent physician practices. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering

[1] MedPAC, "March 2020 Report to the Congress: Medicare Payment Policy," March 13, 2020.
[2] Dunn, Abe and Shapiro, Adam Hale (2014) "Do Physicians Possess Market Power?," *Journal of Law and Economics*: Vol. 57: No. 1, Article 6.
[3] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. J Health Econ. 2018 May

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

demonstrably better quality of care[4]. Physician-owned practices deliver high-quality, cost-effective care regardless of health system affiliation, and this research demonstrates that small and independent practices are being unfairly disadvantaged due to their inability to make the same investments in technical infrastructure and administrative support as compared to larger enterprises.

In addition to funding the QPP-SURS program to provide technical assistance to practices, we encourage the Committee to support practices in making the necessary investments to participate in alternative payment models. For this reason, the AOA strongly supports extending incentive payments for participation in eligible alternative payment models. Ensuring physicians in small and independent practices can participate in payment models that incentivize high-quality, cost-effective care is integral in supporting the physician workforce in our rural and underserved communities.

The Energy and Commerce Committee has said it will review inequities resulting from the area wage index and the geographic practice cost index (GPCI), which is an excellent starting point for review of unique challenges long impacting rural communities. **We highly encourage the subcommittee to extend the 1.0 work GPCI floor.** According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI values raised by the floor to the national average. Without congressional action, the expiration of GPCI floor, established by Congress, will greatly impact rural communities that tend to have more patients in medically underserved areas.[5]

In testimony to the Ways & Means Committee in 2002, Urban Institute economists argued that the GPCI should account for more than just cost of living in order to promote adequate supply of physicians in both urban and rural areas.[6] Economists recognized at the time that a decision to not include secondary factors impacting the economic feasibility of rural physician practices could damage the sustainability of the rural physician workforce. Equalization of real compensation has not happened in the ensuing 21 years, and rural areas face increasingly severe physician shortages.

The AOA would also like to convey our support for the *Provider Reimbursement Stability Act*, which would make the following changes to the Medicare Physician Fee Schedule (MPFS) with the goal of promoting sustainability in reimbursement and ensuring continued access to high quality healthcare: (1) increasing the threshold for applying budget neutrality from $20 million to $53 million to reflect the increase in the Medicare Economic Index (MEI) since the threshold was last updated, (2) require CMS to reconcile any overestimates and underestimates of pricing adjustment and make corresponding payment, and (3) updating prices for direct expenses related to budget neutrality adjustments with the goal of more frequently and accurately updating the costs used to calculate the Relative Value Units (RVUs) that are used to calculate the reimbursement formula for physician services.

---

[4] Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open. 2020;324(10):984-992*

[5] Government Accountability Office. "Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort." 2022

[6] Urban Institute. "Just Why Do We Adjust Medicare Physician Fees for Geographic Practice Cost Differences?" 2002.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

In addition to these legislations being considered by the subcommittee, **the AOA strongly encourages the committee to consider advancing the *Strengthening Medicare for Patients and Providers Act*, and the *Resident Education Deferred Interest (REDI) Act.***

To address the economic disparities across geographic areas, Congress must implement sustainable adjustments to the MPFS such as tie-ins to the Medicare Economic Index (MEI), which was a recommendation to Congress by the Medicare Payment Advisory Commission (MedPAC) for 2024.[7] **Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update.** This change would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R.2474), and the AOA strongly urges the committee to support this legislation.

Ensuring a Stable Workforce of Physicians Serving Medicare Beneficiaries

Substantial student loan debt and year over year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. **AOA strongly urges the Committee to consider the *Resident Education Deferred Interest Act* (REDI Act), H.R. 1202.** The REDI Act would allow resident physicians to defer student loan interest from medical school until the completion of their residency. Medical school graduates must undertake several years of residency with a modest salary[8] and are often unable to begin repaying student debt immediately. While these medical residents are eligible to have payments halted during residency, the debt still accrues interest, causing ballooning balances for many borrowers. The REDI Act would reduce student debt burden without direct forgiveness or reducing the borrower's original balance.

Reducing the total debt burden for physicians completing residencies would enable physicians to have more flexibility in where they choose to practice. The combined impact of substantial student loan debt and year-over-year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. In recent years, the ratio of physicians to Medicare beneficiaries has declined among both primary care and specialists.[9] While most Medicare beneficiaries may not currently report acute access challenges, as suggested by MedPAC, this is quickly changing as the Medicare-eligible population grows and the physician workforce does not keep pace.

A recent AAMC report suggests that the physician workforce shortage will grow to between 37,800 and 124,000 physicians by 2034.[10] In light of this looming shortage, it is essential that steps are taken to preserve access to care across the country, especially for Medicare beneficiaries. For this reason, we urge you to support the ***Resident Physician Shortage Reduction Act, H.R. 2389.*** This legislation would create up to 2,000 new GME slots per year for seven years, prioritizing rural areas, health professional shortage areas, and historically underserved settings, including hospitals affiliated with historically black medical schools. Comprehensive efforts are needed to ensure a stable physician workforce that can care for our country's growing Medicare population.

---

[7] MedPAC. "March 2023 Report to the Congress: Medicare Payment Policy." 2023.
[8] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits
[9] MedPAC March 2023 Report to Congress: Medicare Payment Policy." 2023.
[10] American Association of Medical Colleges. "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034." 2021.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

Again, thank you for the opportunity to submit comments for the record. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Congressional Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

November 8, 2023

The Honorable John Thune
United States Senate
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Tom Carper
United States Senate
513 Hart Senate Office Building
Washington, DC 20510

Dear Senators Thune and Carper,

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students we represent, we applaud your leadership, and offer our support for the Chronic Disease Flexible Coverage Act (S.3224). This bipartisan legislation will support care affordability for patients managing chronic conditions by allowing health savings account (HSA)-eligible high deductible health plans (HDHPs) to cover low-cost preventive care and services that manage chronic conditions on a pre-deductible basis.

HSA-eligible HDHPs are generally prohibited from offering services and medications to manage chronic conditions on a pre-deductible basis. While a preventive services safe harbor exists for pre-deductible coverage, the current exception is narrow and can prevent coverage of vital care management services that can prevent the chronic condition from getting worse or the development of a secondary condition. Your legislation would help fix this gap in coverage. Approximately six in ten Americans have at least one chronic condition and millions struggle to receive the appropriate care due to cost burdens. Improving access to chronic disease care will allow patients to properly manage their chronic disease, thereby reducing hospitalizations and limiting costs for patients, providers and insurers alike while improving patient outcomes.

The core principles of osteopathic medicine emphasize providing patient-centered care with a focus on prevention and care coordination, which entails partnering with our patients to deliver high-quality care that meets their needs. This approach is particularly important when treating patients with complex, chronic conditions. The AOA supports policies that lessen potential roadblocks to accessing care, and this bill is a great step forward towards achieving this goal. By allowing HDHPs to cover preventive services for chronic conditions on a pre-deductible basis, the Chronic Disease Flexible Coverage Act will help ensure that patients can obtain coverage for vital services that will support better long-term outcomes and condition management.

Again, the AOA supports your legislation's goals of ensuring that patients living with chronic conditions are able to access necessary care in a cost-effective way. The AOA and our members stand ready to assist you in securing the enactment of this important legislation. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org, or (202) 349-8748 to support your efforts.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

August 7, 2023

Lina M. Khan
Chair
Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue NW
Suite CC-5610 (Annex C)
Washington, DC 20580

Re: Health Breach Notification Rule, Project No. P205405

Dear Chairwoman Khan:

The American Osteopathic Association, on behalf of the more than 186,000 osteopathic physicians (DOs) and medical students we represent, appreciates this opportunity to comment on the Federal Trade Commission's proposed changes to strengthen the Health Breach Notification (HBN) Rule. We commend the work the Federal Trade Commission (FTC) has undertaken to ensure that patient data housed in platforms not subject to HIPAA is protected from unauthorized disclosures.

As osteopathic physicians, we are trained to deliver high quality, patient-centered, coordinated care. An interoperable health system that enables the appropriate sharing of patients' health information ensures that physicians can have all necessary information at their disposal when treating patients and developing care plans. The AOA strongly supports policies that strengthen patients' control over their health information. As patients continue to have greater ownership over their data and increasingly house their information in platforms not subject to HIPAA, including health and wellness applications, it is essential that action is taken to ensure that patients are protected from any invasion of privacy. We have long advocated for such action and strongly urge FTC to finalize the proposed regulation with the modifications we outline below.

Clarification of Entities Covered

In an effort to ensure privacy and security for data held in health applications and other technologies not subject to HIPAA regulations, FTC makes several revisions to the HBN Rule that expand and more clearly define the scope of the entities covered. In particular, FTC revises the definition of "personal health records (PHR) identifiable information" and adds corresponding definitions for "health care provider" and "health care services or supplies." These changes create greater clarity and establish that entities subject to HBN Rule requirements include "any online service, such as a website, mobile application, or internet-connected device that provides mechanisms to track diseases, health conditions, diagnoses or diagnostic testing, treatment, medications, vital signs, symptoms, bodily functions, fitness, fertility, sexual health, sleep, mental health, genetic information, diet, or that provides other health-related services or tools."

The AOA strongly supports the proposed changes and believes that they would broadly cover most health and wellness related platforms that may send or receive PHR identifiable information. **We**

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

urge FTC to finalize this proposal to ensure that the broad range of platforms currently being used by our patients are covered under the HBN Rule.

Clarification Regarding the Types of Breaches Subject to the Rule

Unauthorized disclosures of patients' health information, and misuse of such information, is not only a violation of privacy, but it can have the added consequence of harming the care patients receive. The AOA strongly supports FTC's proposal to revise the definition of "breach of security" to explicitly include "unauthorized disclosures" and clarify that "incidents of unauthorized access, including sharing of covered information without an individual's authorization" are violations of the HBN Rule.

Health information is some of the most sensitive data an individual can have, and unauthorized disclosures of such information can have harmful consequences, including perpetuating stigma regarding patients' conditions, deterring patients from seeking care, embarrassing patients, interfering in the patient-physician relationship, and even impacting patients' employment. This is especially true for apps that handle exceptionally sensitive data, such as those for HIV management, mental health care, or addiction recovery. As physicians, we are stewards of our patients' most sensitive and personal information, and we take this responsibility seriously. We believe that any platform or product that touches this information should be held to high standards of privacy and security.

The FTC notes in its suits against GoodRx[1] and Easy Health[2] that the health apps are using patients' personally identifiable health information to develop targeted advertising for healthcare related products, including pharmaceutical products. In both cases, the platforms were alleged by FTC to be sharing sensitive data, including users' health conditions, prescriptions filled, and even information related to sexual health. Not only is this a serious violation of patient privacy, but the use of identifiable data for targeted advertising has great potential to harm patient care by disrupting the patient-physician relationship. For example, direct-to-consumer advertising for cancer drugs has been found to result in "patient misinterpretations of expected efficacy and toxic effects of drugs… encouraging patient interest in new drugs when their toxic effects are not fully appreciated".[3] This has been found to be especially harmful for patients with later stage cancers. Often, direct-to-consumer advertising can create unrealistic expectations about the efficacy of a drug or undermine their confidence in physician decision-making. Targeted advertising that preys on patients with specific conditions or characteristics only perpetuates this problem. **The AOA greatly appreciates FTC taking action to ensure that patient health information not subject to HIPAA is protected from unauthorized disclosures that violate privacy and have potentially detrimental impacts on wellbeing.**

---

[1] U.S. v. GoodRx Holdings Inc. US District Court Northern District of California. Filed February 1, 2023. Available here.

[2] U.S. v. Easy Healthcare Corporation. US District Court Northern District of Illinois. Filed May 17, 2023. Available here.

[3] Schnipper LE, Abel GA. Direct-to-Consumer Drug Advertising in Oncology Is Not Beneficial to Patients or Public Health. *JAMA Oncol.* 2016;2(11):1397–1398.

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

In the proposed rule, FTC solicits comment on whether the language added to the "breach of security" definition is necessary in light of its recent enforcement actions against GoodRx and Easy Health. The AOA supports the proposed changes and believes that adopting explicit language in regulation is necessary to provide greater clarity to entities covered under the HBN Rule regarding what constitutes a breach and to ensure compliance.

Revised Scope of PHR Related Entity

To ensure that the HBN Rule appropriately covers the types of platforms and technologies currently being developed to store, share, and utilize patient health information, FTC proposes to revise the definition of a "PHR related entity." The expanded definition would "include entities offering products and services not only through the websites of vendors of personal health records, but also through any online service, including mobile applications." The AOA strongly supports this proposal.

The FTC solicits comment on whether it should be considered a reportable breach under the rule when a third-party service provider, such as an analytics firm, receives PHR identifiable health information (e.g., device identifier and geolocation data from which health information about an individual can be inferred) and then sells it to another entity without the consumer's authorization. **The AOA believes any disclosures that would support inferences about the identity of an individual or enable individuals to be linked to their health data should be considered a breach under the rule. Such disclosures are a violation of privacy and can pose a threat to patient care in ways we previously described.** We would support the addition of clarifying language in final regulatory text.

Clarification of What it Means for a Personal Health Record To Draw Information From Multiple Sources

The Commission proposes to define a "personal health record" as an "electronic record of PHR identifiable health information on an individual that has the technical capacity to draw information from multiple sources and that is managed, shared, and controlled by or primarily for the individual." The Commission also solicits comment regarding "whether an app (or other product) should be considered a personal health record even if it only draws health information from one place (in addition to non-health information drawn elsewhere); or only draws identifiable health information from one place (in addition to non-identifiable health information drawn elsewhere)."

The fact that an app or product only draws information from a single place does not change the fact as to whether the product draws, stores, and is capable of sharing patients' health and wellness information, including any element listed in FTC's proposed definition of "health care services or supplies." **As a result, we urge FTC to revise its definition of a "personal health record" to include any record that has the technical capacity to draw information from one or more sources.**

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

Revised Content and Methods for Breach Notices

FTC proposes permitting entities to notify consumers of breaches via email, offers a model notice that entities may use to notify individuals, and proposes new requirements for breach notices. Under the new notice requirements, entities will be required to disclose the following information when breaches occur: 1) potential harms that may result from the unauthorized disclosure, including potential medical harms; 2) the names, websites, and contact information of any third-parties that may have acquired unsecured PHR identifiable health information in the breach; 3) the types of data involved in the breach; 4) descriptions of what the entity is doing to protect affected individuals; and 5) contact procedures for contacting the entity regarding the breach. **The AOA strongly supports these proposals and agrees with FTC that the changes will ensure that consumers receive meaningful information following a breach that will help them fully understand the implications of the disclosure.** In addition to the new requirements under this rule, the AOA would encourage FTC to engage in a separate consumer education effort to help users of health and wellness apps understand their privacy rights and how privacy protections may differ from those in traditional healthcare settings (i.e., those under HIPAA).

Conclusion

Once again, the AOA thanks you for the opportunity to comment on this proposed rule. We commend the FTC for working to address inappropriate disclosures of sensitive patient information. We look forward to continuing to work with the FTC as it develops final regulations. Should you have any questions regarding our comments or recommendations, please contact John-Michael Villarama, MA, AOA Vice President of Public Policy, at (202) 349-8748 or jvillarama@osteopathic.org at any time.

Sincerely,

Ira P. Monka, DO, MHA, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750

osteopathic.org

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1784-P
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students we represent, appreciates this opportunity to comment on the CY2024 Medicare Physician Fee Schedule Proposed Rule. The AOA is encouraged by many proposals in the rule, particularly proposals that seek to promote comprehensive, coordinated primary care; address social determinants of health; improve payment and access for behavioral health services; and support access to telehealth services. However, we believe that several necessary 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 and recommendations to improve various CMS proposals.

CY2024 Physician Fee Schedule Provisions

Calendar Year 2024 Conversion Factor

While the AOA appreciates CMS' goals of supporting comprehensive, coordinated care by strengthening payment for primary care, behavioral health, and services addressing social needs, we are deeply concerned about the proposed reduction to the CY2024 conversion factor. CMS proposes a conversion factor of $32.7476, which reflects a 3.34% reduction in payment from CY2023. This reduction includes a 1.17% reduction as required under the Consolidated Appropriations Act (CAA) of 2023, and a 2.17% reduction due to a budget neutrality adjustment.

