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September 6, 2024

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:

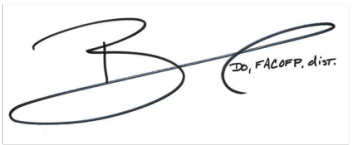
On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2025 Physician Fee Schedule (PFS) and Quality Payment Program Proposed Rule ("Proposed Rule").

ACOFP is the professional organization representing more than 26,000 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 recognizing the value of primary care. However, there are also proposals we request CMS to reconsider to better support family physicians. Specifically, CMS should not finalize its proposal to reduce the conversion factor by 2.8 percent compared to last year. This type of harmful payment reduction threatens the financial viability of osteopathic family physician practices, which are often independent and rural practices, and ultimately would 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,



Brian Kessler, DO, DHA, FACOFP *dist*.
President, ACOFP

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I. Comments on Proposed Changes to the Physician Fee Schedule

a. Proposed CY 2024 Conversion Factor

The estimated CY 2025 PFS conversion factor is $32.36, which represents a decrease of $0.93 (or 2.80 percent) from the current CY 2024 conversion factor of $33.29. ACOFP opposes this proposed cut because it could have a serious financial impact on the ability of osteopathic family physicians to continue practicing and adversely impact 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.

CMS also requests general information on ways to improve the stability and predictability of any future updates. Payment policies must account for inflation and rising practice expense costs for physicians. Physicians need financial stability. Many are small-business owners, who are struggling to cope with administrative burdens, pay staff and facility costs, and purchase essential technology. ACOFP therefore opposes the proposed payment reduction and urges CMS to support stable Medicare reimbursement based on current economic indices, so physicians are able to provide care to beneficiaries.

b. Payment for Medicare Telehealth Services under Section 1834(m) of the *Social Security Act*

CMS is proposing that beginning on January 1, 2025, an interactive telecommunications system may include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home (if it is a permissible originating site) if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. Also, through CY 2025, distant site practitioners will continue to be permitted to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

Moreover, CMS proposes that for a certain subset of services that are required to be furnished under the direct supervision of a physician or other supervising practitioner, the agency would permanently adopt a definition of "direct supervision" that allows the physician or supervising practitioner to provide such supervision through real-time audio and/or visual interactive telecommunications, as appropriate, for certain services. For all other services furnished under direct supervision, CMS would continue defining "immediate availability" to include real-time audio and visual interactive telecommunications technology only through CY 2025. Finally, through CY 2025, CMS proposes to

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continue allowing teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the service is furnished virtually.

In general, ACOFP supports these proposals. Telehealth can increase access to care, particularly for those in rural or underserved areas or those who face barriers to accessing care otherwise. In addition, allowing the physician or supervising practitioner to provide such supervision through real-time audio and/or visual interactive telecommunications, as appropriate, provides more flexibility for physicians and opportunities for teaching. We encourage CMS to extend the distant site provision on a permanent basis to ensure access to care for those who rely on telehealth.

ACOFP supports the coverage of audio only visits because this option is particularly important for patients who do not have access to video technology such as those without access to a smartphone with video communication capability. In addition, we want to highlight the effectiveness of using texting and emailing to communicate with patients who have hearing impairments and urge the agency to ensure coverage of these methods of communication between a physician and patient.

ACOFP firmly believes that in-person care is the gold standard for care and that telehealth is a tool to improve care delivery when in-person care is not possible—not a silver bullet. While we support increased telehealth flexibilities, we also want to highlight the importance of existing physician-patient relationships and care coordination. We believe it is critical that there are safeguards against the potential for telehealth to inadvertently disrupt existing physician-patient relationships and care coordination. Telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth. We want to avoid situations where a patient receives care via telehealth, but there is no follow up or coordination with existing in-person providers afterward. We also want to ensure equitable access so that patients who might need it most, specifically those in rural or underserved areas, are able to maximize telehealth opportunities while not sacrificing the physician-patient relationship. In addition, while ACOFP supports the use of telehealth, it is also important to maintain protections to guard against fraudulent activity.

c. Enhanced Care Management – Advanced Primary Care

First, starting in CY 2025, CMS proposes to adopt coding and payment policies to recognize advanced primary care management (APCM) services for use by practitioners who are providing services as the continuing focal point for all needed health care services and are responsible for all primary care services. Adoption of these codes would provide hybrid payments for primary care services with a mix of encounter and population-based payments.

