AMERICAN OSTEOPATHIC ASSOCIATION

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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.

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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

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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:

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- 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.

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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;

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- 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.

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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

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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.

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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.

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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.**

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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.**

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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