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

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 the rising cost of operating a practice.

While we recognize that CMS must comply with these statutory reductions, we believe that CMS should provide greater transparency in its calculation of budget neutrality adjustments. It is likely that the agency may not be accurately estimating changes to Medicare expenditures under some of this rule's provisions. While CMS highlights that most of the budget neutrality adjustment is attributable to expected utilization of the newly created evaluation and management (E/M) visit complexity add-on code (G2211), we believe CMS may be substantially overestimating utilization. We offer greater detail on this subject in our comments on the visit complexity add-on code.

Determination of Practice Expense RVUs

In 2023, CMS updated MEI weights for the different cost components of the MEI for CY2023 using a new methodology based primarily on a subset of data from the 2017 US Census Bureau's Service Annual Survey. However, in light of the fact that the AMA is currently conducting a physician practice expense survey to generate more current data, CMS is proposing to delay implementation of the proposed MEI weights until completion of the survey. **The AOA strongly supports CMS' decision to delay implementation.** This will ensure that updates to MEI weights reflect national, representative data on current physician practice expense costs.

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

Telehealth Service List

The AOA applauds CMS' decision to continue coverage and payment for all telehealth services included on the Medicare Telehealth Services List as of March 15, 2020. Additionally, CMS proposes to continue to cover telehealth services at the non-facility rate. This will not only support continued access to telehealth services, but it will ensure CMS' policy regarding payment for telehealth services aligns with Congress' intent in ensuring broad access to telehealth services by extending telehealth flexibilities under the Consolidated Appropriations Act (CAA) of 2023.

Despite the expiration of the public health emergency (PHE), it is essential that access to telemedicine services is preserved. Nearly 99 million Americans reside in a primary care health professional shortage area[1], suggesting potential access issues, and many patients rely on telehealth to obtain timely care. While telehealth should not be a substitute for in-person care, physicians are able to deliver clinically equivalent care via telemedicine for many conditions,[2] and telemedicine can allow patients to see a physician when circumstances may otherwise prevent them from doing

[1] Health Resource & Services Administration, 2022.

[2] Baughman DJ, Jabbarpour Y, Westfall JM, et al. Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System. *JAMA Netw Open.* 2022;5(9):e2233267

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

so. **The AOA strongly supports CMS' extension of payment for all services added to the telehealth service list during the PHE.**

Future Review of Telehealth Services

CMS proposes to simplify its methodology for updating its telehealth services list. Rather than having three separate categories of telehealth services, CMS will shift to a binary standard of permanent and "provisional" services. CMS proposes to map current telehealth services to the appropriate list. Under this new approach, CMS also proposes a process for reviewing telehealth services for addition or removal based on evidence. **The AOA supports these proposals and believes the process will be more straightforward and provide greater clarity to stakeholders regarding coverage.**

Implementation of Telehealth Flexibilities Extended under the CAA of 2023

CMS proposes to implement provisions of the CAA of 2023 which extends a broad range of telehealth flexibilities through December 31, 2024. As we note above, extension of telehealth services is important to supporting access to services and can support longitudinal care, especially for patients with limited mobility, patients with chronic conditions, and patients seeking mental health services. **The AOA appreciates CMS' efforts and encourages the agency to work with Members of Congress on a permanent solution to ensure flexibilities are maintained.**

Definition of "Direct Supervision"

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 use of this definition established during the PHE through December 31, 2024. **AOA would like to express caution that long-term extension of this flexibility raises 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. 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 and not only ensures that patients receive appropriate care, but also can help prevent avoidable deteriorations in patients' conditions, hospitalizations, or other adverse outcomes.**

Supervision of Residents in Teaching Settings

CMS is proposing to allow the teaching physician 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 AOA supports this change which will provide greater flexibility for residents to render telehealth services while ensuring an appropriate level of supervision.**

Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

In an effort to expand access to RPM and RTM services, CMS proposes the following changes to its coverage policies for these services:

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

- Clarifying that RPM and RTM codes may be billed with care management services, including CCM, TCM, BHI, PCM, and CPM services.
- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to report RPM and RTM services under the existing general care management code (G0511), and improving reimbursement for the code in a corresponding fashion; and
- Clarifying that beneficiaries getting surgery and related services covered by a global payment can also get RPM/RTM services if the latter is separate from the diagnosis for the procedure/services covered by a global payment.

Overall, AOA supports CMS' proposed changes that seek to support access to RPM and RTM services to improve care for patients with complex conditions and promoting better health outcomes. However, we encourage CMS to clarify that RPM/RTM used in scenarios technically related to a diagnosis under a global period, but not provided for in the global payment, are supported in Part B payment.

Valuation of Specific Codes

CMS proposes several new codes that will support payment to physician practices for providing comprehensive, coordinated primary care that accounts for patients' social needs. **The AOA supports these efforts and urges CMS to finalize its proposed policies regarding services to address health-related social needs with modifications noted below.**

Community Health Integration (CHI) Services

CMS has proposed 2 new codes to account for community health integration services. This change results from CMS efforts to value practitioners' work when they incur additional time and resources helping patients with serious illnesses navigate the healthcare system or removing health-related social barriers that are interfering with the practitioner's ability to execute a medically necessary plan of care.

While the AOA supports CMS' efforts to pay for these vital services and support practices in delivering comprehensive care, we are concerned with the time-based approach that CMS has adopted and the 60-minute service time threshold. We believe that the 60-minute threshold to bill the service is too high, and tracking time spent across the range of activities that this code supports will present a challenge to physician offices. **We urge CMS to either permit the code to be billed when a physician documents relevant activities captured under this service, or to reduce the time threshold to 30 minutes.**

Principal Illness Navigation (PIN)Services

CMS has created 2 new codes for auxiliary personnel providing individualized help to the patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care in a timely manner, especially when the landscape is complex and delaying care can be deadly. CMS notes that PIN services are primarily intended for supporting socioeconomically disadvantaged patients and those facing barriers to care.

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

The AOA commends CMS' efforts to pay for PIN services, but much like with the proposed CHI services, we are concerned with the time-based approach that CMS has adopted and the 60-minute service time threshold. We reiterate that the 60-minute threshold to bill the service is too high, and tracking time will be challenging. We urge CMS to either permit the code to be billed when a physician documents relevant activities captured under this service, or to reduce the time threshold to 30 minutes.

Social Determinants of Health Risk Assessment

CMS is proposing to create a new code to better support qualified health care professionals (QHPs) efforts to identify and help address social determinants of health (SDOH). The code would pay for the administration of evidence-based SDOH risk assessments on the same date as an E/M visit.

DOs are trained to deliver comprehensive, patient-centered care, and many practices currently engage in this work. However, physicians are currently unable to receive appropriate payment for addressing SDOHs. Not only will this proposal incentivize QHPs not currently providing SDOH risk assessments, but it will ensure that physicians engaging in this practice are appropriately paid. **The AOA applauds CMS for establishing a new SDOH code, as well as for allowing the activity to be billed as part of an annual wellness visit, ensuring a patient can receive this service with zero cost sharing.**

Evaluation and Management (E/M) Visits

Visit Complexity Add-on Code

CMS is proposing to move forward with implementation of the office/outpatient (O/O) E/M visit complexity add-on code, G2211. This code was initially going to be implemented in the 2021 rule. However, congress enacted a moratorium on implementation through the end of 2023. The code would be reported in conjunction with O/O E/M visits to better account for additional resources associated with primary care, or similarly ongoing medical care related to a patient's single, serious condition, or complex condition.

While the AOA greatly appreciates CMS' efforts to bolster payment for office-based specialties that rely heavily on E/M services (including primary care, infectious disease, endocrinology, among numerous others), we have several concerns that must be addressed ahead of implementing payment for G2211.

First, CMS must provide greater clarity on when the new code may be reported. This includes providing guidance on the following:

- the typical patient for visits with a G2211 code to ensure that physicians utilize the appropriate code for managing care for patients with chronic conditions;
- the types of visits, services, or activities that the code is intended to account for;
- to what extent alternative codes (such as CCM, TCM, principal care management, or prolonged service codes) should be utilized in different instances;

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

- clarity regarding the phrase "single, serious or complex condition" within the code's descriptor and confirmation that the code may be used to manage care for a patient's serious or complex condition as well as their comorbidities.

A lack of clarity on these issues is not only problematic for physicians and likely to impact adoption of the new code, but it has the potential to prompt audits as a result of unintended inappropriate uses of the code or lack of clarity on the part of compliance officers. Absent guidance on the above issues, we anticipate that utilization of G2211, as a share of eligible E/Ms, will be far lower than projected by CMS.

Second, the AOA is concerned that the assumptions relied upon by CMS in determining the impact of the code's implementation on budget neutrality are flawed and result in an inappropriate reduction to the conversion factor. CMS estimates a fast ramp up for billing by QHPs, with 38% of all E/Ms being billed with the code in 2024, rising in subsequent years to 54%. However, this is likely a significant overestimation, as demonstrated by adoption of chronic care management (CCM) and transitional care management (TCM) codes. Nearly 66% of Medicare beneficiaries are eligible for CCM services, but these codes accounted for only 2.3% of all eligible claims. Similarly, TCM services were only found on 9.3% of claims for the total eligible population.[3]

While we agree with CMS that there is a need for the G2211 code, and many physicians will be quick to adopt it, the overall ramp up estimated by CMS would rely on:

- Clear guidance from the agency on how the new code should be billed;
- Aggressive efforts by stakeholders, including physician associations, to educate physicians on the new code.

Additionally, the new code is intended to account for activities that include chronic disease management tracking, review of consult or lab reports, medication-related monitoring and safety outside of patient visits, and physician input at assisted living or nursing homes. As a result, it will most likely be billed in circumstances where a visit is complex and relates to continuous care. A large share of E/M visits do not meet these requirements.

While the AOA is committed to educate osteopathic physicians on the availability and appropriate use of this new code, we believe it is improbable that 38% of E/M services will be billed with G2211 in the first year of adoption, and that 54% of E/M services will be billed with the code in subsequent years.

Definition of Split (Or Shared) Visits

In its CY2022 proposed rule, CMS proposed a policy for split (or shared) E/M visits for physicians and other qualified health care professionals in the facility setting where "incident to" billing is not allowed. While AOA supported the change overall, we were very concerned with CMS' proposal

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

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

to base the definition of "substantive portion" of a split or shared E/M visit on the practitioner who provides "more than half of the total time" performing the visit.

CMS' proposal to base the definition of the "substantive portion" of a split or shared E/M visit on more than half of the total time is inconsistent with CPT guidelines. E/M services may be reported based on time or medical decision-making, and the CPT code book defines how the substantive portion of a visit may be determined for each. CMS' proposal to base the definition of "substantive portion" of a visit entirely on which practitioner spends the most time with the patient is inconsistent with CPT guidelines. This proposed definition may disadvantage physicians and disincentivize a team-based approach to patient care.

The AOA supports CMS continuing to delay implementation of its revised definition of the "substantive portion" of a visit and urges CMS to ensure that any change in definition aligns with CPT coding guidelines. Until this point, we support CMS continuing to allow the use of either one of the three key components of a visit (history, exam, or medical decision making) or more than half of total time spent to determine who bills for a service.

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

Do the existing E/M HCPCS codes accurately define the full range of E/M services with appropriate gradations for intensity of services?
The AOA believes that current codes accurately define and reflect the full range of E/M services as they exist today, although current Medicare payment may not reflect the total cost of physician activities associated with delivering these services.

The AOA was closely involved in the recent effort by the CPT Editorial Panel and RUC Workgroup on E/M which revised the E/M office visit code descriptors and documentation guidelines that directly address administrative burden by simplifying the reporting and documentation process. The guideline changes allowed physicians to base their code selection on either time or medical decision making, and the RUC process resulted in increased valuations for these services which were ultimately adopted by CMS in 2021. We appreciate CMS' adoption of the workgroup's changes to E/M guidelines and RUC recommended service values. Code refinement is an iterative process as the practice of medicine evolves, and we appreciate CMS being responsive to the needs of the medical community.

The RUC and CPT process involves the participation of societies that reflect the entire physician and allied health professional community, and input from physicians across specialties helps to ensures that current codes, coding guidelines, and code values reflect current practice.

Whether commenters believe that the current AMA RUC is the entity that is best positioned to provide recommendations to CMS on resource inputs for work and PE (Practice Expense) valuations, as well as how to establish values for E/M and other physicians' services; or if another

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

independent entity would better serve CMS and interested parties in providing these recommendations.

The AOA finds this question concerning and firmly believes that the RUC is the entity best situated to make recommendations regarding resource inputs for services. The RUC is comprised of volunteer physicians across specialties that 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 delivering services 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.

Geographic Practice Cost Indices

The AOA endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality health care in rural areas. CMS notes in the proposed rule that CY2024 GPCIs do not reflect a 1.0 work GPCI floor as the required floor expires on December 31, 2023.

The change will result in reduced payment in localities where the work GPCI floor is currently applied. While AOA opposes the change, it recognizes that legislative action is needed to resolve the issue, as this results from the expiration of the floor established by Congress. According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI values raised by the floor to the national average.[4] **The AOA encourages CMS to work with Congress to extend the GPCI floor and permanently extend certain adjustments for cost of practice, especially in rural settings that tend to have more patients in medically underserved areas.**

Advancing Access to Behavioral Health

Osteopathic physicians fill a critical need in our nation's health care system, as many practice in rural and underserved areas. Further, osteopathic physicians are trained in a "whole person" approach to care, which involves treating all aspects of a patient's illness or injury. With the focus on the whole patient as the guiding philosophy of osteopathic medicine, we believe that treatment strategies must be comprehensive and able to address each individual patient's needs. We commend CMS' efforts to support comprehensive care and integration of behavioral health into primary care and other specialty practices.

[4] Government Accountability Office. "Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort." February 2022. Available here.

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

General Behavioral Health Integration Care Management services
Out of concern for undervaluation of care management services as practices seek to implement behavioral health integration, CMS is proposing to update values for the corresponding codes (99484 and G0323). Many practices identify financial barriers and poor payment rates as barriers to integrating behavioral health into their practice. Enhanced payment will support delivery of integrated care as cost is often a barrier for many practices.[5]

Psychotherapy Services
CMS proposed increasing the valuation for psychotherapy services, phasing in the increases over four years to achieve a 19.1% increase over current values. We agree with CMS that these services may be undervalued, and as we previously noted, low payment rates are a primary barrier to physicians integrating behavioral health into their practice, particularly in primary care. **The AOA supports enhanced reimbursement for these services to promote access and support integrated, comprehensive patient care.**

PFS Substance Use Disorder (SUD) bundle (HCPCS codes G2086-G2088)
CMS is proposing to increase the valuation of codes for office-based treatment of SUD to be priced consistent with the crosswalk codes used to value the bundled payments made for OUD treatment services furnished at OTPs. As CMS notes in the rule, beneficiaries receiving buprenorphine in settings outside of OTPs have similarly complex care needs as compared to beneficiaries receiving OUD treatment services at OTPs. **Many addiction medicine specialists provide services outside of an OTP setting, and this change will support appropriate payment for office-based treatment of OUD.**

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes revising the definition of NP in this section to require that an NP be certified as a primary care nurse practitioner at the time of provision of services by a recognized national certifying body that has established standards for nurse practitioners and possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree. The agency notes this change would be consistent with the American Nurses Association definition of NP. However, the agency seeks comment on whether the definition of NPs should specify that an NP's certification be in the area of primary care, or whether this distinction should be removed. While we agree with the proposed definition change, **we advise against removal of the requirement for certification in primary care. It is essential that CMS ensures that all NPs billing Medicare and treating Medicare patients at FQHCs and RHCs be "trained to offer comprehensive, continuous care for patients with most health needs, including chronic conditions."** Allowing nurses without the requisite training to manage patients' care can result in serious harm, especially in settings that

[5] Grazier KL, Smiley ML, Bondalapati KS. Overcoming Barriers to Integrating Behavioral Health and Primary Care Services. J Prim Care Community Health. 2016 Oct;7(4):242-8. doi: 10.1177/2150131916656455. Epub 2016 Jul 4. Available here.

