



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1784-P. 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

Dear Administrator Brooks-LaSure:

On behalf of the 25,000 physician, resident, and medical student members of the Massachusetts Medical Society (MMS), I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on August 7, 2023 (88 Fed. Reg. 52262). The MMS largely supports the comprehensive comments submitted by the American Medical Association (AMA). Our comments, which are guided by MMS policy priorities and advocacy initiatives, highlight specific areas of support, concern, and recommendation regarding the proposed rule. Primary areas of focus in our comments include:

1. Concern about Medicare Physician Fee Schedule payment rates that are insufficient to support and sustain practices and patient access
2. Support for the proposed delay in implementation of the Medicare Economic Index (MEI) practice expense reweighting
3. Support for the New Evaluation and Management (E/M) Add-On Code
4. Support for the extension of telehealth flexibilities and recommendation to permanently extend these flexibilities that were enacted during the COVID-19 Public Health Emergency
5. Support for incentivizing screening for Social Determinants of Health
6. Support expanded coverage for diabetes screening and self-management training
7. Opposition to the increase of the Merit-Based Incentive Performance System (MIPS) performance threshold, and recommendation to reform the MIPS
8. Recommendation to offer more opportunities for physicians to participate in Alternative Payment Models (APMs)
9. Support for Medicare Shared Savings Program (MSSP) and Accountable Care Organization (ACO) Reforms

The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing high quality, equitable care to all patients. The MMS' recommendations are outlined in more detail below. We also urge the Department to carefully consider the extensive and thoughtful commentary provided by the American Medical Association, which is enclosed with these comments.

1. MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT RATES

The MMS is concerned with ongoing conversion factor reductions, specifically the proposed 3.36 percent reduction in the 2024 Medicare conversion factor (CF), with corresponding reductions in anesthesia CF rates. This issue is not solely about physician payment, but rather this area of frustration is, at its core, about practice sustainability and patient access to health care. **We again highlight our deep concern that these proposed cuts will have widespread, negative implications for both physician practices and the patients they serve.**

The proposed payment reductions are attributable to two factors, including a -1.25 percent reduction stemming from a temporary update and a negative budget neutrality adjustment linked to the introduction of an office visit add-on code. These payment cuts are counterproductive to our shared goal of providing high-quality care to Medicare beneficiaries and simultaneously erode the financial sustainability of physician practices. **The MMS understands that certain aspects of this issue are under the purview of Congress, such as annual inflation updates and budget neutrality reform, but the MMS urges CMS to use its full authority to mitigate the currently proposed payment cuts, to reduce administrative burdens, and to preserve and provide more opportunity for physicians to participate in value-based APMs.**

The continued decline in payment rates is unsustainable. Between 2001 to 2023, the cost of operating a medical practice has surged by 47 percent, while physician payment rates have increased by only nine percent. Relative to inflation, Medicare physician payment rates have fallen by 26 percent, underscoring the magnitude of the discrepancy between costs and compensation, which is only projected to worsen in 2024. According to CMS' own estimates, the cost to practice medicine, as measured by the government's Medicare Economic Index (MEI), will increase by 4.5 percent; yet, CMS is proposing payment rate cuts of over 3 percent for all physicians. This imbalance poses a serious threat to the stability and vitality of medical practices across the nation and contributes to high rates of burnout among physicians.

While Medicare payment for non-physician providers has been adjusted to keep pace with inflation, physician payment has remained stagnant, and in 2023, physician payment was even decreased by 2 percent. Critically, these reductions in physician practice reimbursement rates will severely hamper access to care for Medicare patients. Physicians in both small and large medical groups are expressing that they can no longer sustain their practices, leading physicians to reduce in clinical hours, retire early, or consolidate practices with large systems, all of which negatively impact access to care for patients. The Medicare Trustees have explicitly warned that access to Medicare-participating physicians could be seriously compromised in the long term if payment rates fail to adapt. Delays in care, particularly in underserved populations, are associated with worse health outcomes and inequitable health care delivery. It is our shared responsibility to take proactive measures to prevent such outcomes.

