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September 6, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1770-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) 2023 Physician Fee Schedule and Quality Payment Program Proposed Rule ("Proposed Rule").

ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents and students throughout the United States who are deeply committed to advancing our nation's healthcare system by improving healthcare delivery and outcomes and ensuring that patients have access to high-quality care.

In general, we believe the Proposed Rule would help improve care delivery and expand access to care. However, there are also some proposals we hope CMS will reconsider or adjust to better support family physician practices. For example, CMS should continue telephone evaluation and management (E/M) codes to ensure maximum flexibility in provision of primary care rather than discontinue telephone E/M services codes at the end of the public health emergency (PHE) and 151-day post-PHE extension period.

Our full comments are detailed on the following page. 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,

Bruce R. Williams, DO, FACOFP
ACOFP President

I. Comments to Proposed Changes to the Physician Fee Schedule

Determination of Practice Expense (PE) Relative Unit Codes (RVUs)

CMS proposes to rebase and revise the Medicare Economic Index (MEI) "to reflect more current market conditions faced by physicians in providing services." CMS believes the MEI is the best available measure of the relative weights of the three PFS payment components: work, PE and malpractice (MP). CMS is proposing to delay the applicable adjustments and implementation of the rebased and revised MEI as used in the PE geographic practice cost index (GPCI). CMS also solicits comment on appropriate timing for implementation for potential future rulemaking.

ACOFP appreciates CMS' efforts to ensure the MEI is updated and appropriately incorporated into the work, PE and MP relative weights. We are concerned, however, that the resulting change within the budget neutral PFS could have unanticipated consequences. We agree that the applicable adjustments and implementation should be delayed so stakeholders have more time to assess the potential impact of this proposal. Specifically, we ask that greater details are provided regarding the overall impact of the proposed rebasing and revising on the family medicine specialty and the services we provide.

Telehealth Payment

CMS is proposing to add certain services to the telehealth service list as Category 1 codes and on a Category 3 basis through CY 2023. In addition, CMS is proposing to discontinue telephone E/M services codes at the end of the 151-day post-PHE extension period, while implementing provisions of the *Consolidated Appropriations Act, 2021* and the *Consolidated Appropriations Act, 2022* (*CAA, 2022*) that together extend specific Medicare telehealth flexibilities adopted during the PHE for 151 days after the PHE expires.

CMS further proposes that starting on January 1, 2023, healthcare practitioners would be required to append CPT modifier "93" when billing for telehealth services furnished using audio-only communications technology to identify them as having been furnished using audio-only technology.

We support CMS' proposal to add additional services to the telehealth list. In general, ACOFP supports greater access to care and strongly believe expanded access to telehealth services can ensure patients receive necessary treatment, even if they are unable to see a provider in person. As we have indicated previously, we appreciate CMS taking a measured approach to identifying and assigning specific codes to the telehealth list. We reiterate our concerns that certain codes cannot and should not be delivered via telehealth and that certain telehealth services should be available only when provided by the patient's family physician. These protections are needed to ensure continuity of care and to avoid unnecessary services that may be provided via telehealth.

Telehealth flexibilities have been critical to ensuring that seniors and other vulnerable populations have access to care during the COVID-19 pandemic and remain necessary as physicians respond to the new variants. Telehealth is a powerful tool for care delivery due to its potential to improve access to care for countless Americans. In particular, the availability of telephone E/M services have greatly increased access to necessary preventive care furnished by family physicians. We strongly urge CMS to continue to recognize and reimburse for these codes to ensure maximum flexibility in provision of family medicine.

Potentially Underutilized Medicare Services

CMS is seeking comment on methods to identify services that are high-value and potentially underutilized, as well as barriers to accessing those potentially underutilized services. CMS is also seeking comment on how the agency can mitigate obstacles to accessing potentially underutilized services. The agency seeks comment on how to best define and identify high value, potentially underutilized health services, and new and innovative ideas to increase utilization and access to such services.

Osteopathic manipulative treatment (OMT)—a clinically appropriate chronic pain management (CPM) treatment that can help reduce the need for addictive medications—is a valuable tool that can be used to provide holistic care and treatment to all patients. OMT is a high-value and underutilized service that improves health outcomes and must be more available to patients. The opioid epidemic has reemerged during the COVID-19 PHE, and we continue to stress that OMT is an appropriate alternative chronic pain management treatment that should be leveraged to reduce reliance on addictive medications.