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

predominantly treat low-income patients who present with worse health status and more complex needs.

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 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 Quality Payment Program

MIPS Performance Category Weights

The AOA appreciates CMS maintaining MIPS performance category weights for the 2024 performance year consistent with 2023 weights. This will support stability within the program and help physicians in performing to consistent targets year-over-year. Additionally, small and independent practices continue to face challenges in meeting requirements under the promoting interoperability performance category. We have appreciated CMS granting these practices flexibility in recent years in light of the challenges these practices face with adopting certified health IT and engaging in health information exchange. **We encourage CMS to continue its policy of granting exceptions to these practices in subsequent years.**

MIPS Performance Threshold

CMS is proposing to increase the performance threshold used to determine physicians' payment adjustments from 75 points to 82 points. CMS is basing the new performance threshold on mean performance between the 2017 and 2019 performance years. **While the AOA appreciates that CMS plans to use multiple years of performance data to determine threshold changes, we are deeply concerned about CMS implementing the performance threshold change at this moment. While this change will present challenges for physicians across practice settings, we are especially concerned about how this may disadvantage physicians in small and independent practices.**

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

The MIPS program was very different during the time period used as the benchmark for the new performance threshold. During the 2017 to 2019 performance years, performance category weights were substantially different, as were the available measures across the various performance categories. For example, the cost category was weighted at 0%, 10%, and 15% for 2017, 2018, and 2019, respectively. However, it comprises 30% of the total score today, and physicians now perform against newly developed episode-based cost measures and a revised total per capita cost measure.

Additionally, the increased threshold may make performance exceptionally challenging for many small and independent practices. Many practices have been exempted from MIPS requirements since 2020 through applying for an extreme and uncontrollable circumstances (EUC) exemption due to the COVID-19 pandemic. For the last 3 years, these physicians would receive no adjustment to their payment under MIPS. However, the program has changed substantially since many of these physicians last participated in the program, and they will be re-entering with a higher performance threshold which will compound challenges they face complying with program requirements. Additionally, these changes come amid the backdrop of the PHE expiring only a few months ago. Not only are many practices struggling to recover from challenges they faced during the PHE, but they are also adjusting to post-PHE policies.

In light of these concerns, we urge CMS to delay its proposal for at least 2 years to (1) allow physicians to adjust to new program requirements, and (2) calculate the new performance threshold using more current performance scores that reflect the current state of the program.

Value in Primary Care MIPS Value Pathway (MVP)

CMS proposes to consolidate the Promoting Wellness and Optimizing Chronic Disease Management MVPs into a single MVP, referred to as the Value in Primary Care MVP. Accordingly, CMS proposes changes to measures and activities under each of the performance categories. While the AOA appreciates CMS' efforts to simplify the MIPS programs, and MVPs, it is concerned about the duplicative nature of having both episode-based cost measures and a total per capita cost (TPCC) measure under the cost category. This will result in care rendered for episodes associated with asthma/COPD, diabetes, depression, and heart failure to have an outsized influence on physicians' cost score. Each of these measures are already captured under the TPCC. Additionally, we are concerned about continued challenges with the TPCC measure including issues with patient attribution, risk adjustment, and potential outliers. In particular, we remain concerned about how the TPCC measure, as constructed, holds physicians accountable for costs they may not be able to control, such as drug prices, including services and drugs administered by other physicians. **With this in mind, we urge CMS to re-evaluate its approach to the cost category for the new Value in Primary Care MVP.**

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750

osteopathic.org

New MIPS Value Pathways

CMS proposes to establish 5 new MVPs which include: (1) Focusing on Women's Health; (2) Prevention and Treatment of Infectious Disease, Including Hepatitis C and HIV; (3) Quality Care in Mental Health and Substance Use Disorders; (4) Quality Care for Ear, Nose, and Throat (ENT) Disorders; and (5) Rehabilitative Support for Musculoskeletal 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. Ultimately, this will support improved quality measurement and make participation in the MIPS program easier for many specialists.

Conclusion

The AOA is pleased to have the opportunity to comment on the CY2024 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,

Ira P. Monka, DO, MHA, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

October 4, 2023

The Honorable Denis Richard McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Secretary McDonough:

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and medical students we represent, thanks the Department of Veterans Affairs (VA) for the opportunity to provide comments as it develops national standards of practice for 50 health professions across VA facilities, an effort referred to as the Supremacy Project. As background, the AOA promotes public health, encourages scientific research, serves as the primary certifying body for DOs and is the accrediting agency for osteopathic medical schools.

We appreciate the VA convening a series of listening sessions to allow external stakeholders the opportunity to provide input in the standards development process, and we hope that the VA will continue to collaborate with external stakeholders throughout this process.

The AOA supports the physician-led team-based approach to medical care because it ensures that professionals with complete medical education and training are adequately involved in patient care. Physicians across the United States must meet the same education, training and testing requirements and practice in supervised environments that afford progressively greater autonomy before ultimately becoming eligible to treat patients on their own. These requirements ensure that all patients receive safe treatment and the same standard of care regardless of their location, socioeconomic status, or other factors. They also uniquely prepare physicians to understand and recognize the subtle differences between many minor ailments (i.e. the common cold, indigestion) and serious ones (i.e. pneumonia, heart attack) that share similar symptoms, and to engage in safe prescribing practices.

We are deeply concerned that if the VA expands the scope of practice for healthcare professions that receive far less training than physicians, such as physician assistants (PAs), certified registered nurse anesthetists (CRNAs), and optometrists, via the supremacy project, this will result in America's veterans receiving a lower standard of care within the VA system relative to patients seeking care in civilian hospitals.

The physician-led, team-based model of care is used in nearly every hospital across the country, and due to the depth and rigor of physician training, this is essential to ensuring that patients receive the highest standard of care. The requirements for licensure as an osteopathic physician (DO) or an allopathic physician (MD) in the United States are substantially similar, and include:

- **Four years of medical school,** which includes **two years of didactic study** totaling upwards of 750 lecture/practice learning hours just within the first two years, **plus two more years of clinical rotations** performed in community hospitals, major medical centers and doctors' offices.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

- Physicians also complete a **comprehensive, three-part licensing examination** series designed to test their knowledge and ability to safely deliver care to patients before they are granted a license to independently practice medicine.
- **12,000 to 16,000 hours of supervised postgraduate medical education** ("residencies") completed over the course of **three to seven years,** during which DO and MD physicians develop advanced knowledge and clinical skills relating to a wide variety of patient conditions.
- Many physicians then choose to sit for certifying board examinations which serve as a mark of excellence in their chosen specialty.

Veterans treated in the VA system often have unique healthcare needs as a result of their military service, and physician expertise is essential to ensuring proper management of their care. Indeed, a 2022 study of 44 VA emergency departments comparing the productivity of non-physician clinicians (specifically, nurse practitioners [NPs]) and physicians in VA emergency departments concluded that NPs practicing without physician involvement raised the 30-day preventable hospitalization rate by 20% and increased length of stay by 11%.[1] The study also concluded that their higher resource use and worse outcomes made NPs less productive, on average, than physicians, and that these productivity differences were so significant that it is more costly to employ NPs than physicians, even accounting for differences in salary.[2]

Untested models of care have the potential to expose America's veterans to unnecessary tests and medications as a result of non-physician providers' comparably lower level of training, which does not equip them to adequately address the complex needs of this population. Outlined below are additional, specific concerns with proposed changes to standards of practice for CRNAs, optometrists and PAs, which are currently being developed by the VA.

Certified Registered Nurse Anesthetists

Veteran patients are often at high risk when undergoing anesthesia due to underlying co-morbidities such as toxic lung exposure, cancer, chronic obstructive pulmonary disease, neuromuscular degeneration from loss of limbs, heart disease, and numerous other ailments. CRNAs are not equipped with the expertise to safely make split-second decisions that physicians' unique training affords, which could make a life-or-death difference for these patients. CRNAs only complete a two-year master's degree in a nurse anesthesia program, and they have no required post-graduate training.

The current team model of anesthesia care was reaffirmed by the VA in 2017 after a multi-year rulemaking process that generated a record number of 200,000 comments, including more than 20,000 comments by veterans, in favor of the anesthesia team model. The VA agreed and rejected a nurse-only model for anesthesia care in the final rule (38 CFR § 17.415). Alternative care models are untested and present risk for increased costs, and more importantly, patient harm.

The above-mentioned study of NPs – who receive a similar amount of training to CRNAs – in VA emergency departments found that "on average, NPs use more resources but achieve worse patient outcomes relative to physicians." When accounting for the cost of ED care, the cost of hospital admissions for severe cases, and the costs of 30-day preventable hospitalizations, the study found that substituting NPs with physicians in the ED

[1] Chan, D. and Chen, Y. *The Productivity of Professions: Evidence from the Emergency Department.* June 2023. Available at: http://web.stanford.edu/~chand04/papers/np_md_paper.pdf
[2] *Ibid.*

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

settings may cost the VA system up to $160 million per year. We are deeply concerned about similar costs and negative outcomes resulting from CRNAs being granted authority to practice independently.

While many stakeholder groups representing CRNAs and other non-physician clinicians have urged for expanding scope of practice to address patient access challenges, research demonstrates that allowing non-physician clinicians to practice independently does not solve access-to-care issues. In fact, it shows that these individuals largely choose to practice in areas where physicians are already practicing.[3] Additionally, expanding scope of practice for CRNAs within the VA does not solve any demonstrated problem, as there is currently no evidence of shortages of anesthesiologists within the VA system. Maintaining physician-led anesthesia care as the standard across the VA system will ensure that veterans continue to receive high-quality, safe, and effective care.

Optometrists

Optometry and ophthalmology are significantly different fields of practice with vastly different training. An optometrist holds a four-year doctorate degree and a license to practice optometry, while an ophthalmologist is a physician specialist who has completed a four-year medical doctorate, plus three years of postgraduate medical education in ophthalmology, and often holds a specialty board certification which involves an additional examination that demonstrates their mastery of the field. Generally, optometrists' education involves 110 combined hours of course work and clinical training in general and ocular pharmacology for their doctorate degree, one year of supervised experience, and a two-hour course in preventing medical errors. While optometry programs in the United States and Canada require clinical training for their students during their final academic year, the length is unspecified, and it typically varies between only 8 and 16 weeks. Optometry training typically does not entail extensive clinical training in laser and surgical procedures.

The tissue in and around the eye is extremely delicate and, if damaged, very difficult, if not impossible, to repair. For that reason, optometrists have historically been required to refer patients to an ophthalmologist for surgery because of the complexity of the procedures and seriousness of the potential negative outcomes, which can include blindness. For this reason, most states do not allow optometrists to perform surgical procedures. Only 12 states allow optometrists to perform some surgical procedures and among these, only eight allow optometrists to perform a limited range of laser procedures. However, in states that have expanded scope of practice, evidence shows a substantial risk of patient harm.

For example, a 2016 study in Oklahoma, a state with expanded scope of practice for optometrists, analyzed the results of laser trabeculoplasty (LTP) procedures performed by optometrists and ophthalmologists. LTP is a procedure that applies laser energy to the trabecular meshwork (a narrow zone around the base of the cornea that regulates eye pressure) in patients with elevated eye pressures or glaucoma. The study found that "the proportion of eyes undergoing laser trabeculoplasty (LTP) by an optometrist requiring 1 or more subsequent LTP session (35.9%) was more than double the proportion of eyes that received this procedure by an ophthalmologist (15.1%). Medicare beneficiaries undergoing LTP by optometrists had a 189% increased hazard of requiring additional LTPs in the same eye compared with those receiving LTP by ophthalmologists."[4] Due to the lack of appropriate

[3] See sample NP workforce maps for Wyoming, Delaware.

[4] Stein JD, Zhao PY, Andrews C, Skuta GL. Comparison of Outcomes of Laser Trabeculoplasty Performed by Optometrists vs Ophthalmologists in Oklahoma. JAMA Ophthalmology. 2016 Oct 1;134(10):1095-1101. doi: 10.1001/jamaophthalmol.2016.2495. PMID: 27467233.

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

training in laser procedures among optometrists, and the demonstrated risk for harmful outcomes, it is in the VA's interest to reconsider any substantial changes to standards of practice for optometrists.

Physician Assistants

Authorizing the independent practice of medicine by PAs, who do not complete the comprehensive medical education, training, and competency demonstration requirements that physicians complete, could place the health and safety of the VA's patients at risk. **PA education entails:**[5]

- A **two-year master's degree** comprised of **fourteen months of didactic study** and **one year of clinical rotations.**
- **No supervised postgraduate "residency" training.**
- A **single, national certifying examination** created by an organization comprised of other PAs.

PAs do not have the extensive medical education and training that physicians receive that prepares them to understand medical treatment of disease, complex case management and safe prescribing practices. Granting them the ability to practice similarly to a primary care physician, without evidence regarding patient safety outcomes, could result in harm to our veterans. Evidence shows that nonphysician clinicians, including PAs, tend to issue poorer quality referrals to specialists[6] and order unnecessary diagnostic imaging[7] compared to physicians, resulting in increased costs and worse outcomes.

Conclusion:

The AOA strongly supports the physician-led, team-based model of care for the health and safety of our veterans. We welcome the opportunity to work with the VA and hope that the agency chooses to engage with physician stakeholder groups, which develop clinical guidelines for many of the services that would be impacted and have expertise in leading patient care, as part of its standard development process. Physician input is essential to ensure patient safety, and we encourage the VA to continue to seek input from experts beyond its internal stakeholders. If the AOA can help support your efforts, please contact John-Michael Villarama, MA, Vice President, Public Policy at jvillarama@osteopathic.org. On behalf of the osteopathic medical profession, thank you again for considering our comments.

Sincerely,

Ira P. Monka, DO, MHA, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

[5] https://www.dmu.edu/pa/curriculum/.

[6] R. Lohr, C. West, M. Beliveau, et al. Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners. Mayo Clinic Proceedings, Oct. 11, 2013.

[7] D. Hughes, M. Jiang and R. Duszak Jr. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Medicine, January 2015.

December 20, 2023

The Honorable Ur M. Jaddou
Director
U.S. Citizenship and Immigration Services
U.S. Department of Homeland Security
5900 Capital Gateway Drive
Camp Springs, MD 20746

Re: DHS Docket No. USCIS–2023–0005: Modernizing H-1B Requirements, Providing Flexibility in the F-1 Program, and Program Improvements Affecting Other Nonimmigrant Workers

Dear Director Jaddou,

As organizations that together represent close to 600,000 frontline physicians, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and the American Psychiatric Association write to provide comments on the Department of Homeland Security's (DHS) recent proposed rule Modernizing H-1B Requirements, Providing Flexibility in the F-1 Program, and Program Improvements Affecting Other Nonimmigrant Workers.

H-1B physicians and other international medial graduates (IMGs) are vital to addressing our country's worsening physician shortages, strengthening our ability to respond to current and future public health threats, and ensuring equitable access to high-quality health care. More than 10,000 physicians are employed each year through the H-1B program to provide essential patient care across the nation.[1] Health systems rely on H-1B physicians to fully staff hospitals and outpatient clinics, particularly in rural and other underserved communities. IMGs are more likely to become primary care physicians and practice in rural and other underserved areas where physician shortages are the most dire.[2,3] In fact, nearly 21 million Americans live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians.[4] Thus, to ensure our immigration system supports H-1B physicians' ability to continue living and practicing in the United States, we offer the following comments on the proposed rule.

<u>Labor Condition of Application</u>

H-1B physicians and other employees are required to have a certified labor condition of application (LCA) from the Secretary of Labor. To obtain an LCA, employers must attest that certain conditions are met, including specifying the geographic area of intended employment of the H-1B visa holder. A new or amended LCA is required if an H-1B employee wants or needs to work in other geographic areas. This requirement created significant challenges for H-1B physicians, their employers, and their communities during the COVID-19 public health emergency since they could not fill health care gaps in geographies other than those specified in the LCA. The requirement to file new petitions delayed physicians' ability to provide telehealth services or provide in-person care in COVID-19 hotspots or underserved areas, potentially worsening access barriers and care delays for patients.