Furthermore, the MMS is concerned that more physicians and group practices may face a MIPS penalty in 2024 based on the newly released 2022 performance period feedback. These penalties can reduce Medicare payment by as much as 9 percent. The MIPS program was largely paused during the 2020 and 2021 performance periods due to the COVID-19 public health emergency, and we have serious concerns that it may be unfairly penalizing physician practices—particularly small, independent, and rural practices—due to a lack of awareness of the expiration of the automatic COVID-19 flexibilities. Further, there is growing [evidence](#) that this program is unduly burdensome, divorced from quality improvement, and exacerbating health inequities. **When finalizing its proposals, CMS must consider the totality of the payment reductions facing physicians in 2024.**

The problems with the MPFS have reverberated throughout the entire health care system, causing more cost-shifting to the private sector and a growing reluctance of the private sector to cover the cost-shift, physician employment shifts and market consolidation, substantial numbers of physicians retiring early, growing physician shortages overall, and disincentives to embrace value-based care. The MPFS is the foundation for value-based payment systems, Alternative Payment Models, and Medicare Advantage. CMS noted in the proposed rule that many stakeholders have suggested that Medicare’s payment policies are directly responsible for the consolidation of privately owned physician practices into larger health systems. Because of the Medicare site of service payment differential, this consolidation has driven up costs. MMS physician members practice in a variety of settings from solo practice to very large medical groups in integrated settings, and we urge CMS to adopt payment policies that will allow physicians a choice of cost-effective practice environments and patients an appropriate choice of physicians. Moreover, the MPFS is integral to the success of CMS’ value-based care models, including MSSP, ACOs, and APMs, that promote financial accountability, clinical improvement, coordination of care, population health, and reduction of health care disparities.

While we appreciate that Congress partially mitigated the 4.5 percent cut to the MFS rates that was supposed to take effect in January 2023 through passage of the Consolidated Appropriations Act (CAA) of 2023, the forthcoming 1.25 percent reduction in 2024 that was included in the CAA, compounded by a two percent reduction that took effect for 2023, amplifies the financial stress on physician practices. **We urge both Congress and CMS to collaborate urgently to address this pressing issue and ensure that physician practices can continue to provide exceptional care without the strain of financial vulnerability.**

2. DELAY OF MEDICARE ECONOMIC INDEX (MEI) PRACTICE EXPENSE REWEIGHTING PROPOSAL

MMS applauds CMS’ decision to delay implementation of the flawed Medicare Economic Index (MEI) cost weights pending more public comment and completion of the AMA’s Physician Practice Information Survey (PPIS), which will collect practice expense data directly from physician practices rather than using surrogate data sources. We believe that waiting for more direct physician data in determining the appropriate MEI cost weights and the mechanisms for computing those weights will result in more accurate information on which to base payment. The AMA and Mathematica formally launched the PPIS on July 31, 2023. The survey is supported by 173 health care organizations and will provide more than 10,000

physician practices with the opportunity to share their practice cost data and number of direct patient care hours provided by both physicians and other qualified health care professionals. This survey will be in the field through April 2024, and data will be shared with CMS in early 2025, in time for the 2026 Medicare Physician Fee Schedule Rule, which also coincides with the 2026 Geographic Practice Cost Index update.

In 2023, nine of the largest state medical societies met with the Centers for Medicare and Medicaid Services (CMS) to discuss the negative impact of the 2024 Medicare Economic Index (MEI) reweighting plan on physicians in our states. This proposal would have rebased and revised the MEI practice expense GPCIs. It would have harmed the majority of physician practices in our higher-cost regions and made it more difficult for physicians to operate viable medical practices and maintain patient access to care. Because CMS did not publish a state or regional impact chart in the final 2023 Medicare Physician Fee Schedule, the California Medical Association calculated the impact on high-cost states. The State Impact Chart below shows at least \$230 million in net reduced payments per year to physicians in nine high-cost states because of the 2024 MEI changes. Over \$6 million would have been shifted away from Massachusetts physicians. These losses will increase significantly in future years as new Medicare Advantage plan county benchmarks become impacted by actual changes in Fee-for-Service per capita expenditures.

	Alt peGPCI Impact Using 2020 RVUs	Est 2024 Impact*
CA	\$ (74,052,602)	\$ (86,631,071)
DC	\$ (18,679,706)	\$ (21,852,613)
FL	\$ (52,366,355)	\$ (61,261,229)
HI	\$ (2,853,347)	\$ (3,338,012)
MD	\$ (6,352,043)	\$ (7,430,991)
MA	\$ (5,236,808)	\$ (6,126,325)
NJ	\$ (10,526,005)	\$ (12,313,937)
NY	\$ (25,759,151)	\$ (30,134,563)
TX	\$ (1,446,917)	\$ (1,692,688)
	*-4% annual increase in RVUs	

The flawed plan would inaccurately redistribute physician payments between geographic regions without any scientific basis. CMS did not apply appropriate physician practice data or make appropriate calculations. Unfortunately, the plan resulted in inaccurate payment rates that would reduce access to physicians in high-cost regions of the country, inconsistent with the intent of the Medicare geographic payment law. The substantial geographic redistributions were not based on accurate data. For instance, CMS proposed to reduce the weight of office rent from 10.2% of all physician practice expenses to 5.6%, which would lead to substantial reductions in Medicare reimbursement in high-cost urban areas and particularly to small practices where office rent can comprise 16% of total expenses. Based on samples of office practices, we believe rent was undervalued and the purchased services category was over-valued in the plan. Moreover, there was a great deal of variation in practice expense weights between geographic regions. As CMS is also aware, nursing, and other clinical and non-clinical staff wages have skyrocketed.