We urge CMS to identify OMT as a high-value and underutilized health service and promote access to such services to ensure OMT is available and more accessible to patients. In particular, current coding guidelines and reimbursement for E/M and OMT services creates a barrier to accessing OMT services. We also strongly urge that OMT be included among the various pain management treatment options and as a specifically identified tool to support chronic pain management programs.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes two new Healthcare Common Procedure Coding System (HCPCS) codes to describe chronic pain management (CPM) and treatment services to pay separately for pain management and treatment services. CMS proposes a new HCPCS code for general behavioral health integration (BHI) services. The agency also proposes to apply the 151-day extension of non-in-person visits (as per the *CAA, 2022* telehealth flexibilities provided during the PHE) to all RHC and FQHC mental health visits.

ACOFP supports the addition of the HCPCS codes and application of the 151-day extension of non-in-person visits to all RHC and FQHC mental health visits. Specifically, ACOFP believes the current reimbursement options do not adequately support appropriate management of chronic pain. CMS' proposal will support the delivery of family medicine, improve patient outcomes and reduce costs. ACOFP supports reimbursement policies that reward high-quality care provided by family physicians that are proven to improve patient outcomes.

In addition, non-in-person visits have played a critical role for access to care for individuals in rural areas where mental health services are not readily available. This has been essential to ensure that all individuals receive the mental health services they need, regardless of where they reside. The COVID-19 pandemic highlighted these disparities in access to care, and while we would prefer a permanent solution, we appreciate CMS implementing the statutorily required 151-day extension.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

CMS is proposing to base the CY 2023 payment amount for the drug component of HCPCS codes G2067 and G2078 on the CY 2021 payment amount, adjusted for inflation. CMS also proposes to modify the payment rate for individual therapy based on a crosswalk to CPT code 90834 instead of 90832. CMS also proposes to allow the OTP intake code to be furnished via two-way audio-video communications technology (or audio-only when audio-video technology is not available to the beneficiary) when billed for the initiation of buprenorphine treatment. Currently, this flexibility is only available for periodic assessments.

We support CMS' proposals as they more appropriately align the costs associated with operating and providing care through an OTP as well as ensure access to necessary treatment. In particular, allowing the OTP intake to occur via audio-video communications technology (or audio-only) is an important change that will increase access to care and ensure that all patients can receive lifesaving buprenorphine treatment.

Medicare Part B Payment for Preventive Vaccine Administration Services

CMS proposes to align payment rates for the COVID-19 vaccine with the payment rates for other preventive vaccines in the January of the year following the end of the PHE. In addition, CMS proposes to use the geographic adjustment factor (GAF) to adjust payment to reflect costs of administering preventative vaccines in each of the PFS fee schedule areas beginning in CY 2023. The agency also proposes to annually update the payment for administration of preventative vaccines by the MEI available at the time of rulemaking, which is forecasted to be 3.8 percent in CY 2023. CMS believes it would not be appropriate to establish annual updates that would likely be offset by reduced costs given the more established infrastructure and delivery approaches.

CMS also proposes to continue the additional payment of $35.50 for COVID-19 vaccination administration and adjust the payment to reflect geographic cost differences using the GAF and updated with the CY 2023 MEI. CMS also proposes to apply the GAF to the payment amount of monoclonal antibody products, as long as the U.S. Food and Drug Administration Emergency Use Authorization (EUA) declaration is in place to reflect cost differences in each geographic area. The agency proposes to continue paying for monoclonal antibody products under the Part B benefit even after the EUA declaration is terminated so long as the products have market authorization. For payments for monoclonal antibody products, CMS proposes to apply the GAF, but not update the payment amount with the MEI, effective January 1, 2023.

In general, ACOFP supports these proposals. As we have previously commented, vaccines are incredibly important for the general health and well-being of the communities we serve. Ensuring appropriate reimbursement for vaccine administration is essential to ensuring access in rural and underserved areas. Therefore we, in particular, support the continued add-on payment for COVID-19 vaccine administration as there continue to be patients in our communities who are unvaccinated. Furthermore, continued coverage of the monoclonal antibody products is essential in effectively treating those patients who test positive for COVID-19.

