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September 1, 2023

VIA ELECTRONIC SUBMISSION

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–1784–P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2024 Physician Fee Schedule (PFS) and Quality Payment Program Proposed Rule ("Proposed Rule").

ACOFP is the professional organization representing more than 25,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients have access to high-quality care.

We support many of the proposals in the Proposed Rule, particularly those aimed at addressing social determinants of health, as well as the implementation of a separate payment for the office/outpatient E/M visit complexity add-on code for separate payment. However, there are also proposals we request CMS to reconsider to better support family physician practices. Specifically, CMS should not finalize its proposal to reduce the conversion factor by 3.36 percent compared to last year. These harmful payment reductions would threaten the financial viability of osteopathic family physician practices and therefore create barriers to beneficiary access to care.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

David Park, DO, FACOFP, dist.

David Park, DO, FACOFP, *dist*.
President, ACOFP

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I. Comments to Proposed Changes to the Physician Fee Schedule

a. Proposed CY 2024 Conversion Factor

The CY 2023 conversion factor is 33.8872, and the proposed conversion factor for CY 2024 is 32.7476, which is a 3.36 percent reduction from the prior year. ACOFP opposes this proposed cut because this type of reduction could have a serious financial impact on the ability of osteopathic family physicians to continue practicing and ensuring access to care for patients.

Physicians face an increasingly challenging environment providing Medicare beneficiaries with access to care. Osteopathic family physicians are essential to the nation's public health system and play a critical role in providing care to Medicare beneficiaries. Despite osteopathic family physicians' contributions to patient care and public health, they have been forced to contend with Medicare payments that do not cover the cost of providing care. The failure of the PFS to keep pace with the increasing cost of providing care has created an unstable financial environment for osteopathic family physicians. Many of our solo, independent, and rural members have been struggling to remain open. These practices do not have the resources that large physician groups or hospitals have to weather an economic downturn. Also, as you know, once a primary care physician office closes in a community, it is very difficult to attract new physicians to serve that community.

Physicians need financial stability. Many providers are small-business owners, who are struggling to cope with administrative burdens, pay staff and facility costs, and purchase essential technology. ACOFP therefore opposes this proposed payment reduction and urges CMS to support stable Medicare reimbursement so physicians can provide care to beneficiaries.

b. Proposed Implementation of Care Complexity Add-on Code (G2211)

CMS proposes to implement a separate payment for the office/outpatient (O/O) E/M visit complexity add-on code (G2211) for separate payment. CMS originally intended to implement this proposal in CY 2021, but Congress enacted a delay of its implementation until CY 2024. ACOFP supports the agency's proposal to implement the code complexity add-on code in order to ensure appropriate reimbursement for primary care services. While we support this proposal, we also want to encourage CMS to consider the impact of the resulting budget neutrality requirement which could negatively affect primary care providers and ultimately negate the benefit of this add-on code. As CMS states in the proposed rule, the need "to address valuation distortions" for primary care necessitates action to appropriately capture the inherent complexity in the provision of E/M services. However, the implementation of this new add-on code results in reductions to the overall PFS payment system, reducing the impact of this new code, while also creating additional burdens and potential billing pitfalls for primary care physicians. We appreciate CMS' efforts on these issues but remain concerned that this is not the appropriate way to ensure primary care physician Medicare payment accurately reflects the value of the care provided.

c. Split (or shared) E/M Visits

CMS states that it continues to work to address the definition of split (or shared) visits, which CMS delayed last year. The agency postponed the implementation of the definition of "substantive portion" as more than half of the total time for one year in the CY 2023 PFS final rule. For CY 2024, CMS proposes an additional one-year delay of the implementation of the definition of "substantive portion" as more than half of the total

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time through at least December 31, 2024 and maintaining the current definition of substantive portion for CY 2024 that allows for use of one of the three key components (history, exam, or medical decision making (MDM)) or more than half of the total time spent to determine who bills the visit. CMS is proposing to revise the definition of "substantive portion" in the interim while it continues to analyze and collect information from interested parties as to whether it should permanently modify its current definition.

ACOFP supports the delayed implementation of the definition of "substantive portion" to give providers more time to adjust to this policy change. Providers are already burdened with administrative requirements, often caused by substantive changes to established procedures, and CMS should provide adequate time for providers to make these changes and adjust their practices.

d. Services Addressing Health-Related Social Needs (Community Health Integration (CHI) Services, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN) Services)

CMS is proposing new coding to expressly identify and value care management services under PFS, and separate new measures from the care management services that already receive reimbursement. First, CMS is proposing to designate CHI services as care management services that may be furnished under the general supervision of the billing practitioner. Second, the agency is also proposing new coding for Principal Illness Navigation Services (PIN).

Community Health Integration (CHI)

CMS is proposing to designate CHI services as care management services that may be furnished under the general supervision of the billing practitioner. CHI services involve a person-centered assessment to better understand the patient's life story, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services. CMS is proposing to define SDOHs to include 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 is seeking public comment on whether it should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for CHI services, including, for example, an annual wellness visit (AWV) that may or may not include the optional SDOH risk assessment.

ACOFP supports separate new measures from the care management services that already receive reimbursement, which will help identify and value practitioners' work when they incur additional time and resources helping patients address health-related social barriers.

Principal Illness Navigation Services (PIN)

CMS is proposing new coding for PIN services. Under CMS' proposal, PIN services could be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease, with the following characteristics:

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- One serious, high-risk condition expected to last at least three months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;
- The condition requires development, monitoring, or revision of a disease specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

CMS proposes that the PIN initiating visit would be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff) performed by the billing practitioner who will also be furnishing the PIN services during the subsequent calendar month(s). The PIN initiating visit would be separately billed (if all requirements to do so are met) and would be a pre-requisite to billing for PIN services. CMS is seeking comment on whether the agency should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for PIN services, including, for example, an AWV that may or may not include the optional SDOH risk assessment.