The proposed rule would specify that short-term placements of less than 30 days, or in some cases 60 days, in other geographic areas would not require an amended or new LCA, assuming there are no other

material changes. **Our organizations support these additional flexibilities, but we strongly recommend that DHS allow longer temporary short-term placements for physicians beyond those proposed in the rule. This would enable physicians to provide care during public health emergencies, including those due to natural disasters or localized disease outbreaks, and enable underserved communities across the nation to maximize their capacity to respond to health care emergencies.**

F-1 Cap-Gap Extension

Due to adjudication delays, DHS proposes to extend the cap-gap extension by six months to April 1 of the relevant fiscal year to avoid disruptions for F-1 visa students that are transitioning to H-1B employment. **Our organizations support this proposal, as we believe it will prevent employment and visa disruptions for F-1 medical students to remain in the U.S. for their residency.**

Definition and Criteria of a Specialty Occupation

DHS is proposing to amend the definition of "specialty occupation" to clarify that the required specialized studies and degree must be directly related to the position. DHS also has proposed to add language stating that a position is not a specialty occupation if attainment of a general degree, without further specialization, is sufficient to qualify for the position. Moreover, the proposed rule states that an individual must have at least a U.S. baccalaureate or higher degree in a directly related specific specialty, or its equivalent, to qualify for an H-1B.

Our organizations note that physicians clearly meet the education requirement by obtaining a medical degree and then undergoing between three and seven years of residency training to gain specialized knowledge and training in their chosen area of medicine. However, we are concerned that the new definition could be interpreted to mean that the Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degrees physicians obtain are "general degrees" and thus disadvantage physicians. **We recommend DHS clarify in the final rule that the amended definition does not disadvantage or change the "specialty occupation" status for physicians.**

H-1B Cap Exemptions

DHS proposed to revise the requirements to qualify for an H-1B cap exemption when a visa holder is not directly employed by a qualifying entity and to revise the definition of "non-profit research organization" and "governmental research organization." Specifically, the proposed rule clarifies that H-1B visa holders that equally split their work time between a cap-exempt entity and a non-cap-exempt entity may be eligible for a cap exemption. DHS also proposed to remove the requirement that a beneficiary's duties "directly and predominately further the essential purpose, mission, objectives or functions" of the qualifying institution, organization, or entity and replace it with the requirement that the beneficiary's duties "directly further an activity that supports or advances one of the fundamental purposes, missions, objectives, or functions" of the qualifying entity. Our organizations support these proposals and believe they will provide physicians and their employers with helpful flexibilities, as well as support H-1B physician researchers.

We appreciate the opportunity to provide comments on the proposed rule. Should you have any questions, please contact Meredith Yinger, the AAFP's Senior Manager of Federal Policy at myinger@aafp.org.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Osteopathic Association
American Psychiatric Association

---

[1] Kahn PA, Gardin TM. Distribution of Physicians With H-1B Visas By State and Sponsoring Employer. JAMA. 2017;317(21):2235-2237. doi:10.1001/jama.2017.4877

[2] Thompson MJ, Hagopian A, Fordyce M, Hart LG. Do international medical graduates (IMGs) "fill the gap" in rural primary care in the United States? A national study. *J Rural Health*. 2009 Spring;25(2):124-34. doi: 10.1111/j.1748-0361.2009.00208.x. PMID: 19785577

[3] Ranasinghe PD. International Medical Graduates in the US physician workforce. The Journal of the American Osteopathic Association, April 2015, Vol. 115, 236-241. Available at: https://jaoa.org/article.aspx?articleid=2213422#:~:text=Compared%20with%20US%20graduates%2C%20IMGs,the%20US%20health%20care%20system.

[4] American Immigration Council. Foreign-Trained doctors are critical to serving many U.S. Communities. 2018. Available at: https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

January 5, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4205-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4205-P)

Dear Administrator Brooks-LaSure:

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students we represent, appreciates this opportunity to comment on the Contract Year 2025 Medicare Advantage (MA) and Part D proposed rule. We also wish to express our gratitude to the Centers for Medicare & Medicaid Services (CMS) for its commitment to alleviating physician administrative burden, improving access to care, increasing transparency, and promoting health equity.

As osteopathic physicians, we are trained in a patient-centered, whole-person approach to care. As we partner with our patients to understand their backgrounds and health care needs, having a variety of treatment tools at our disposal and freedom to discuss all treatment options is crucial. We believe policies should be tailored to empower physicians in partnering with patients to make treatment decisions that will result in the best outcomes. As physicians practicing in rural and underserved settings, we also recognize the impact delays in access have on adherence to treatment plans and how policies can support vulnerable patients' access to care. It is with this perspective that we share the following comments on the changes proposed by CMS.

Expanding Network Adequacy Requirements for Behavioral Health

The AOA commends CMS' efforts to improve access to behavioral health services, recognizing the critical importance of meeting Medicare beneficiaries' behavioral health needs. Nearly a quarter of Medicare beneficiaries live with a mental illness, yet less than half are estimated to receive treatment.[1] This gap can be attributed to shortages of providers as well as the need for

[1] McGinty, Beth. "Medicare's Mental Health Coverage: What's Included, What's Changed, and What Gaps Remain," The Commonwealth Fund. March 2, 2023. Available here.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

more robust plan networks. It is estimated that Medicare Advantage plans pay 13-14% less for mental health services than fee-for-service Medicare, which may contribute to low participation in MA plans by behavioral health providers and poor access among MA beneficiaries.[2] CMS' proposal to create an "Outpatient Behavioral Health" facility-specialty type for MA network adequacy standards would help to address this issue. Quantitative time and distance standards are essential to ensuring MA beneficiaries can access needed care. This is especially critical for patients with substance use disorder (SUD), where any delays in finding and accessing a provider may result in the patient not seeking treatment.

In addition to establishing this new facility type, we believe it is critical for CMS to ensure that MA plans are contracting with a sufficient number of individual providers that would further support appropriate access to outpatient treatment. While CMS describes challenges in adopting network requirements for individual clinicians authorized to offer medication-assisted opioid use disorder treatment, adding a network requirement for addiction medicine specialists could be an appropriate alternative. Ultimately, access to office-based services is essential to ensuring timely access to behavioral health services when and where patients need it.

Standards for Electronic Prescribing (§ 423.160)

CMS is proposing a series of changes to support electronic prescribing and related electronic transactions, including:

- Requiring use of National Council of Prescription Drug Programs (NCPDP) SCRIPT standard version 2023011or communication of a prescription or prescription-related information supported by Part D sponsors;
- Requiring use of NCPDP Real-Time Prescription Benefit (RTPB) standard version 13 for prescriber Real-Time Benefit Tools (RTBTs);
- Requiring use of NCPDP Formulary and Benefit (F&B) standard version 60; and
- Cross-referencing standards adopted for eligibility transactions in Health Insurance Portability and Accountability Act (HIPAA) regulations at 45 CFR 162.1202 for requirements related to eligibility inquiries.

Part D sponsors would be required to comply with the new standards by January 1, 2027. The AOA appreciates CMS' efforts to promote the adoption of the most current technological standards to support efficient electronic prescribing, prior authorization, and benefit check processes. CMS' efforts to align its regulations with the standards from the Office of the National Coordinator for Health Information Technology (ONC) under the Health IT (HIT) certification program, and the Office for Civil Rights (OCR) HIPAA transaction standards, will help alleviate compliance challenges for developers, promote use of the most current standards, and support continued widespread adoption of electronic processes related to prescribing.

---

[2] Pelech and Hayford. "Medicare Advantage And Commercial Prices For Mental Health Services." Health Affairs. Vol. 38, No. 2. February 2019. Available here.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

Additionally, the requirement for the NCPDP RTPB standard version 13 will strongly support broader adoption of RTBT tools. Policies that support the availability and adoption of RTBTs allow physicians to view patient's plan benefits at the point of care, often within their workflow, and make prescribing decisions accordingly. Several analyses[3], including one conducted by Johns Hopkins Medicine, have found the use of RTBTs alleviate physician burden. The tools do so by helping guide physicians to prescribing options that do not require prior authorization, and they reduce patient costs by displaying prescribing options based on a patient's plan benefit. Display of costs as well as pharmacy networks help to reduce prescription abandonment.[4] Currently, CMS regulation for Part D plans only requires plan sponsors to support at least 1 RTBT tool and does not require compliance with standards. The lack of established standards creates interoperability challenges, hinders workflows, and limits adoption of these technologies. This may be a contributing factor towards findings from ONC that only 50% of acute care hospitals' EMR systems broadly integrate with health plan real-time prescription benefit information.[5] This number is likely lower for physician practices.

Overall, the AOA supports efforts to promote interoperability and reduce provider burdens. CMS' proposal to adopt new technological standards and align Part D regulation with ONC certification program and HIPAA regulation will support these goals.

Additional Changes to an Approved Formulary— Biosimilar Biological Product Maintenance Changes and Timing of Substitutions (§§ 423.4, 423.100, and 423.120(e)(2))

Substituting Biosimilar Biological Products for Their Reference Products as Maintenance Changes

CMS proposes to include substitutions of biosimilar biological products other than interchangeable biological products for their reference products as maintenance changes. This means that plans may make negative formulary changes by removing a reference product from their formulary, or moving it to a higher cost-sharing tier, and substituting it with a biosimilar, as long as the plan submits a change request to CMS and provide a 30-day notice to enrollees. CMS also notes that it is continuing to consider its proposal from the December 2022 proposed rule to permit plan sponsors to immediately substitute an authorized generic for a brand name drug, an interchangeable biological product for a reference product, or an unbranded biological product for its corresponding brand name biological product.

While we recognize that biosimilars are rigorously evaluated by FDA for safety and efficacy, we are deeply concerned about interventions by plans that remove control of the treatment plan from the physician and disrupt the patient-physician relationship. We are particularly troubled by

---

[3] Shiven Bhardwaj, Jessica W. Merrey, Martin A. Bishop, Hsin-Chieh Yeh, Jeremy A. Epstein, Impact of Real-Time Benefit Tools on Patients' Access to Medications: A Retrospective Cohort Study, The American Journal of Medicine, Volume 135, Issue 11, 2022

[4] Ashwini Davison and Jessica Merrey. NCPDP Foundation RTPB Grant: Final Report. Johns Hopkins Medicine. February 2021. Available at: http://ncpdpfoundation.org/pdf/NCPDPFoundationRTPBGrant_FinalReport.pdf

[5] HHS Office of the National Coordinator for Health Information Technology. "Hospital Adoption of Real-Time Benefit Tools". Available here.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

provisions to permit immediate substitutions of interchangeable biologics without advance notice to plan enrollees or providers.

The AOA opposes this proposal as such substitutions can cause disruption to patient care or result in unexpected cost-sharing when patients seek to continue accessing the originally prescribed reference product. Instead of permitting substitutions that undermine physicians in working with patients to make decisions that are best for their care, CMS should instead focus on policies that empower physicians when partnering with their patients. This could include efforts to drive broader access to, and use of, RTBTs among providers. As we noted in our support above for the RTPB proposals, allowing physicians to review patients' health plan coverage, formularies, and benefits at the point of care would be an effective approach to ensure that patients and their physicians are making informed decisions that best meet each patient's unique needs. While we acknowledge the administration's goal to increase competition and ensure adequate pharmaceutical access, we urge CMS to reconsider this proposal.

Supplemental Benefits for Enrollees

In recent years, the number of plans using rebate dollars to offer supplemental benefits to enrollees has been steadily increasing. Many of these supplemental benefits provide great promise for addressing health related social needs, and include services such as meal and nutrition services, transportation, fitness benefits, and in-home support.[6] The availability of these services through MA plans aligns closely with broader CMS efforts to address social determinants of health and support provider efforts to connect patients with these needed services.

However, CMS notes that utilization of these supplemental benefits is low, limiting their impact. The AOA supports CMS' proposal to require MA plans to engage with enrollees in midyear outreach to help make them aware of unused benefits to increase supplemental benefit utilization. By providing resources, instructions, and specific details of benefits not yet used to each enrollee, MA plans would be able to support their beneficiaries with the high-quality, comprehensive benefits they offered at enrollment.

Annual Health Equity Analysis of Utilization Management (UM) Policies and Procedures

The AOA strongly supports CMS' proposals to improve oversight of plans' utilization management practices to ensure that they do not drive inequities or disproportionately impact specific populations. As examples, studies have found that:

- In qualified health plans (QHPs), regional disparities exist in prior authorization (PA) for pre-exposure prophylaxis (PrEP) for HIV prevention, with beneficiaries in the south being 16 times more likely to be subject to PA for PrEP than beneficiaries in the Northeastern U.S.;[7]

[6] Avalere Health. "More Medicare Advantage Plans Will Offer Non-Medical Benefits in 2022." October 2021. Available here.

[7] McManus KA, Powers S, Killelea A, Tello-Trillo S, Rogawski McQuade E. Regional Disparities in Qualified Health Plans' Prior Authorization Requirements for HIV Pre-exposure Prophylaxis in the United States. JAMA Netw Open. 2020;3(6):e207445. doi:10.1001/jamanetworkopen.2020.7445

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

- An analysis by the Kaiser Family Foundation finding that individuals with specific health conditions (such as mental health conditions or diabetes) being more likely to experience PA requirements than other beneficiaries;[8] and
- Hispanic patients have been found less likely than white patients to fill a prescription after it was rejected by prior authorization (31% vs 44%).[9]

Prior authorization places substantial time and cost burden on physician practices, and care delays associated with PA often lead to serious adverse events among patients. CMS' proposals in this rule make a significant step forward in promoting transparency, ensuring accountability in UM practices, and ensuring that UM does not exacerbate health inequities.

CMS proposes to require plans to confirm at least one member of their UM committee has "health equity expertise" as defined in the proposed rule. The AOA supports this proposal, and for an informed understanding of health equity within the health care system, we encourage CMS to expand its definition of a "health equity expert" to include a provider with clinical experience.

CMS also proposes to require plans to conduct annual health equity analyses for the use of prior authorization to evaluate the impact of PA on dual eligible and disabled enrollees, comparing data on the use of PA for these beneficiaries to other enrollees. While this change will be a significant step forward, several elements of this proposal that can be improved to better protect patients from unnecessary, and even discriminatory, prior authorization practices.

First, the AOA is concerned with the narrow definition of "disabled enrollees" for conducting analyses. CMS proposes to require reporting of data for disabled enrollees by determining disability status using the variable original reason for entitlement code (OREC) for Medicare. However, it is also important to include in the analysis of potential inequities those Medicare enrollees who are over the age of 65 and have a disability but did not originally qualify for Medicare on that basis. According to the 2021 Census Bureau American Community Survey, almost 20 million Americans ages 65 and over reported having a disability[10]. In November 2023, only 7.4 million Americans of all ages received Social Security Disability Insurance (SSDI) benefits.[11] After a 24-month qualifying period receiving SSDI, patients with qualifying disabilities become eligible for Medicare. This means there are millions of beneficiaries over 65 who likely never qualified for Medicare due to their disability status but may still face challenges with PA due to a disability. We commend CMS' efforts to identify disparities in health care access for vulnerable populations that enroll in Medicare Advantage and encourage CMS to

[8] Pestaina, Lopes, Wallace, and Lo. "Consumer Problems with Prior Authorization: Evidence from KFF Survey." Kaiser Family Foundation. September 29, 2023. Available here.
[9] American Journal of Managed Care. Expert Panel Offers Insight Into Multifaceted Approach to Addressing Health Care Disparities. Available here.
[10] US Census Bureau. "S1810 Disability Characteristics." 2021. Available here.
[11] Center on Budget and Policy Priorities. "Chart Book: Social Security Disability Insurance." December 13, 2023. Available here.

511 2nd Street, NE
Washington, DC 20002
312.202.8000
osteopathic.org

expand the definition of "disability" for the health equity analysis. This will ensure that plan analyses comprehensively describe how PA impacts all of their disabled enrollees.

Second, CMS solicits comments on whether MA plans should be required to make the PA equity analysis data available in disaggregated format. The AOA strongly urges CMS to require detailed information regarding prior authorization metrics be publicly available, including metrics at the individual service level. Aggregated data of all services covered by a plan will not provide any useful insight to patients or providers that they can act on. It will be especially difficult to understand how PA impacts specific populations, including those with different disabilities, without understanding how PA is applied to the services they utilize.