Relatedly, we support the application of the GAF to the payment amounts to reflect the cost differences. We disagree with CMS that it is not appropriate to establish annual updates to monoclonal antibody products. Like vaccines, monoclonal antibody products are incredibly important for individuals who contract COVID-19. Establishing appropriate reimbursement is critical so that all individuals receive access to care they need to recover from the virus, especially those in rural and underserved areas who struggled to obtain access to adequate care and are more at risk of getting COVID-19.

II. Comments to Proposed Changes to the Quality Payment Program

Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) and Alternative Payment Model (APM) Participant Reporting

We are encouraged that CMS is committed to improving provider and patient experience in the Medicare program. As we have previously commented, many ACOFP members have encountered difficulties with MIPS. The majority of our physician members operate small or solo practices, primarily in rural and underserved areas, and have found the program to be challenging administratively, with confusing elements not linked to patient care.

Small, solo and independent family physician practices have been particularly frustrated with the program, since they have limited resources to meet the many requirements of MIPS. Family physicians have also been forced to make significant practice changes and investments in electronic health record (EHR) systems to ensure they are complying with the MIPS program. Our members have also spent considerable time keeping up with annual updates and policy changes since the program was implemented.

While we have long called for more specific model options for family medicine, and in full recognition of Primary Care First and ACO REACH programs, we urge a measured approach to transitioning from MIPS to MVPs. Many of our members only recently have developed sufficient familiarity with MIPS, implementing practice changes to comply with the myriad requirements. As such, they are reluctant to start over with a new program. They are also concerned that MVPs will require updates to their EHR systems and new changes to their practices. While larger entities may be equipped to make these necessary investments, small, solo and independent practices are particularly disadvantaged when such changes are needed, adversely impacting their ability to succeed under new programs.

Therefore, we urge CMS to closely monitor the transition to MVPs and be prepared to delay its implementation or provide exceptions for certain practice types. If there is low participation in MVPs in the years close to 2028, CMS should consider delaying the mandatory participation Additionally, if physicians are reporting issues with the transition—whether it be lack of relevant MVPs or measures within those MVPs or the inability for some practices to transition to MVPs—CMS should delay the start date. For the MVP program to be successful, there must be a deliberate transition that allows physicians to become familiar and comfortable with the program.

Lastly, we urge CMS to ensure that the MVP program will not require physicians to make unreasonable updates to their EHR systems or practice patterns. Physicians should be able to maintain their current practices and not spend additional dollars on their EHR systems. ACOFP members are very concerned that they will have to make continual EHR updates and changes to comply with shifting CMS programs. To the extent possible, the MVP program should not force physicians to invest additional dollars to meet administrative or operational requirements, as these costs will directly take away from a practice's ability to provide patient care.

MVP Reporting Requirements

As a general matter, ACOFP members continually highlight the 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 could gather data from state public health departments, health information exchanges and/or U.S. Centers for Disease Control and Prevention datasets for public health measures included in the MVP foundational layer.

Proposed MVPs

CMS is proposing revisions to the seven MVPs CMS finalized in the CY 2022 PFS final rule based on the proposed removals of certain activities from the improvement activities inventory and additional relevant existing quality measures for MVP participants to choose from. CMS also proposes five new MVPs: (1) Advancing Cancer Care; (2) Optimal Care for Kidney Health; (3) Optimal Care for Neurological Conditions; (4) Supportive Care for Cognitive-Based Neurological Conditions; and (5) Promoting Wellness.

ACOFP appreciates CMS' commitment to refining and improving MIPS and MVPs. More targeted and applicable improvement activities and quality measures, especially reusing those quality measures that physicians have experience reporting on, will only help to improve the program. We also appreciate the addition of the Promoting Wellness MVP, which promotes general physical and mental wellness within patients. ACOFP recognizes the importance of promoting wellness and that it plays an essential role in patient's well-being, as well as how family physicians care for their patients. ACOFP believes that promoting wellness is essential to both physical and mental health and should be a priority for all physicians when treating their patients.

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 is establishing. 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 preventive health care services. In particular, many of our solo, small and independent practices were not ready to participate in either Primary Care First or ACO REACH and continue to be left out of delivery system reform efforts. We encourage CMS to consider how to develop an MVP that both recognizes the unique characteristics of such family medicine practices and rewards them for improved patient outcomes.