ACOFP supports policies that will help identify and value practitioners' work when they incur additional time and resources helping patients address health-related social barriers. However, we want to caution against burdensome pre-requisite requirements that could interfere with treatment. While we support separately billed PIN initiating visits, we also want to ensure that PIN services are accessible and available for patients.

SDOH Risk Assessment

An SDOH is defined in the proposed rule as, "Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity."[1] CMS is proposing a new stand-alone G code, GXXX5, for the administration of a standardized, evidence based SDOH Risk Assessment. GXXX5 is meant to identify and value the work involved in administering a SDOH Risk Assessment as part of a comprehensive social history when it is medically reasonable and necessary in relation to an E/M visit. CMS is further proposing that the SDOH Risk Assessment must be performed on the same date the practitioner performs an E/M visit. CMS is seeking public comment on whether it should condition SDOH Risk Assessment payment on whether the billing practitioner also has the capacity to furnish CHI, PIN, or other care management services, or partner with community based organizations (CBOs) to provide such services.

ACOFP supports the recognition of the work involved with administering an SDOH Risk Assessment. Osteopathic family physicians are committed to treating vulnerable populations, such as rural patients, uninsured/underinsured individuals, and racial/ethnic minorities. SDOH have been shown to have a major impact on patients' overall health. Even when a physician provides high-quality care, follows evidence-based guidelines, and provides access to community resources, patients may still not achieve the desired health outcomes because of SDOH. Making changes to a patient's social environment is key. We support the administration of SDOH Risk Assessments but want to ensure that providers are fairly compensated for this important service.

We oppose conditioning SDOH Risk Assessment payment on whether the billing practitioner also has the capacity to furnish CHI, PIN, or other care management services, or partner with CBOs to provide such services. This requirement would create additional burdens for providers. Further, many providers will continue

[1] 2021 CPT Codebook, p. 14.

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providing these types of services even if such a limitation is in place. Providers deserve to be compensated for work related to addressing SDOH, as this is a critical part of effectively treating patients but requires significant time and resources.

e. A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (AWV)

CMS proposes to add an element, the SDOH Risk Assessment, to the AWV. This element would be optional, separately payable, and not include beneficiary cost sharing if furnished in the same visit with the same date of service with the AWV. CMS proposes that the SDOH Risk Assessment service include the administration of a standardized, evidence based SDOH risk assessment tool, furnished in a manner that all communication with the patient be appropriate for the patient's educational, developmental, and health literacy level, and be culturally and linguistically appropriate.

ACOFP supports the addition of an SDOH Risk Assessment to the AWV. The goals of the AWV are health promotion, disease prevention and detection, and include education, counseling, a health risk assessment, referrals for prevention services, and a review of opioid use. An SDOH Risk Assessment could be used to effectively address these objectives. As osteopathic family physicians, we have been trained to treat the patient holistically and look beyond the disease. We pride ourselves on understanding the SDOH for our patients. Guided by our foundational principles, we treat all patients, regardless of their ethnicity or racial background. ACOFP supports policies that are intended to improve the lives of populations in our country that are disadvantaged or underserved including addressing SDOH as part of comprehensive health care.

II. Comments to Proposed Changes to the Quality Payment Program

a. Development of New Merit-based Incentive Payment System (MIPS) MIPS Value Pathway (MVP)

CMS is implementing MVPs intended to allow clinicians to report on measures that are directly relevant to their clinical practice. As part of this reporting option, CMS proposes the inclusion of five new MVPs:

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 Disorder;
4. Quality Care for Ear, Nose, and Throat (ENT); and
5. Rehabilitative Support for Musculoskeletal Care.

Further, through the MVP maintenance process, CMS is proposing to consolidate the previously finalized Promoting Wellness and Optimizing Chronic Disease Management MVPs into a single consolidated primary care MVP titled "Value in Primary Care MVP".

b. Proposed MVP Changes

We are encouraged by CMS highlighting the importance of primary care and therefore support the establishment of this new MVP. ACOFP appreciates CMS's commitment to refining and improving MVPs. More targeted and applicable improvement activities and quality measures, especially retaining those quality measures that physicians have experience reporting on, will only help to improve the program. We appreciate

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the addition of the Value in Primary Care MVP, as ACOFP recognizes the critical importance of promoting primary care, including recognizing its value.

As it relates to MVPs more generally, we note that ACOFP members provide a broad range of services for their patients that do not fit neatly into the discrete MVPs that CMS has established thus far. While the MVPs may capture parts of what family physicians do and provide to their patients, we believe that there needs to be greater consideration for the types of family medicine practices that provide the spectrum of health care services. We therefore encourage CMS to consider developing an MVP that both recognizes the unique characteristics of family medicine practices and rewards these practices for improved patient outcomes.

c. MVP Reporting Requirements

We also encourage CMS to better align the clinician experience with MVPs. As a general matter, ACOFP members are concerned about Medicare administrative burdens not related to patient care. As CMS continues to refine the MVPs and other elements of the PFS, we urge CMS to balance reporting requirements with the burden such requirements will place on physicians. Family physicians are already overburdened with reporting requirements, and CMS should limit to the greatest extent possible time-consuming data reporting requirements. Rather than placing further reporting burdens on physicians, CMS should consider gathering comprehensive data from existing datasets and entities. For example, CMS should gather data from state public health departments, health information exchanges, and/or CDC datasets for public health measures included in the MVP foundational layer.