ACOFP supports this proposal to support access to primary care services. Family medicine plays a critical role in overall health, contributing to improved patient outcomes and reduced healthcare costs. We encourage CMS to continue developing policies that promote primary care. Many of our members are the focal point of care for their patients, especially in rural and underserved areas, and we appreciate this recognition of the role they play in coordinating and addressing all needed health care services.

We also recommend that the APCM codes should be available for primary care physicians because physician-led care teams are the gold standard for care delivery. While nonphysician practitioners

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are also critically important to the team, there is a distinction in training and education between physicians and nonphysicians. Also, while the use of nonphysician practitioners may be appropriate under certain circumstances and with adequate physician supervision, the nonphysician practitioner model is not an equivalent substitute to the use of family physicians.

Second, the proposed coding and payment would incorporate elements of several specific, existing care management and communication technology-based services (CTBS) into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management. CMS would establish three new Healthcare Common Procedure Coding System (HCPCS) G-codes for APCM services that are stratified into three levels based on number of chronic conditions and enrollment as a Qualified Medicare Beneficiary. The agency is also proposing as a condition of payment for APCM services a performance measurement requirement, which can be satisfied by reporting the Value in Primary Care Merit-based Incentive Payment System (MIPS) Value Pathway (MVP). Reporting for the MVP would begin in 2026 based on the 2025 performance year.

ACOFP appreciates that the APCM codes would simplify the claims submission process when delivering Principal Care Management (PCM), Transitional Care Management (TCM), and Chronic Care Management (CCM) services, while preserving their availability should the APCM code not be available but one of those other services are provided. While we continue to review and assess the potential impact of this change, we are hopeful that the APCM services will more accurately reflect the cost and resources associated with serving as the focal point of care.

We caution, however, that conditioning payment on a performance measure requirement could pose challenges for providers. As the MIPS program continues to change and given the current voluntary nature of MIPS Value Pathways, this could be too much, too fast, for the typically solo, small, and rural practices who serve as the focal point of care. We want to discourage any additional administrative burden associated with APCM. At a minimum, we urge there to be a reasonable transition period to allow family physicians to assess the impact of this change, implement necessary coding and documentation changes, and also consider the implications of transitioning to the Primary Care MVP.

d. Care Complexity Add-on Code (G2211)

Beginning in CY 2025, CMS proposes allowing payment of the Office/Outpatient (O/O) evaluation and management (E/M) visit complexity add-on code G2211 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

ACOFP previously supported the implementation of this complexity add-on code in order to ensure appropriate reimbursement for primary care services. We support the expanded use of this code and want to emphasize the need for Medicare payment to accurately reflect the value of the care provided.

e. Services Addressing Health-Related Social Needs

CMS is broadly requesting information on the following codes for services addressing health-related social needs that were implemented under the CY 2024 PFS final rule:

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- Community Health Integration (CHI) (HCPCS codes G0019, G0022);
- Principal Illness Navigation (PIN) (HCPCS codes G0023, G0024);
- Principal Illness Navigation-Peer Support (PIN-PS) (HCPCS codes G0140, G0146); and
- Social Determinants of Health Risk Assessment (SDOH RA) (HCPCS code G0136).

CMS is seeking information from interested parties on additional policy refinements regarding these codes to consider in future rulemaking. CMS is also requesting comment on addressing the social needs of beneficiaries broadly.

ACOFP supports policies, including these new codes, that help identify and value practitioners' work when they incur additional time and resources helping patients address health-related social barriers. ACOFP also supports policies that are intended to improve the lives of populations in our country that are disadvantaged or underserved. This includes addressing SDOH as part of comprehensive health care. 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 provide the highest level of care to all patients, regardless of their ethnicity or racial background.

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 coding for these services addressing health-related social needs and want to ensure that providers are fairly compensated for these important services.

f. Teaching Physician Services Furnished under the Primary Care Exception

CMS is requesting information on whether and how best to expand the array of services included under the primary care exception in future rulemaking. The agency is interested in more feedback on the types of services that could be allowed under the primary care exception, specifically preventive services, and whether the currently required six months of training in an approved program is sufficient for residents to furnish these types of services without the presence of a teaching physician.