Third, while each of these changes will improve transparency and accountability for plans' PA practices, we believe broader actions can help mitigate the burden and patient harm caused by inappropriate application of PA, especially for at-risk communities. These steps include:

- Publishing broader service-level data regarding utilization management practices applied across a plan, beyond those described in § 422.137 of the proposed rule, including appeal rates and decision reversals upon appeal;
- Implementing gold card programs designed to ensure that physicians who have a track record of appropriate utilization and proper documentation are waived from needing to obtain PAs for specific items or services for which they are regularly approved;
- Improving the application of PA within the pharmacy benefit and establishing parallel requirements as proposed for services; and
- Prohibiting low-value PA policies that create burden and provide limited benefit to patient safety or appropriate utilization.

We commend CMS' efforts to identify and address disparities in health care access for vulnerable populations enrolled in Medicare Advantage and hope to partner with the agency to continue developing comprehensive reform.

Agent Broker Compensation

The AOA supports CMS' proposal to redefine "compensation" to close the loophole that currently allows financial incentives for agents and brokers to direct beneficiaries to plans, not for the beneficiary's best interest, but for excessive compensation. We hope these proposed guardrails are finalized to ensure patients receive the health care coverage that best meets their needs.

Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization

The AOA supports CMS' proposal to increase the frequency of special enrollment periods for dually eligible enrollees with Medicare Advantage coverage to align coverage with their Medicaid provider or switch to traditional Medicare. Affordable and accessible health care coverage is necessary in supporting uninterrupted care and maintaining relationships between physicians and their patients.

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

Conclusion

Once again, the AOA is pleased to have the opportunity to comment on the proposed policy changes for the CY2025 MA and Part D rule. We commend CMS for incorporating feedback from the physician community as it works to reduce the administrative burden for physicians and improve other aspects of the MA and Part D programs. The AOA looks 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, MA, AOA Vice President of Public Policy, at jvillarama@osteopathic.org. Thank you again for considering the AOA's feedback as you continue your rulemaking effort.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750

osteopathic.org

January 12, 20224

Jackie Monson, JD
Chair
National Committee on Vital and Health
Statistics
CDC/National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782-2002

Sharon B. Arnold, PhD
Executive Staff Director, NCVHS
Associate Deputy Secretary
ASPE, Science and Data Policy
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20024

Rebecca Hines, MHS
Designated Federal Officer, NCVHS
Health Scientist
CDC/National Center for Health Statistics
Office of Planning, Budget, and Legislation
3311 Toledo Rd
Hyattsville, MD 20782

Re: ICD-11 Request for Information

Dear Ms. Monson, Dr. Arnold, and Ms. Hines:

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and medical students we represent, appreciates the National Council on Vital Health Statistics (NCVHS) seeking stakeholder input on the adoption and implementation of the ICD-11 through this request for information (RFI). While the International Classification of Disease (ICD) maintained by the World Health Organization is the global standard for health data, clinical documentation, and statistical aggregation, it must be implemented in a manner that meets the distinct needs of the U.S. healthcare system. This includes accounting for differences in public health reporting systems, documentation and billing, monitoring care quality, and research, among a range of other essential functions that the ICD system is used for.

As osteopathic physicians, we are trained in a patient-centered, whole-person approach to care. Osteopathic physicians play a critical role in our healthcare system, often serving in rural and underserved settings, and practicing across all medical specialties. DOs are fully licensed physicians for the complete scope and practice of medicine and surgery in all 50 states. We are unique in that our education focuses on a whole-person approach to care, and we receive additional training in osteopathic manipulative treatment (OMT). OMT is a non-interventional, non-pharmacologic treatment modality that involves the therapeutic application of manually guided forces by an osteopathic physician to improve physiologic function. As the organization representing osteopathic physicians who practice across different geographic settings, practice settings, and specialties, we offer the following feedback regarding adoption and implementation of ICD-11 in the US.

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

Question 1: Related to ICD–11 content and addressing U.S.-specific needs, which enhancements in classification content would be most useful?

d. Content on other topics?

Overall, the ICD-11 must be implemented in a manner that meets the distinct needs of the U.S. healthcare system. While some stakeholders have suggested that a full adoption of ICD-11 without modification may be possible, and studies of code mappings for specific disease areas suggest that a high match rate (above 95%) is possible, we are deeply concerned that there remain areas where complete mapping may not be possible without modifications.[1] This would have serious consequences for morbidity coding, billing, public health surveillance, and ultimately, overall patient care. As a result, while we appreciate the greater granularity ICD-11 affords in many areas, it is also essential that the codes available in ICD-11 reflect codes in ICD-10 as closely as possible.

In particular, the AOA is concerned about coding for "somatic dysfunction". The term "somatic dysfunction" is used to designate impaired or altered function of related components of the somatic (body framework) system, skeletal, arthrodial, and myofascial structures, and related vascular, lymphatic, and neural elements. A diagnosis of somatic dysfunction must include the appropriate body region where it is identified. While the ICD-10 had 10 separately billable codes to diagnose "segmental and somatic dysfunction" of various body regions, the ICD-11, as currently adopted by the WHO, collapses these into a single code. This will have harmful implications for documentation of patient conditions, reporting, billing, research, and other functions if implemented in the U.S.

When treating somatic dysfunction, physicians must report one of the 10 billable ICD-10 codes for segmental and somatic dysfunction (M99.00-M99.09) as a primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental. Documentation of the body regions affected and treated with OMT is necessary to justify the procedure code billed and the medical necessity of the service being performed, and to receive payment.

Additionally, the system of billing for OMT is based on the number of body regions treated. For the purpose of performing OMT, there are 10 body regions, with ICD-10 codes corresponding to the dysfunction of each region. The Common Procedural Terminology (CPT) codes for OMT (98925-98929) correspond to the total number of body regions treated, from 1 to 10. The collapsing of the segmental and somatic dysfunction codes to a single code (ME93.0) in the ICD-11 will have harmful consequences if implemented in the U.S. healthcare system, with implications across coding and payment systems. This change will hinder reporting of diagnoses in a uniform fashion, which will have implications for collecting data on morbidity and services performed, conducting OMT research, submitting appropriate documentation to payers, and receiving efficient claims review and payment. **When implementing ICD-11 in the US, HHS must ensure that 10 separate codes are adopted for identifying somatic dysfunction.**

[1] Fung KW, Xu J, McConnell-Lamptey S, Pickett D, Bodenreider O. A practical strategy to use the ICD-11 for morbidity coding in the United States without a clinical modification. J Am Med Inform Assoc. 2023 Sep 25;30(10):1614-1621.

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

NCVHS should also work with stakeholders to identify other areas where post-coordination of ICD-11 codes would not enable a complete mapping to ICD-10. Ultimately, this assessment, development of necessary enhancements, the accompanying development of crosswalks and educational materials, and updating of corresponding technical standards will be an extensive process, and we urge HHS to allow for a multi-year transition timeframe for the adoption of ICD-11.

Question 4: What are the most important considerations and requirements for a U.S. governing body for ICD–11?

The U.S. governing body for ICD-11 will need to coordinate across a diverse range of stakeholders throughout the process of adopting, implementing, and maintaining the ICD-11 code set. The U.S. governing body for ICD-11 should be well positioned to:

1. Engage with Standards Developing Organizations (SDOs) that maintain code sets used in electronic transactions across our healthcare system (e.g. HL7, X12, NCPDP, etc.) to ensure appropriate updates to standards and comprehensive crosswalks between standards are developed;
2. Coordinate across federal agencies and within HHS to update and align regulation related to coding issues, including updating of standards that rely on ICD codes (e.g. Health Information Portability and Accountability Act transactions adopted by HHS Office of Civil Rights, Health IT certification standards adopted by the HHS Office of the National Coordinator for Health IT);
3. Convene stakeholders and engage in extensive outreach to identify coding needs and develop refinements to the code set.

The AOA has supported HHS' historical approach of maintaining a federal interdepartmental committee comprised of representatives from the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) to oversee implementation of the ICD and manage updates. This process has also provided a public forum for presentation and discussion of potentially relevant updates. We urge the agency to continue this approach that ensures public input. We agree with NCVHS that a single agency should be responsible for coordination with WHO on requests for updates to the ICD-11

Question 5: What financial, educational, or human resources will be needed for:

c. Meeting the needs of smaller, less resourced, or less externally supported entities.

Physician practices will have diverse resource needs based on a broad range of factors, including their geographic location, specialty, and primary patient population. Overall, as physician practices begin transitioning to ICD-11, nearly all practices will need to:

- Educate their clinical and office staff on the ICD-11 code set and proper coding, including cluster coding;
- Implement updated electronic medical records and practice management systems and educate staff on use of the updated technologies; and
- Understand changes impacting administrative transactions, including transactions with payers.

This entire process will have implications for:

- physician workflows during transition as processes may be slowed down;

511 2nd Street, NE
Washington, DC 20002
202.349.8750
osteopathic.org

- how practices utilize technologies as they are updated;
- physician documentation in medical records;
- payment and potential payment denials during the transition period due to either provider or payer errors.

Each of these process changes, and accompanying challenges, will require significant financial, time, and staff investments, making the transition a costly process for small practices with limited resources. As practices prepare for the transition, the following resources, at a minimum, will be essential to support the best possible outcomes:

- A clear process and timeline for the transition to ICD-11;
- Comprehensive mappings and crosswalks of ICD-10-CM codes to ICD-11;
- Educational resources, including webinars, written materials, trainings, and open forums with federal agencies to facilitate the transition, ensure practices have the information they need, and provide opportunities for agency staff to answer questions;
- Timelines for updates to regulatory requirements to align with the transition, and educational material on any regulatory changes; and
- Educational resources on process and timeline for code set maintenance following initial implementation.

Small practices have limited resources and face an increasingly challenging environment to maintain operations due to declining Medicare payment rates. Financial support will be necessary to ensure that practices can make needed investments and do their part in achieving a timely transition across our health system.

Conclusion

The AOA appreciates the opportunity to comment on this ICD-11 RFI. Transition to ICD-11 presents a tremendous undertaking for all stakeholders across our healthcare system. While we appreciate NCVHS' recent efforts to solicit feedback from stakeholders in recent months, more time is needed to identify specific gaps in mapping ICD-10-CM to ICD-11, evaluate the technical changes that need to take place, and develop a longer-term transition plan. We strongly urge NCVHS, and HHS more broadly, to take a prudent approach to prevent unnecessary burden on stakeholders and allow ample time for stakeholders to prepare. The AOA looks forward to continuing to work with NCVHS on refining and implementing ICD-11 for the U.S. healthcare system. Should you have any questions regarding our comments or recommendations, please contact John-Michael Villarama, MA, AOA Vice President of Public Policy, at jvillarama@osteopathic.org.

Sincerely,

Ira P. Monka, DO, MHA, FACOFP
President, AOA

Kathleen Creason
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

DSOMS DELAWARE STATE OSTEOPATHIC MEDICAL SOCIETY

November 15, 2023

The Honorable Lisa Blunt Rochester
United States House of Representatives
1724 Longworth House Office Building
Washington, DC 20515

Dear Representative Blunt Rochester,

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students, and the Delaware State Osteopathic Medical Society (DSOMS), which represents the interests of more than 740 DOs in the state of Delaware, we write to express our sincere appreciation for your co-sponsorship of *Dillon's Law,* H.R. 3910. As you know, the legislation creates a grant preference under an existing federal grant program for preventative health services for states that allow trained individuals to carry and administer epinephrine to someone suffering from a severe allergic reaction. This legislation represents a commonsense solution that can help prevent the needless deaths of the estimated 500 – 1,000 Americans who experience fatal cases of anaphylaxis each year.[1]

Anaphylaxis occurs when someone suffers a severe and life-threatening allergic reaction (oftentimes 1 to 15 minutes after exposure), most commonly from insect stings, food items, and medications. In addition to the 500-1000 fatal cases of anaphylaxis that occur per year in the United States, anaphylaxis is the cause of hundreds of thousands of hospitalizations and emergency room visits every year.[2] Training individuals to deliver emergency epinephrine in the event of anaphylactic shock is an easy, cost-effective way to prevent senseless tragedies from occurring every year.

Under Dillon's Law, states would be incentivized through grant prioritization to train, certify, and enable good Samaritans to administer epinephrine to an individual experiencing a severe allergic reaction in the event they need the medication before emergency medical services can arrive. In addition, the bill directs states to establish civil liability protections for individuals trained in administering epinephrine. Dillon's Law is similar to legislation passed in Wisconsin, Minnesota, and Indiana.

Dillon's Law is named after Dillon Mueller, an individual from Mishicot, Wisconsin who tragically passed away at the age of 18 from anaphylaxis as the result of a bee sting. Dillon's parents championed this law in Wisconsin and have since trained over 3,000 individuals in the safe administration of epinephrine through training programs approved and certified by the Wisconsin Department of Health. Dillon's Law has saved several lives in Wisconsin since its passage in 2017.

Again, thank you for your support of this legislation. The AOA, DSOMS, and our members stand ready to assist in securing the enactment of *Dillon's Law*. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact AOA Vice President of Government Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748 to support your efforts.

Sincerely,

Ira P. Monka, DO
President, AOA

Julieanne P. Sees, DO
President, DSOMS

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

[1] See https://www.jaci-inpractice.org/article/S2213-2198(17)30515-9/fulltext.
[2] See https://www.aafa.org/allergy-facts/.

AMERICAN OSTEOPATHIC ASSOCIATION

January 2, 2024

The Honorable Chrissy Houlahan
United States House of Representatives
1727 Longworth House Office Building
Washington, DC 20515

The Honorable Stephanie Bice
United States House of Representatives
1223 Longworth Office Building
Washington, DC 20515

Dear Representatives Houlahan and Bice,

On behalf of the American Osteopathic Association (AOA), alongside the American College of Osteopathic Pediatricians (ACOP), collectively representing more than 186,000 osteopathic physicians (DOs) and osteopathic medical students, we write to express our support for the *Access to Donor Milk Act* (H.R.5486). This bipartisan, bicameral legislation would allow states to use Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) funding to promote viability and access for donor milk programs, and provide funding for emergency capacity to mitigate shortages during major disaster declared by the President. Enactment of this legislation would allow low-income parents to access donor milk and help to alleviate the pressure of potential infant formula shortages in the future.

In 2022, the United States experienced a severe shortage of infant formula as a result of global supply chain issues and import restrictions, compounded by large-scale product recalls and manufacturing stoppages after the deaths of two infants who had been fed domestically produced infant formula. During the formula shortage, physicians sought to help parents and newborns by recommending alternatives to infant formula, including pasteurized human donor milk. Many physicians found donor milk to be a viable and relatively low-cost intervention – particularly for medically fragile infants – but low-income parents struggled to equitably access donor milk due to supply pressures on donor milk banks and out of pocket costs arising from lack of Medicaid or WIC coverage.

As pediatricians continue to work to ensure the health and wellbeing of patients in the event of a future infant formula shortages, a reliable and equitably accessible supply of donor milk is an important factor in their preparation. Allowing WIC funds to support donor milk procurement in states, and providing funds to provide education to parents and mitigate demand surges will allow states to have the resources necessary to assist pediatricians in providing the best care to their patients.

Again, the AOA and our affiliates offer our support for this essential legislation and stand ready to assist in securing the enactment of the *Access to Donor Milk Act*. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

Jamee Goldstein, DO, FACOP
President, ACOP

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

January 29, 2024

The Honorable Brittany Pettersen
U.S. House of Representatives
1230 Longworth House Office Building
Washington, DC 20515

The Honorable Kim Schrier, MD
U.S. House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

The Honorable Nikki Budzinski
U.S. House of Representatives
1009 Longworth House Office Building
Washington, DC 20515

Dear Representatives Pettersen, Schrier, and Budzinski:

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students we represent, we offer our support for the "*Hospitals as Naloxone Distribution Sites (HANDS) Act"* (H.R. 5506). This legislation will support enhancing hospital-based dispensing of naloxone with no cost sharing, reducing barriers for at-risk patients seeking care, and an important step in preventing opioid related overdose deaths.