It is also important to note that because of the one-quarter work GPCI adjustment, three-fourths of the work GPCI is not applied to Medicare payments for most physicians in the country; and, therefore, physician work is already devalued. The CMS plan would exacerbate this discrepancy for physicians in higher-cost regions.

The states listed in the chart above are extremely concerned with the declining trends in patient access to care because of the already low Medicare rates. If Medicare payment rates are reduced even further in our high-cost regions, it will exacerbate existing access challenges. We believe the reweighting plan will harm small practices, further incentivize the provision of services in more expensive hospital settings, and reduce access to care, particularly for patients with more costly, complex conditions. Under the CMS plan, physicians operating on tight financial margins will be further disincentivized to care for patients with chronic conditions or serve underserved and marginalized communities.

We thank CMS for postponing the implementation of updated MEI weights and for acknowledging the AMA's current survey to collect practice cost data from physician practices. The MEI serves as a pivotal measure of practice cost inflation and forms the foundation for determining the proportion of payments allocated to physician earnings and practice costs. We agree that MEI weights must be based on reliable and contemporary data sources to ensure accuracy and fairness in rate-setting and urge the agency to continue to use reliable and accurate data for this purpose, as it will produce more accurate, reliable physician payment and protect patient access to care.

3. EVALUATION AND MANAGEMENT (E/M) ADD-ON CODE

The MMS greatly appreciates the reduction in the utilization assumption for the G2211 E/M add-on code from 90 percent, under the previous administration, to 38 percent in the current proposed rule. **According to additional information from the AMA and several primary care and surgical specialty organizations, MMS agrees that the utilization assumption should be even further reduced until there is further clarity on the appropriate use of the code and to prevent further unwarranted budget neutrality reductions.** Accordingly, we must strongly echo the concerns raised by various stakeholders regarding the utilization assumptions for G2211, which are driving nearly all of the 2024 budget neutrality reduction proposed by CMS. The lack of clarity surrounding the appropriate circumstances for reporting this code, combined with potential implications for patient cost-sharing, has created significant ambiguity among health care practitioners. **We urge the agency to further refine these assumptions to prevent unwarranted reductions in the Medicare conversion factor.**

The new code will help to sustain physician practices that provide comprehensive services and promote more timely access to primary care. It is intended to support physicians who are working to coordinate patient care across teams of physicians and other practitioners, as well as to address unmet social needs. Incentivizing coordinated care among multiple physicians and enhancing continuity of care through this code can improve quality of care, reduce hospitalizations, and thus improve health care spending.

Existing billing codes do not account for care coordination services or more complex care provided by physicians longitudinally. For instance, the PCM codes are limited to patients with a single high-risk disease; CCM codes are limited to patients with two or more co-occurring chronic conditions; and TCM codes are limited to patients experiencing a discharge from the hospital/facility setting and focus on care management for only 30 days following a discharge, rather than on an ongoing basis. G2211 is needed to better account for the unique and additional costs of providing and coordinating continual, longitudinal wrap around care for all patients.

Primary care physicians must often manage numerous interdependent chronic conditions and balance multiple clinical guidelines and medications, while working alongside additional physician specialists. A 2015 study [found](#) that primary care specialties uniquely experience increasing numbers of chronic medical problems, complexity of medication regimens, numbers of guideline-indicated services, demand for preventive services, and pressures for accountability and performance. As more Medicare patients have multiple chronic conditions, managing their overall health requires coordination among the care team and various specialists. This additional complexity is not captured in the current E/M code structure and is important for optimal patient care.

While CMS recently updated the E/M office visit codes, those new codes do not fully account for the complexity or unique costs of providing on-going coordinated primary care. We believe G2211 will help to sustain and build a primary care workforce to meet the needs of a sicker, more diverse, and growing population of seniors who need more primary care coordination among specialists. This code fills a gap that has frustrated physicians and caused many to reduce the number of patients they accept. **Accordingly, the MMS supports the new E/M Add-on Code G2211 to reflect the provision of more complex care of sicker patients needing more coordination among physician specialists.**

4. EXTENSION OF TELEHEALTH FLEXIBILITIES

Telehealth Services

The MMS strongly supports CMS' proposals to continue paying for telehealth services provided nationwide and to patients in their homes and to continue paying for all Medicare telehealth services that were covered in 2022 through the end of 2024, including the CPT codes for audio-only telephone visits. We further urge the Biden Administration to support legislation to permanently extend Medicare telehealth policies. We also greatly appreciate the new guidance issued by CMS earlier this year recognizing, covering, and reimbursing for e-consults or interprofessional telephone/internet/electronic consultation. Facilitating interprofessional, peer-to-peer consultations promotes high quality clinical care, especially in complex cases.