CMS also seeks comment on whether adding certain preventive services or higher-level E/M services to the primary care exception would hinder the teaching physician from maintaining sufficient personal involvement in the care to warrant PFS payment for the services being furnished by up to four residents at any given time.

ACOFP supports allowing teaching physicians to bill for these services and expanding the array of services included under the primary care exception. It is important for CMS to appropriately value time spent teaching students. We do not believe that adding services would hinder the teaching physician's ability to sufficiently maintain personal involvement in providing care.

When considering additional services to include under this exception, we recommend adding osteopathic manipulative treatment (OMT). OMT is a clinically appropriate chronic pain management treatment that can help reduce the need for addictive medications. It is a valuable tool that can be

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used to provide holistic care and treatment to all patients. OMT is an underutilized service that improves health outcomes and must be made more available to patients. In order to do so, more residents need to be trained on the appropriate use and delivery of OMT. We therefore urge CMS to expand the array of services included under the primary care exception to include OMT.

g. Dental Services Inextricably Linked to Specific Covered Services

CMS proposes to codify policies to permit payment for certain dental services, described below, that are inextricably linked to other covered services:

- Dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease; and
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with end-stage renal disease.

We support this proposal to permit payment for certain dental services. Further, we suggest that CMS consider increased dental coverage for Medicare beneficiaries outside of these specific situations. Oral health is an important part of overall health and in many cases can address many factors leading to poor overall health. A lack of access to dentistry can lead to serious health conditions that are painful, costly, and severe. Access to dentistry therefore can help diagnose, prevent, and treat health conditions including oral diseases. We support treating patients holistically and this includes supporting access to oral health care and coordinating care with our oral health colleagues.

h. Medicare Shared Savings Program

CMS proposes establishing a new "prepaid shared savings" option for eligible Accountable Care Organizations (ACOs) with a history of earning shared savings. Eligible ACOs include those participating in Levels C-E of the BASIC track or the ENHANCED track with consistent prior success in earning shared savings in the Shared Savings Program. The initial application cycle to apply for prepaid shared savings would be for a January 1, 2026 start date.

We support this proposal, as advanced payment could be very helpful to ACOs. ACOFP supports reimbursement policies that reward care provided by family physicians who provide high-quality and improved patient outcomes. As described above, physicians face a challenging financial environment, and we support policies that could alleviate this increasing burden.

II. Comments on Proposed Changes to the Quality Payment Program

CMS proposes the inclusion of new MVPs around the following topics:

- Ophthalmologic Care;.
- Dermatological Care;
- Gastroenterology Care;
- Optimal Care for Patients with Urologic Conditions;
- Pulmonology Care; and

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- Surgical Care.

CMS also is requesting information focused on public health reporting and data exchange specific to MIPS.

We 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. This type of administrative burden directly leads to burnout. Rather than placing further reporting strains 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 the Centers for Disease Control and Prevention (CDC) datasets for public health measures included in the MVP foundational layer.

We also reiterate prior concerns regarding how outcomes measures are assessed and implemented. As the focal point for all needed health care services, our members have raised concerns regarding outcomes measures that set thresholds, but do not account for improvements. Many patients may experience improved health outcomes, but will never reach the threshold that CMS sets. There needs to be greater flexibility and recognition that for some patients, improvement on an outcome measure is clinically significant, even if it does not meet a prescribed threshold associated with the measure. We therefore urge the agency to consider improvement in a health outcome in addition to attainment of a set threshold when assessing quality of care.

Finally, we are concerned with the uncertainty regarding the future of the MIPS program. As we have expressed previously, many of our solo, small, and rural physician practice members faced difficulties transitioning their practices to meet MIPS requirements. An eventual transition to MVPs could prove problematic absent a sufficient period to effectively do so. Instead of potentially further complicating the MIPS program, we encourage CMS to consider opportunities to further expand the availability of primary care-focused alternative payment models (APMs). The current limited nature and scope of existing APMs do not allow primary care practices to meaningfully participate as independent entities, which likely unintentionally sets a precedent that for solo, small, and rural practices to move to value-based care, they must partner with or join another entity.

III. Conclusion

ACOFP appreciates CMS's commitment to ensuring access to primary care services to improve patient care. We support CMS finalizing most of the aforementioned policies but urge the agency to not finalize its proposal to reduce the conversion factor by 2.8 percent compared to last year. Such reduction threatens the financial viability of osteopathic family physician practices and will impact beneficiary access to care.