In 2022, over 110,000 people in the United States died from a drug overdose[1], with opioid involvement reported for nearly 70% of those deaths. In 2012, only ten years prior, 40,000 overdose deaths were recorded, meaning the number of overdose deaths nearly tripled in ten years. The President's Council of Economic Advisors (CEA) published a report in 2017 that found the annual economic cost of the opioid crisis was $504 billion[2], due to health care costs and employment earnings lost to premature death. In the report, the CEA noted that most opioid-involved overdose deaths in the US occur among people between the ages of 25 and 55; nearly two-thirds of the United States labor force falls in this age range. The Joint Economic Committee estimated the opioid epidemic cost the United States almost $1.5 trillion in 2020 alone[3]. The continued increase in both deaths and economic cost requires additional government response to address these crises. In March 2023, the FDA approved over-the-counter naloxone nasal spray, a significant action for increasing access; however, some patients are unable to purchase this lifesaving medication due to financial barriers.

The AOA strongly supports policies that advance intervention and education around preventing opioid deaths. This legislation would help establish distribution of naloxone at the point of care for at-risk patients. In addition to issuing guidance to enhance hospital-based naloxone dispensing, the legislation would address the financial barriers for many at-risk patients by requiring Medicare, Medicaid, and TRICARE to cover the cost of take-home naloxone when dispensed to patients prior to discharge.

---

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. 2023. "National Vital Statistics System – Drug Overdose Data". Available here.
[2] The Council of Economic Advisers. November 2017. "The Underestimated Cost of the Opioid Crisis". Available here.
[3] Senate Joint Economic Council. September 2022. "The Economic Toll of the Opioid Crisis Reached Nearly $1.5 Trillion in 2020". Available here.

AMERICAN
OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

The AOA deeply appreciates your efforts to ensure that patients have access to interventions to prevent opioid overdose deaths. The AOA and our members stand ready to assist you in securing the enactment of this important legislation. If you have any questions or if the AOA can be of assistance in any way, please do not hesitate to contact John-Michael Villarama, MA, AOA Vice President of Congressional Affairs and Public Policy, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

Ira P. Monka, DO, FACOFP
President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

AMERICAN OSTEOPATHIC ASSOCIATION

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

CY2024 Medicare Physician Fee Schedule and Quality Payment Program Final Rule

On November 2, the Centers for Medicare & Medicaid Services (CMS) issued the CY2024 Medicare Physician Fee Schedule final rule which includes updates to physician payment policies and the Quality Payment Program (QPP). The rule makes critical changes to payment that we want to highlight. The Public Policy team will continue to go through the final rule and develop a more detailed outline and assessment, which will be available in the coming days.

Most significantly, CMS has reduced the CY2024 conversion factor by 3.37 percent from $33.8872 to $32.7442. The anesthesia conversion factor will also decrease from $21.1249 to $20.4349. These reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions that AOA has been fighting to address. Statutory requirements prevent CMS from upwardly adjusting payment under the physician fee schedule each year. Statute also requires that any changes to the fee schedule are applied in a budget neutral manner. This means that any changes to RVUs may not result in a net increase to Medicare expenditures when accounting for anticipated utilization. The drivers of the 3.37% conversion factor reduction include the following:

- A 1.22% reduction as required under the Consolidated Appropriations Act (CAA) of 2023; and
- A 2.15% reduction due to a budget neutrality adjustment.

These cuts come amid rising costs of practicing medicine which are unsustainable. Between 2010 and 2022, practice costs as measured by the Medicare Economic Index increased 24%, and in 2024, CMS expects costs will further increase by 4.6%. AOA has been continuously working with lawmakers to express the urgent need to reform physician payment and avert the cuts that will take effect in 2024.

Most recently, AOA submitted statements for a hearing held by the House Energy and Commerce Subcommittee on Health and urged action to address declining Medicare payment by establishing annual inflation-based updates, reforming budget neutrality requirements, extending the 1.0 work geographic practice cost index floor, and averting laboratory service payment cuts. AOA submitted similar comments to the House Ways and Means Committee on October 4, and has also launched a campaign calling on Congress to pass legislation that would protect physician practices by establishing annual, stable updates to payment. AOA members can take action now by telling your Member of Congress to support H.R. 2474.

The AOA is also disappointed that CMS chose not to modify its anticipated utilization assumptions for the newly created office/outpatient evaluation and management (E/M) visit complexity add-on code (G2211), which impacted the final conversion factor. AOA submitted comments on the proposed rule outlining expectations for utilization for CMS to consider in its final budget neutrality calculation. This included data demonstrating the low uptake of chronic care management and transitional care management codes, as well as expectations for being able to broadly educate physicians on the newly created code.

While much of the budget neutrality adjustment is attributable to the implementation of the G2211 code, the new code presents an opportunity for enhanced payment for longitudinal patient care. In the final rule, CMS provides clearer guidance on appropriate use of the new code, defining key terms within the code's descriptor. AOA will develop resources to support members in taking advantage of this new code. In parallel, the AOA will also continue working with Congress to reform statutory budget neutrality requirements.

511 2nd Street, NE
Washington, DC 20002
312.202.8000

osteopathic.org

Overall, the rule reflects a commitment by CMS to support comprehensive, longitudinal patient care and to address social determinants of health. CMS is finalizing provisions to pay for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services which account for resources when clinicians involve certain types of health care support staff in providing comprehensive care. CMS is also finalizing a range of provisions that will support continued delivery of telehealth services and improve payment for behavioral health services.

In another advocacy win, CMS withdrew its proposal to increase the Merit-Based Incentive Payment System (MIPS) performance threshold and will instead maintain the current threshold of 75 points for the 2024 performance year. AOA expressed concern that raising the performance threshold would disadvantage small and independent practices, especially those that sought extreme and uncontrollable circumstance exemptions from the MIPS program through 2023 and are just resuming full participation. More broadly, AOA will continue to advocate for reforms to the Quality Payment Program to alleviate physician burden.

AOA will continue to review the rule and provide additional details in the coming days.

CY2024 Medicare Physician Fee Schedule

Key Takeaways for Physicians

American Osteopathic Association

511 2nd St NE
Washington, DC 20002
(312) 202-8000
osteopathic.org

AMERICAN OSTEOPATHIC ASSOCIATION

Table of Contents

Executive Summary 4

Physician Fee Schedule Provisions 4

- **Conversion Factor and Rate Setting** 5
- **Telehealth Services Provisions** 6
- Telehealth Service List and Payment Rates 6
- Elimination of Frequency Limitations for Certain Services 6
- Implementation of Telehealth Flexibilities under the CAA 2023 6
- Definition of "Direct Supervision" 7
- Supervision of Residents in Teaching Settings 7
- Remote Patient Monitoring and Remote Therapeutic Monitoring 7
- **New Codes to Address Health-Related Social Needs** 8
- Community Health Integration Services 9
- Principal Illness Navigation Services 9
- Social Determinants of Health Risk Assessment 10
- **Evaluation and Management Services Provisions** 11
- Visit Complexity Add-on Code 11
- Definition of Split/Shared Visits 12
- **Advancing Access to Behavioral Health Provisions** 13
- General Behavioral Health Integration Care Management 13
- Psychotherapy Services 13
- Physician Fee Schedule Substance Use Disorder Bundle 13
- Marriage and Family Therapists and Mental Health Counselors 14

Quality Payment Program Provisions 14

- **MIPS Performance Threshold** 15
- **MIPS Performance Category Changes** 15
- Cost Performance Category 15

Quality Performance Category 15
Improvement Activities Performance Category 15
Promoting Interoperability Performance Category 16
MIPS Value Pathways (MVPs) 16
Modifications to Existing MVPs 16
Newly Created MVPs 17
APM Performance Track Changes 17
Medicare Shared Savings Program Provisions 18
Medicare CQMs for Shared Savings Program ACOs 18
Aligning CEHRT Requirements for Shared Savings Program ACOs with MIPS 18
Benchmarking Methodology Modifications 18
Beneficiary Assignment Methodology 19
Advanced Investment Payments 19
Appendix 20
Appendix A: Medicare Payment Formula 20
Appendix B: Medicare Anesthesia Payment Calculation 20
Appendix C: Full Code Descriptors for New HCPCS Codes for Services Addressing Health Related Social Needs 21
Appendix D: New and Revised Code Values for Behavioral Health Services 22
Appendix E: Work RVUs for New and Revised Codes 26

Executive Summary

On November 2, the Centers for Medicare & Medicaid Services (CMS) issued the CY2024 Medicare Physician Fee Schedule final rule which includes updates to physician payment policies, the Quality Payment Program (QPP), and the Medicare Shared Savings Program (MSSP). Most significantly, CMS has reduced the CY2024 conversion factor by 3.37 percent from $33.8872 to $32.7442. The anesthesia conversion factor will also decrease from $21.1249 to $20.4349. These reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions, which the AOA has been fighting to address through legislation.

Despite the statutorily required reductions to the conversion factor, the rule overall reflects a commitment from CMS to support payment for longitudinal, coordinated care. Key takeaways include the following:

- With the moratorium on implementation of the care complexity add-on code (G2211) expiring on December 31, 2023, CMS has finalized policy to move forward with implementation. This new code presents an opportunity for enhanced payment for office/outpatient evaluation and management (E/M) services, particularly for primary care and office-based specialties, and could allow for a net increase in payment for these specialties. It is important to note that most of the reduction to the CY2024 conversion factor is attributable to implementation of this code. AOA submitted comments on the proposed rule that CMS' assumptions and estimates of utilization for this code were flawed, resulting in an unnecessarily large downward adjustment, but CMS chose to move forward using its analysis from the proposed rule.
- The Biden Administration is heavily focused on addressing behavioral health issues and promoting equity. Several provisions in the rule reflect these priorities, including enhanced payment for a range of behavioral health services, and the creation of new payable codes for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services.
- CMS has finalized policies that will support continued payment and access for telehealth services.

The rule also contains a range of changes to the QPP and MSSP. Overall, CMS has made modifications to the measure lists across each MIPS performance category and made substantial changes to the MIPS value pathways. Additionally, following AOA advocacy CMS will maintain the MIPS performance threshold, upon which payment adjustments are determined, at 75 points. AOA expressed concern that raising the performance threshold would disadvantage small and independent practices, especially those that sought extreme and uncontrollable circumstance exemptions from the MIPS program through 2023 and are just resuming full participation.

Physician Fee Schedule Provisions

This section outlines key changes to payment policy under the physician fee schedule, including changes to the conversion factor, service relative values, telehealth service coverage, evaluation and management services, and behavioral health services. This section also addresses newly created codes, focusing on those that are expected to be widely used across specialties, will have high volume, or relate to a pressing public health challenge. In addition, CMS finalized values for

a large number of codes under this rule. A list of new and revised codes can be found in appendix E of this document.

Conversion Factor and Rate Setting

CMS reduced the CY2024 conversion factor by 3.37 percent from $33.8872 to $32.7442. The anesthesia conversion factor will also decrease from $21.1249 to $20.4349. For physician services (excluding anesthesia), total payment is calculated by first determining the total relative value units (RVUs) for a given services (comprised of three components: physician work, practice expense, and liability insurance) and multiplying the total RVUs by the conversion factor. The formulas used to calculate final payment for Medicare services can be found in Appendices A and B of this document.

The conversion factor reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions, which the AOA has been fighting to address. Statutory requirements prevent CMS from providing positive payment adjustment under the physician fee schedule without a corresponding negative reduction – changes to the fee schedule must be applied in a budget neutral manner. This means that any changes to RVUs may not result in a net increase to Medicare expenditures when accounting for anticipated utilization. The drivers of the 3.37 percent conversion factor reduction include the following:

- A 1.22 percent reduction as required under the Consolidated Appropriations Act (CAA) of 2023; and
- A 2.15 percent reduction due to a budget neutrality adjustment.

Additionally, the finalized CY2024 geographic practice cost indices (GPCIs) do not reflect a 1.0 work GPCI floor as it expires on December 31, 2023. The AOA endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality health care in rural areas, and advocates for the extension of the GPCI floor beyond 2023.

The change will result in reduced payment in localities where the work GPCI floor is currently applied. According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI floor values raised.[1]

All of these cuts come amid rising costs of practicing medicine, which are unsustainable. The AOA continues to work with lawmakers to address the urgent need to reform physician payment and avert the cuts that will take effect in 2024.

[1] Government Accountability Office. “Information on Geographic Adjustments to Physician Payments for Physicians’ Time, Skills, and Effort.” February 2022. Available here.

Telehealth Services Provisions

Telehealth Service List and Payment Rates

With the AOA's support, CMS finalized a range of policies that will preserve payment for telehealth services. The agency finalized its proposal to pay for telehealth services when the patient's home is the originating site, at the non-facility rate. All claims should appropriately indicate when services were provided via telehealth, with the patient's home as the originating site, using a place of service (POS) modifier 10. CMS will continue to define the patient's "home" to include temporary lodging such as hotels or homeless shelters, or settings where the patient has travelled a short distance from their residence for privacy or personal reasons. The agency is implementing this policy with the recognition that physician practices still functionally maintain their practice expenses when providing services via telehealth. Under the new policy, telehealth services rendered when the originating site is not the patient's home should be billed with a POS modifier 2, and these services will be paid at the facility rate. Additionally, a modifier 95 should be used when the billing physician is in a hospital setting and the patient is at home.

CMS will also continue coverage and payment for all telehealth services included on the Medicare Telehealth Services List as of March 15, 2020.

Beginning in 2024, CMS proposes to simplify its methodology for updating its telehealth services list. Rather than having three separate categories of telehealth services, CMS will shift to a binary standard of "permanent" and "provisional" services. All current Category 3 and "temporary Category 2" codes will be mapped to the provisional list, while all Category 1 and permanent Category 2 codes will be mapped to the new "permanent" code list. Beginning CY2024, CMS has also added the new social determinants of health risk assessment (G0136), described later in this document, to the list of permanent telehealth services.

Elimination of Frequency Limitations for Certain Services

CMS finalized the policy continuing to suspend frequency limitations for Medicare telehealth subsequent care services in inpatient settings, nursing facility settings, and critical care consultations on a temporary basis for CY2024. This will allow the agency more time to continue collecting data on these services and "evaluate patient safety while preserving access in a way that is not disruptive to practice patterns that were established during the Public Health Emergency (PHE)." Frequency limitations will continue to be suspended for the following codes:

- Subsequent inpatient visit (99231, 99232, 99233)
- Subsequent nursing facility visit (99307, 99308, 99310, G0508, G0509)
- Critical care consultations (G0508, G0509)

CMS will reevaluate this policy based on new data in future rulemaking.

Implementation of Telehealth Flexibilities under the CAA 2023

The *Consolidated Appropriations Act, 2023*, extended temporary Medicare telehealth flexibilities established during the COVID-19 PHE through **December of 2024**. CMS finalized policy implementing these extensions, which include the following.

- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHC) can serve as a distant site provider for non-behavioral/mental telehealth services.
- Medicare patients can receive telehealth services authorized under the Medicare telehealth service list in their home.
- There are no geographic restrictions for originating sites for non-behavioral/mental telehealth services.
- Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.
- Telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist.

Definition of "Direct Supervision"

CMS will 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 extended this policy through 2024 to ensure continuity in light of how many practices have restructured following flexibilities granted during the PHE. CMS will re-evaluate this policy in future rulemaking based on availability of additional data regarding patient safety. The AOA expressed concern and opposed the long-term extension of this flexibility to CMS in our response to the proposed rule due to 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.

Supervision of Residents in Teaching Settings

CMS finalized policy to allow the teaching physician 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).

Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

In an effort to expand access to RPM and RTM services, CMS finalized the following changes to its coverage policies for these services:

- Clarifying that RPM and RTM codes may be billed concurrently with care management services, including Chronic Care Management (CCM), Transitional Care Management (TCM), Behavioral Health Integration (BHI), Principal Care Management (PCM), and Chronic Pain Management (CPM) services. However, RPM and RTM services may not be billed together;
- RPM and RTM services may only be furnished to established patients;
- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to report RPM and RTM services under the existing general care management code (G0511), and improving reimbursement for the code in a corresponding fashion; and
- Clarifying that beneficiaries getting surgery and related services covered by a global payment can also get RPM/RTM services if the latter is separate from the diagnosis for the procedure/services covered by a global payment.