The MMS applauds CMS' proposal to implement the telehealth flexibilities that were included in the Consolidated Appropriations Act (CAA), 2023, by waiving the geographic and originating site requirements for Medicare telehealth services through the end of CY 2024. By doing so, patients nationwide in both urban and rural areas will retain the ability to access telehealth services, particularly from their own homes, in the ways to which they have become accustomed over the past several years. We also thank CMS for extending payment for the CPT codes for audio-only telephone visits through 2024 and for proposing to continue payment for all other services that were on the 2022 Medicare Telehealth Services List in any category through 2024 when they are

provided via telehealth. Additionally, we support the delay of in-person visit requirements for telehealth services for patients with mental health conditions.

The MMS deeply appreciates, and strongly supports, these policy proposals and urges that they be finalized. The rapid, widespread uptick in utilization of telehealth throughout the COVID Public Health Emergency (PHE) clearly demonstrated the value of virtual care and, more broadly, digitally enabled medical care combining in-person, virtual, remote monitoring, and other service modalities to deliver care that meets patient needs. It is critical that Medicare patients nationwide are able to continue receiving telehealth services, including audio-only services, and that they can continue receiving them in their homes. The MMS strongly urges the Biden Administration to join us in supporting legislation to permanently extend these Medicare telehealth policies.

Frequency Limits on Subsequent Nursing Facility Telehealth Visits

The MMS recommends that CMS permanently remove the frequency limit on physicians furnishing subsequent nursing facility visits via telehealth. Federal regulations at 42 CFR 483.30 already require that patients in a nursing facility “must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.” Effective May 7, 2022, one year prior to the expiration of the COVID PHE, CMS reinstated the requirement that the nursing facility patient visits required by these federal regulations must be provided by the physician in-person and cannot be provided via telehealth. Given that these regulatory visits are already required to be provided in-person, the MMS recommends that CMS remove the frequency limit on physicians furnishing subsequent nursing facility visits via telehealth.

When a patient in a nursing facility develops a new problem or their condition is exacerbated such that they need to see a physician, the visit should be provided in the *most expeditious manner*. If the physician cannot quickly be in-person at the facility but could provide the visit via telehealth, that should be permitted. Additionally, it is likely that rapid availability of a telehealth visit in nursing facilities would help prevent avoidable patient transfers from nursing facilities to emergency departments.

Direct Supervision

The MMS recommends that CMS permanently allow the supervising physician to be present and immediately available through real-time audio and visual interactive telecommunications. During the PHE and continuing through calendar year 2023, CMS has modified the definition of Direct Supervision to allow this supervision to be provided through the presence and immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications. In the 2024 rule, CMS proposes to extend this definition of Direct Supervision through the end of calendar year 2024 and seeks information about future policy on virtual Direct Supervision for 2025 and beyond.

The MMS supports the proposal to continue the current policy through 2024 allowing the supervising physician to be present or immediately available through real-time audio and visual interactive telecommunications and we recommend that this policy be made permanent. Although remote supervision may be inappropriate in some cases, that does not justify refusing to pay for it under any circumstance. In many rural and underserved areas patients may be unable to access important services if the only physician available has to supervise or deliver services at multiple locations and may not be available to supervise services in-person when all patients need

them. In reality, failure to allow supervision via interactive telecommunications could mean that a patient would be unable to receive the service at all, rather than forcing in-person supervision to occur. Both patients and CMS rely on physicians' professional judgment to determine the most appropriate services to deliver, and the same principle should apply to how supervision is provided.

Reporting Home Address for Telemedicine Visits

The MMS strongly urges CMS to allow physicians to continue to render telehealth services as needed from locations other than their primary practice setting *without* having to add their home address to their Medicare enrollment form.