New Codes to Address Health Related Social Needs

In recent years, CMS has worked to develop ways to better promote comprehensive, coordinated care and "value practitioners' work when they incur additional time and resources helping patients with serious illnesses navigate the healthcare system or removing health-related social barriers interfering with the practitioner's ability to execute a medically necessary plan of care." To this end, CMS finalized a range of new codes to support the work and time spent by physicians and auxiliary personnel. These include Community Health Integration services, Principal Illness Navigation services, and Social Determinants of Health Risk Assessment. CMS also states that payment for these new codes will promote equity and access to care, and support the White House's National Strategy on Hunger, Nutrition and Health, and the Cancer Moonshot Initiative.

As an example of the type of work CMS views as undervalued, CMS describes how "practitioners and their staff of auxiliary personnel sometimes help newly diagnosed cancer patients and other patients with similarly serious, high-risk illnesses navigate their care, such as helping them understand and implement the plan of care and locate and reach the right practitioners and providers to access recommended treatments and diagnostic services, taking into account the personal circumstances of each patient." It is important to note that these codes are intended for a broad range of patients and conditions. The table below outlines the newly created codes.

Table 1. Newly Created Codes for Health Related Social Needs

Code	Short Descriptor	Work RVUs
Community Health Integration (CHI)		
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month; in specified activities (see full descriptor below)	1.00
G0022	Community health integration services, each additional 30 minutes per calendar month	0.70
SDOH Risk Assessment		
G0136	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes	0.18
Principal Illness Navigation (PIN)		
G0023	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, for specified activities (see full descriptor below)	1.00
G0024	Principal Illness Navigation services, additional 30 minutes per calendar month	0.70
G0140	Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, for specified activities (see full descriptor below)	1.00

G0146	Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month	0.70

Community Health Integration (CHI) Services

CMS finalized 2 new codes to account for community health integration services. CHI services can be furnished monthly, as medically necessary, following a CHI initiating visit in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit. E/M services and annual wellness visits (AWVs) may serve as the initiating visits for CHI services. The codes finalized include G0019, 60 minutes of CHI services performed by auxiliary personnel in a calendar month, and G0022, for each additional 30 minutes of time spent on CHI services for a patient. CMS chose to maintain the 60 minute threshold for G0019 as it felt that it would be difficult for personnel to address patients' social needs in under an hour. CMS is not placing limits on G0022 being billed more than once per month.

For purposes of this code, CMS adopts the CPT's definition of SDOH and states that SDOHs "may include but are not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when they significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the CHI initiating visit." The agency also notes that the new CHI codes are intended to include the following services: a person-centered assessment, practitioner, home- and community-based care coordination, health education, building patient self-advocacy skills, health care access/health system navigation, facilitating and providing social and emotional support, and leveraging lived experience when applicable.

CMS is designating CHI services as care management services that may be furnished under the general supervision of the billing practitioner. General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service. Additionally, CHI services may only be billed by practitioners who have an "incident to" benefit for billing their services (e.g., physicians). Services must be appropriately documented in the medical record, and patient consent must be obtained for these services to be billed. Full descriptors for these services can be found in Appendix C of this document.

Work and practice expense values for G0019 are crosswalked to 99490, and values for G0022 are crosswalked to 99439.

Principal Illness Navigation (PIN) Services

CMS created 4 new codes for Principal Illness Navigation services. Two of the codes are intended for auxiliary personnel providing individualized help to a patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care in a timely manner, especially when the landscape is complex and delaying care can be deadly. The other two codes are for PIN service provided specifically by peer support specialists for behavioral health conditions.

Overall, CMS notes that PIN services are primarily intended for supporting socioeconomically disadvantaged patients and those facing barriers to care. They are particularly important for

patients undergoing treatment for severe and/or debilitating conditions. Examples provided by CMS include the following:

- surgery, imaging and radiation therapy, chemotherapy for cancer;
- psychiatry, psychology, vocational rehabilitation for severe mental illness;
- psychiatry, psychology, vocational rehabilitation, rehabilitation and recovery programs for substance use disorder; and
- infectious disease, neurology and immunology for human immunodeficiency virus (HIV)-associated neurocognitive disorders.

The new PIN codes seek to better recognize and pay for "when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death."

Services that qualify as PIN initiating visits include:

- Outpatient E/M services;
- Transitional Care Management (TCM) services;
- Psychiatric diagnostic evaluation (90791);
- Health Behavior Assessment and Intervention Services (96156, 96158, 96159, 96164, 96165, 96167, and 96168); and
- AWVs when the billing physician identifies in the medical record high-risk conditions that qualify for PIN services.

CMS is designating PIN services as care management services that may be furnished under the general supervision of the billing practitioner. Services must be appropriately documented in the medical record, and patient consent must be obtained for these services to be billed. PIN services may be billed by the same practitioner more than once per month for any single serious high-risk condition, and they may be billed in addition to other care management services. However, time and effort may not be duplicated. Full descriptors for these services can be found in appendix C of this document.

CMS is establishing crosswalks for G0023 and G0140 to 99490 with a work RVU of 1.00, and crosswalks for G0024 and G0146 to 99439 with a work RVU of 0.70.

Social Determinants of Health (SDOH) Risk Assessment

CMS finalized its new stand-alone G code, HCPCS code G0136, for *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months*.

SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. CMS created this code in recognition of the impact SDOHs have on a patient's overall health, and to identify and value the work involved in the administering an SDOH risk assessment as part of a comprehensive social history. The SDOH risk assessment must utilize a standardized, evidence-based tool and be furnished in conjunction with one of the following services:

- An outpatient E/M;
- AWV;
- Psychiatric diagnostic evaluation (90791);
- Health Behavior Assessment and Intervention Service (96156, 96158, 96159, 96164, 96165, 96167, and 96168); or
- Hospital discharge visit.

CMS outlines that any standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research may be used. Examples include, but are not limited to, the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

The SDOH risk assessment is intended to be used when a practitioner has reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment. As a result, the service is not considered a screening. Additionally, CMS clarifies that this service does not include practitioners asking screening questions ahead of a visit. SDOH needs identified through the risk assessment must be documented in the medical record. However, physicians rendering the service are not required to have the capacity to directly address these needs. CMS wants to encourage wider efforts among physicians and other providers to identify SDOH needs, even if many providers currently lack the capacity to directly address these needs through CHI, PIN, and other care management services.

CMS is directly cross-walking the work and practice expense (PE) values for this code to G0444 which has a work RVU of 0.18.

Evaluation and Management (E/M) Services

Visit Complexity Add-on Code

CMS is proposing to move forward with implementation of the office/outpatient (O/O) E/M visit complexity add-on code, G2211. This code was initially going to be implemented in the 2021 rule. However, Congress enacted a moratorium on implementation through the end of 2023. The code would be reported in conjunction with O/O E/M visits to better account for additional resources associated with primary care, or similarly ongoing medical care related to a patient's single, serious condition, or complex condition.

The O/O E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time. The code is intended to be used widely across O/O E/M visits.

CMS explains the need for this code, stating the following:

> The expertise of those who rely predominantly on E/M services to report their services is left relatively underrecognized within the previous and current E/M coding and valuation structure. This is because E/M valuation is broad-based and the same E/M visit codes are routinely reported both alone and with many different procedural codes. We believe that

this specific gap in appropriate valuation and coding is in addition to, and not overlapping with, the gaps in coding and valuation that led to the creation of care management coding, remote patient monitoring, etc.

The full descriptor for the code is as follows.

G2211 *medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition.*

CMS provides guidance in the rule for application of code. First, it defines the following key terms in the descriptor:

- **continuing focal point for all needed health care services:** describes a relationship between the patient and the practitioner, when the practitioner is the continuing focal point for all health care services that the patient needs. For example, a patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion. The inherent complexity that this code (G2211) captures is not in the clinical condition itself— sinus congestion —but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship.
- **ongoing care:** describes a longitudinal relationship between the practitioner and the patient which is not limited to primary care. (e.g., an infectious disease physician caring for a patient with HIV).

Second, CMS elaborates that application of the code "is not based on the characteristics of particular patients (even though the rationale for valuing the code is based on recognizing the typical complexity of patient needs) but rather the relationship between the patient and the practitioner" and the need to recognize the complexity inherent to O/O E/M visits that is generally unrecognized. Therefore, the code is intended to be used widely by physicians, regardless of specialty, for O/O E/M visits that serve as the continuing focal point for all needed health care services. However, the code should not be used for visits where the relationship with the physician is of a "discrete routine, or time-limited nature" such as visits with a new provider for the removal of a mole or treatment of a simple virus. Additionally, G2211 may not be billed with an E/M appended with a modifier -25 where a minor procedure is performed on the same day.

Definition of Split (Or Shared) Visit

Split (or shared) E/M visits refer to visits provided in part by physicians and other practitioners in hospitals and other institutional settings where clinicians do not have the ability to bill "incident to" a physician service. For 2024, CMS will not be implementing its original proposal and will instead, for purposes of Medicare billing for split (or shared) services, define the "substantive portion" as more than half of the total time spent by the physician and NPP performing the split (or shared) visit, or a substantive part of the medical decision making as defined by CPT. However, critical care services which do not use medical decision making and only use time, "substantive portion" continues to mean more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

In its CY2022 proposed rule, CMS proposed a policy for split (or shared) E/M visits for physicians and other qualified health care professionals in the facility setting and established a definition for what constituted the "substantive portion" of a visit to determine who billed the service. AOA expressed concern with CMS' proposal to base the definition of "substantive portion" of a split or shared E/M visit on the practitioner who provides "more than half of the total time" performing the visit as CMS' proposal was inconsistent with CPT guidelines.

Advancing Access to Behavioral Health Provisions

In recognition of the ongoing behavioral health crisis and behavioral health workforce shortage, CMS has finalized a series of payment changes to support payment and access for a broad range of behavioral health services. Exact changes to work RVUs can be found in appendix D of this document.

General Behavioral Health Integration Care Management

Out of concern for undervaluation of care management services as practices seek to implement behavioral health integration, CMS has finalized updated values for the corresponding codes (99484 and G0323). Many practices identify financial barriers and poor payment rates as barriers to integrating behavioral health into their practice. Enhanced payment will support delivery of integrated care.

Psychotherapy Codes

Similar to its approach to other cognitive services, CMS believes that physician work for psychotherapy services is undervalued, which may contribute to workforce and access challenges. To address this, CMS is finalizing a 19.1 percent increase to the work RVUs for psychotherapy services, including standalone psychotherapy codes, E/M psychotherapy add-on codes (90833, 90836, and 90838), and Health Behavior Assessment and Intervention codes (96156, 96158, 96159, 96164, 96165, 96167, and 96168). This increase will be phased in over 4 years.

While CMS did not initially propose to include E/M psychotherapy add-on codes for increases in work RVUs, CMS has ultimately decided to include them as this is how psychiatrists often bill their services, and CMS hopes that inclusion of these codes will promote psychiatrist participation in Medicare and more appropriately support code relativity.

Physician Fee Schedule Substance Use Disorder (SUD) Bundle

CMS is increasing the valuation of codes for office-based treatment of SUD to be priced consistent with the crosswalk codes used to value the bundled payments made for OUD treatment services furnished at Opioid Treatment Programs (OTPs). As CMS notes in the rule, beneficiaries receiving buprenorphine in settings outside of OTPs have similarly complex health care needs as compared to beneficiaries receiving OUD treatment services at OTPs. Additionally, this change is intended to increase the value consistent with the newly finalized value of psychotherapy services, which are included in this payment bundle. Many addiction medicine specialists provide services outside of an OTP setting, and this change will support appropriate payment for office-based treatment of OUD billed with HCPCS codes G2086 and G2087.

Marriage and Family Therapists (MFT) and Mental Health Counselors (MHCs)

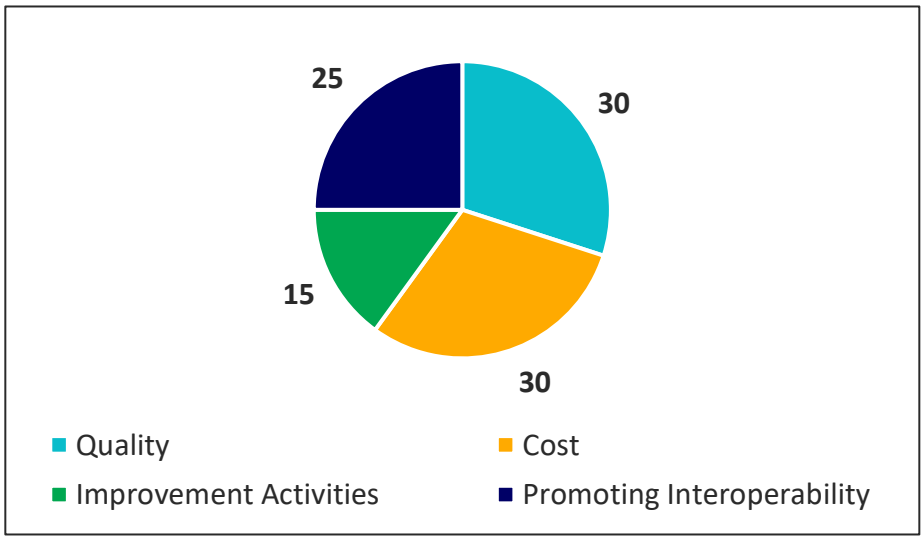
CMS is implementing provisions of the Consolidated Appropriations Act of 2023 providing for Medicare coverage and payment of services provided by marriage and family therapists and Mental Health Counselors. These clinicians, who are trained in providing mental health care services, will now be able to bill Medicare directly. CMS defines both provider types and the services they provide in its regulation. This change will support broader access to behavioral health services.

Quality Payment Program Provisions

Physicians who participate in the Medicare program and do not meet the low-volume threshold for Medicare allowed charges and beneficiaries treated in a year must participate in the Quality Payment Program. Physicians must report under either the Merit Based Incentive Payment System (MIPS) or the Alternative Payment Model (APM) Performance Pathway. This section outlines key changes related to performance under MIPS and APMs.

Physicians participating in MIPS are measured under 4 performance categories: cost, quality, promoting interoperability, and improvement activities. The weights for each of these categories determine a physician's final MIPS score, which is displayed in the chart below.

Table 1. Proposed MIPS Performance Category Weights



This section outlines key changes to each of the MIPS performance categories, the performance threshold upon which payment adjustments are determined, and changes to the APM performance pathway. The final rule implements changes across each performance category. Details regarding new and revised measures under each category, as well as new and revised MIPS Value Pathways, can be found on the QPP webpage.

MIPS Performance Threshold

CMS withdrew its proposal to increase the Merit-Based Incentive Payment System (MIPS) performance threshold and will instead maintain the current threshold of 75 points for the 2024 performance year. In AOA's letter to CMS, we expressed concern to their proposal to raise the performance threshold citing how it would disadvantage small and independent practices, especially those that sought extreme and uncontrollable circumstance exemptions from the MIPS program through 2023 and are just resuming full participation.

MIPS Performance Category Changes

Cost Performance Category

The cost performance category accounts for 30 percent of a physician's total MIPS score. CMS is finalizing 5 new episode-based cost measures, which will each have a 20-episode case minimum. These measures include:

- Heart failure;
- Psychoses and related conditions;
- Depression;
- Low back pain; and
- Emergency medicine.

CMS is also removing its Simple Pneumonia with Hospitalization episode-based cost measure.

CMS established in previous rulemaking that the MIPS cost category would include improvement scoring to reward participants that showed progress. Physicians will be eligible for a 1 percent improvement score which is calculated at the performance category level without statistical significance.

Quality Performance Category

The quality performance category accounts for 30 percent of a physician's total MIPS score. CMS has finalized a measure set inventory of 198 quality measures, which includes the addition of 11 new measures, removal of 11 measures, and partial removal of 3 measures whereby these measures will only be available for physicians participating in applicable MVPs. CMS has also made modifications to 59 existing measures. It is important to note that this list excludes Qualified Clinical Data Registry (QCDR) measures.

CMS finalized its proposal to maintain the data completeness criteria threshold to at least 75 percent for the CY 2026 performance period/2028 MIPS payment year, and not finalizing the proposal to increase the data completeness criteria threshold to at least 80 percent for the CY 2027 performance period/2029 MIPS payment year.

Improvement Activities Performance Category

The improvement activities performance category accounts for 15 percent of a physician's total MIPS score. CMS finalized an inventory of 106 IA measures, which includes the addition of 5 new, modification of 1 existing, and removal of 3 existing improvement activities. New activities include:

- Human Immunodeficiency Virus (HIV) Prevention Services;
- Practice-Wide Quality Improvement in MIPS Value Pathways;
- Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines;
- Behavioral/mental Health and Substance Use Screening and Referrals for Pregnant and Post-partum Women; and
- Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults.

CMS is also removing three current IA measures and modifying 1 existing measure.

Promoting Interoperability Performance Category

The promoting interoperability category accounts for 25 percent of a physician's total MIPS score. CMS finalized a range of changes to this category, which include:

- lengthening the performance period for this category from 90 days to 180 days;
- modifying one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure; and
- modifying the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to require MIPS eligible clinicians to affirmatively attest to completion of the self-assessment of their implementation of safety practices.

Additionally, CMS will continue to automatically reweight this performance category for MIPS eligible clinicians, groups, and virtual groups that are:

- ambulatory surgical center (ASC)-based;
- Hospital-based;
- Non-patient facing; and
- Small practices.

MIPS Value Pathways (MVPs)

Modifications to Existing MVPs

CMS continues to refine the MIPS program to better promote value. The MVP performance pathway streamlines activities and measures in each of the performance categories to focus on those that are relevant to a particular specialty, condition, or episode of care. In turn, this also supports improved performance measurement by allowing clinicians to report on a smaller, more relevant set of measures. This pathway may also help alleviate burden associated with reporting under traditional MIPS by allowing physicians to report a reduced number of measures or activities. For CY2024, CMS made changes to the 12 existing MVPs and proposed 5 new MVPs.

CMS has also modified its subgroup scoring policies for MVP participants. CMS will not calculate a facility-based score at the subgroup level and will continue to calculate a facility-based score in traditional MIPS and assign the higher of the two final scores. Subgroups will receive their affiliated group's complex patient bonus, if applicable. Subgroups will only receive reweighting based on any reweighting applied to its affiliated group. Additionally, subgroups will be allowed to submit a targeted review beginning with the 2023 performance period.

Table 3. Existing MVPs

Existing MVPs	
Advancing Cancer Care	Advancing Rheumatology Patient Care
Optimal Care for Kidney Health	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
Optimal Care for Patients with Episodic Neurological Conditions	Advancing Care for Heart Disease
Supportive Care for Neurodegenerative Conditions	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
Promoting Wellness*	Improving Care for Lower Extremity Joint Repair
Optimizing Chronic Disease Management*	Patient Safety and Support of Positive Experiences with Anesthesia

*The Promoting Wellness and Optimizing Chronic Disease Management MVPs were consolidated into a new, single Value in Primary Care MVP.

Newly Created MVPs

CMS finalized 5 new MVPs, which include:

1. Focusing on Women's Health;
2. Prevention and Treatment of Infectious Disease, Including Hepatitis C and HIV;
3. Quality Care in Mental Health and Substance Use Disorders;
4. Quality Care for Ear, Nose, and Throat (ENT) Disorders; and
5. Rehabilitative Support for Musculoskeletal Care.

CMS has consolidated the Promoting Wellness and Optimizing Chronic Disease Management MVPs into a single MVP, referred to as the Value in Primary Care MVP. Accordingly, CMS made changes to measures and activities under each of the performance categories.

Currently, participation in MVPs is optional. However, CMS has stated that its goal is to fully shift participation into MVPs or Alternative Payment Models (APMs) and ultimately sunset traditional MIPS. The agency has not established a timeline for this effort and must still establish a comprehensive range of participation options across specialties.

Advanced Alternative Payment Model (APM) Track

The Advanced APM pathway is the second track for participation in the Quality Payment Program and was intended to incentivize high-quality, high-value care and help shift physicians away from fee-for-service. CMS finalized 2 key changes for CY2024, consistent with requirements under statute related to the QP threshold and the APM incentive payment.

To participate in this track and qualify for an APM incentive bonus, physicians must meet minimum thresholds of either payment or patient volume through the APM to be determined a Qualifying Participant (QP). For CY2024, CMS finalized policy, consistent with statutory requirements, to raise the QP thresholds to the following:

- 75 percent of Medicare Part B payments must be through an APM
- 50 percent of Medicare patients must be through an APM

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided for a 5 percent incentive payment for clinicians participating in Advanced APMs through the 2022 performance year, which was then extended for an additional year at 3.5 percent under the CAA 2023. This incentive is no longer available in 2024. Statute also provides for payments for Advanced APM participants to be determined using a slightly higher conversion factor. MACRA provides for two separate conversion factors to be implemented beginning in 2024, where APM participants will receive an annual 0.75 percent update to payment each year, while the general Medicare conversion factor will receive a 0.25 percent update.

While CMS initially proposed to end the use of APM entity-level QP determinations and make all QP determinations at the individual eligible clinician level, it has withdrawn this proposal for 2024.

Medicare Shared Savings Program Provisions (MSSP)

CMS is seeking to increase participation by accountable care organizations (ACOs) in the MSSP to promote a transition to value-based care. In this rule, CMS finalized several policies it believes will support this transition and encourage participation.

Medicare Clinical Quality Measures (CQM) for Shared Savings Program ACOs

CMS is establishing the Medicare CQMs for ACOs participating in the Medicare Shared Savings Program as a new collection type for MSSP ACOs under the APM Performance Pathway (APP). To facilitate population-based activities that promote health, CMS will:

- Provide all ACOs with a list of beneficiaries eligible for Medicare CQMs each quarter throughout the performance year;
- Align standards for data completeness, benchmarking, and scoring ACOs for the Medicare CQM collection type with MIPS benchmarking and scoring policies; and
- Continue to permit practices to report quality data using the CMS web interface measures, eCQMs and/or MIPS CQMs collection types in performance year 2024.

Aligning Certified Electronic Health Record Technology (CEHRT) Requirements for Shared Savings Program ACOs with MIPS

Beginning in 2025, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP), or Partial QP, regardless of track, would be required to report the MIPS Promoting Interoperability performance category measures and requirements to MIPS and earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM Entity level.

Benchmarking Methodology Modifications

CMS finalized several significant benchmarking refinements designed to encourage sustained participation in the program and protect ACOs that serve complex populations. These include:

- Capping the risk score growth in an ACO's regional service area when calculating regional trends used to update the historical benchmark, while also accounting for an ACOs market share;
- Eliminating overall negative regional adjustments to support participation by ACOs serving medically complex and high-cost populations; and
- Applying the same CMS-Hierarchical Condition Categories (HCC) risk adjustment model used in the performance year for all benchmark years, when calculating prospective HCC risk scores to risk adjust expenditures used to establish, adjust, and update an ACO's benchmark.

Beneficiary Assignment Methodology

CMS finalized its proposal to modify the beneficiary assignment methodology to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month assignment window and who received at least one primary care service from a physician used in assignment in the preceding 12-months. Beginning in 2025, CMS will apply a revised beneficiary assignment methodology that will include a new third step, which will use an expanded window for assignment (a 24-month period that includes the applicable 12-month assignment window and the preceding 12-months) to identify additional beneficiaries for assignment.

Advance Investment Payments (AIPs)

In its CY2023 rule, CMS finalized a policy providing new MSSP participants the option to receive advance shared savings payments to help with the significant costs associated with starting an ACO. CMS is finalizing a series of refinements to this policy, including:

- Permitting ACOs receiving an AIP to progress to performance-based risk by allowing them to advance to two-sided model levels within the BASIC track's glide path beginning in performance year three of the agreement period in which they receive advance investment payments;
- Permitting AIP participants to early renew a participation agreement after their second performance year without triggering full recoupment of advance investment payments at that time;
- Requiring ACOs to report spend plan updates and actual spend information to CMS in addition to publicly reporting such information; and
- Specifying that CMS will immediately terminate advance investment payments to an ACO for future quarters if the ACO voluntarily terminates from the Shared Savings Program.

Helpful Links:

- The text of the final rule can be accessed here.
- The CMS fact sheet for the fee schedule is available here.
- The CMS fact sheet and FAQs on the 2024 Quality Payment Program are available here.
- The CMS fact sheet on Medicare Shared Savings Program is available here.

Questions?

If you have any questions about this document or the contents of the MPFS rule, please contact Gabriel Miller, Senior Director of Regulatory Affairs, at gmiller@osteopathic.org or 202-349-8749.

Appendix

Appendix A: Medicare Payment Calculation Formula

Step 1: Calculate Total RVUs

[Physician Work RVU × Physician Work GPCI] + [Practice Expense RVU × Practice Expense GPCI] + [Malpractice RVU × Malpractice GPCI] = Total RVU

Step 2: Calculate Final Medicare Payment

Total RVU × Medicare Conversion Factor = Medicare Payment

Appendix B: Medicare Anesthesia Payment Calculation

Step 1: Calculate Total Anesthesia Units

[Anesthesia Units for Billed CPT Code] + [Total Service Time ÷ 15] = Total Anesthesia Units

Step 2: Calculate Final Medicare Payment

Total Anesthesia Units × Medicare Anesthesia Conversion Factor = Medicare Payment

Appendix C: Full Code Descriptors for New HCPCS Codes for Services Addressing Health Related Social Needs

Community Health Integration Services
G0019

Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:
• *Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.*
  ○ *Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).*
  ○ *Facilitating patient-driven goal-setting and establishing an action plan.*
  ○ *Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.*
• *Practitioner, Home-, and Community-Based Care Coordination*
  ○ *Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).*
  ○ *Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.*
  ○ *Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.*
  ○ *Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).*
• *Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making.*
• *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.*
• *Health care access / health system navigation.*
  ○ *Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.*

- *Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.*
- *Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.*
- *Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

G0022

Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).

Principal Illness Navigation (PIN)

G0023

Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.
  - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support as needed to accomplish the practitioner's treatment plan.
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, Home, and Community-Based Care Coordination
  - Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregivers (if applicable).
  - Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
  - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).
- Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.

- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.
- Health care access / health system navigation.
    - Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.
    - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

G0024

Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023).

G0140

Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:

- *Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.*
    - *Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately).*
    - *Facilitating patient-driven goal setting and establishing an action plan.*
    - *Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan.*
- *Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.*
- *Practitioner, Home, and Community-Based Care Communication*
    - *Assist the patient in communicating with their practitioners, home-, and community based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).*
- *Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.*

• *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.* • *Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.* • *Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals.* • *Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*
G0146
Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140).
Social Determinants of Health Risk Assessment
G0136
Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.

Appendix D: New and Revised Code Values for Behavioral Health Services

Code	Short Descriptor	Current Work RVUs	New Work RVUs
	Behavioral Health Integration		
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.	0.61	0.93
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, clinical social worker, mental health counselor, clinical professional counselor, professional counselor, or marriage and family therapist time, per calendar month.	0.61	0.93

Psychotherapy Standalone			
90832	Psychotherapy, 30 minutes with patient	1.70	1.78
90834	Psychotherapy, 45 minutes with patient	2.24	2.35
90837	Psychotherapy, 60 minutes with patient	3.31	3.47
90839	Psychotherapy for crisis; first 60 minutes	3.13	3.28
90840	Psychotherapy for crisis; each additional 30 minutes	1.50	1.57
90845	Psychoanalysis	2.10	2.20
90846	Family psychotherapy (without the patient present), 50 minutes	2.40	2.51
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	2.50	2.62
90849	Multiple-family group psychotherapy	0.59	0.62
90853	Group psychotherapy (other than of a multiple-family group)	0.59	0.62
Psychotherapy E/M Add-on			
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	1.50	1.57
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	1.90	1.99
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	2.50	2.62
Health Behavior Assessment and Intervention			
96156	Health behavior assessment, or re-assessment (i.e., health focused clinical interview, behavioral observations, clinical decision making)	2.10	2.20
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	1.45	1.52
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	0.50	0.52
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	0.21	0.22
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	0.10	0.10
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	1.55	1.62
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	0.55	0.58
Substance Use Disorder Bundle			
G2086	Office-based treatment for a substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	7.06	8.36

G2087	Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	6.89	8.19

Appendix E: Work RVUs for New and Revised Codes

This table, which can be found on pages 404-412 of the final rule lists all new and revised codes for which CMS has adopted changes (excluding behavioral health services and services to address health related social needs, which are listed above). For specific details regarding any coding or value changes, please refer to the rule or contact AOA.

Code	Short Descriptor	Current Work RVUs	New Work RVUs
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	New	32.00
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	New	35.50
22838	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	New	36.00
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	27.13	27.13
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (e.g., bone allograft[s], synthetic device[s]), without placement of trans fixation device	New	7.86
30117	Excision or destruction (e.g., laser), intranasal lesion; internal approach	3.26	3.91
30118	Excision or destruction (e.g., laser), intranasal lesion; external approach (lateral rhinotomy)	9.92	7.75
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	New	2.70
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	New	2.70
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]) including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation when performed	New	9.50
33277	Insertion of phrenic nerve stimulator transvenous sensing lead	New	5.43

33278	Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	New	9.55
33279	Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	New	5.42
33280	Removal of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	New	3.04
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	New	6.00
33287	Removal and replacement of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming when performed; pulse generator	New	6.05
33288	Removal and replacement of phrenic nerve stimulator including vessel catheterization, all imaging guidance, and interrogation and programming when performed; transvenous stimulation or sensing lead	New	8.51
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	New	3.10
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	New	7.21
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	36.58	37.00
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	18.34	18.76
59425	Antepartum care only; 4-6 visits	7.80	7.80
59426	Antepartum care only; 7 or more visits	14.30	14.30
59430	Postpartum care only (separate procedure)	3.22	3.22
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	40.39	41.05
59515	Cesarean delivery only; including postpartum care	22.13	22.79
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	38.29	38.71
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	20.06	20.48
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following	40.91	41.57

	attempted vaginal delivery after previous cesarean delivery		
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	22.66	23.32
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	New	25.75
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	New	11.25
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	New	15.00
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver	5.19	5.19
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array, with detachable connection to	5.30	4.35
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver direct or inductive coupling, requiring pocket creation and connection between electrode array and pulse generator or receiver	2.45	5.10
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	1.78	3.79
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; initial electrode array	New	C
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator including imaging guidance, when performed; each additional electrode array	New	C
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	New	C
65778	Placement of amniotic membrane on the ocular surface; without sutures	1.00	0.84
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	2,50	1.75
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	7.81	7.03

67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	New	1.53
75580	Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	New	0.75
76881	Ultrasound, complete joint (i.e., joint space and periarticular soft-tissue structures), real-time with image documentation	0.90	0.90
76882	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (e.g., joint space, periarticular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation	0.69	0.69
76883	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity	1.21	1.21
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, with permanent recording and reporting	0.30	0.30
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic	New	0.60
76987	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	New	1.90
76988	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	New	1.20
76989	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; interpretation and report only	New	0.70
76998	Ultrasonic guidance, intraoperative	1.20	0.91
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes		1.25
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes	New	0.33
92972	Percutaneous transluminal coronary lithotripsy	New	2.97
93150	Therapy activation of implanted phrenic nerve stimulator system including all interrogation and programming	New	0.85

93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	New	0.80
93152	Interrogation and programming of implanted phrenic nerve stimulator system during a polysomnography	New	1.82
93153	Interrogation, without programming of implanted phrenic nerve stimulator system	New	0.43
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	0.52	0.52
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	0.52	0.52
93584	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart	New	1.20
93585	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemi-azygos venous system	New	1.13
93586	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus	New	1.43
93587	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (e.g., from innominate vein)	New	2.11
93588	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating below the heart (e.g., from the inferior vena cava)	New	2.13
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes	New	C
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes	New	C
97037	Application of a modality to 1 or more areas; low-level laser therapy (i.e., non-thermal and non-ablative), for post operative pain reduction	New	N
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home	New	1.00

	or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes		
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; each additional 15 minutes	New	0.54
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers	New	0.23
99459	Pelvic examination	New	0.00
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	1.50	1.50
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes	1.40	1.40