The MMS is concerned with the public display of a physician's home address on public websites that include a physician lookup feature, such as the Medicare website. Specifically, we advise CMS to continue to allow physicians to render telehealth services from their homes without reporting their home address on their Medicare enrollment form while continuing to bill from their currently enrolled location. CMS allowed this practice during the COVID-19 public health emergency, and we urge the agency to consider permanently extending this flexibility beyond December 31, 2023, when it is set to expire. Physician privacy and safety is of utmost concern, and we fear the unintended consequences of this personal information becoming available to the public. For example, physicians who provide behavioral health services may only conduct telemedicine visits from their home. The nature of this physician's population of patients introduces a heightened level of safety concerns, that we find outweigh the perceived benefits of having the physician's address listed publicly.

Concerns for privacy and safety are not new, but escalating trends in violence towards physicians and other health care providers demonstrate that these professionals have never been at a greater risk of injury due to workplace violence. According to the U.S. Bureau of Labor Statistics, the rate of injuries from violent attacks against medical professionals grew by 63 percent from 2011 to 2018, and hospital safety directors say that aggression against staff escalated as the COVID-19 pandemic intensified in 2020.¹ Notably, hospitals have turned to intensifying security protocols that have become more pronounced since the beginning of the COVID-19 pandemic.² However, while hospital settings are attempting to respond with investments to protect the safety of staff and patients, reasons for aggression may vary and ultimately become targeted towards an individual outside the walls of a secure hospital.³ The potential for negative externalities may further threaten physicians' willingness to serve in capacities where their professional judgments impact the livelihoods or legal statuses of individuals, such as physicians serving on medical tribunals or as medical experts in lawsuits. We stress that any effort towards preserving the privacy and safety of health care professionals must be a top priority for CMS.

¹ U.S. Bureau of Labor Statistics, "Injuries, Illnesses, and Fatalities: Fact Sheet, Workplace Violence in Healthcare," 2018, <https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm>; see also AAMC News, "Threats against health care workers are rising. Here's how hospitals are protecting their staffs", Aug. 18, 2022

² Kara Hartnett, "As violence worsens, providers seek to balance security, patient care," Modern Healthcare, Aug. 10, 2023, <https://www.modernhealthcare.com/providers/violence-in-healthcare-security-solutions>

³ Sachin H. Jain, "Violence Against Healthcare Workers Is Rising: Here's How We Can Protect Them," Forbes, Aug. 2, 2023, <https://www.forbes.com/sites/sachinjain/2023/08/02/violence-against-healthcare-workers-is-rising-heres-how-we-can-protect-them/?sh=6f576de73940>

Should CMS decide to allow the flexibility to expire, an announcement must be made in advance of December 31, 2023, to allow physicians who may have their home address listed sufficient time to provide an alternate address or have their home address suppressed if they desire.

Supervision of Residents in Teaching Settings

The MMS applauds CMS for its consideration of the expansion of remote resident physician supervision. We commend CMS' proposal to allow the teaching physician to have a virtual presence in all teaching settings when the service is furnished virtually through December 31, 2024 and look forward to staying engaged with CMS to help consider how telehealth services can be furnished in all residency training locations beyond December 31, 2024 in addition to considering what other clinical treatment situations are appropriate to permit the virtual presence of a teaching physician.

The MMS appreciates CMS' decision in the 2021 Physician Fee Schedule to permanently allow virtual supervision of residents for certain types of services in non-metropolitan areas; however, many physician groups have expressed how important the virtual supervision of residents has become post COVID-19 and how vital it is to permanently continue this additional supervision option regardless of location. **Therefore, as CMS considers how teaching physicians' virtual presence could continue post COVID-19, we urge CMS to maintain virtual supervision of residents in all settings permanently.**

While we thank CMS for recognizing the importance of access to care in rural areas, it is important to recognize that significant workforce shortages are also impacting access to care in other regions of the country. According to data from the Health Resources and Services Administration (HRSA), as of April 24, 2023, 160 million people currently reside in a Mental Health Professional Shortage Area (HPSA), and there are 8,200 fewer practitioners than are needed.⁴ Approximately 25 percent of mental health HPSAs are located in urban areas and 24 percent span both rural and non-rural areas.⁵ Currently, 99 million people reside in a Primary Care Shortage Area and there are 17,199 primary care practitioners that are needed. Additionally, a June 2021 report from the AAMC predicts a shortage of up to 124,000 physicians by 2034.⁶ These shortages have a critical impact on access to care for patients.

Additionally, the ACGME recently amended its rules to allow for audio/visual supervision of residents, and its guidelines now state that direct supervision can occur when "the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology."⁷ Therefore, in accordance with ACGME guidance, **the MMS acknowledges and supports individually tailoring the virtual supervision of each resident according to their level of competency, training, and specialty since this would enable residents to**

⁴ HRSA data on health professional shortage areas by discipline can be found here: <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

⁵ Designated Health professional shortage areas statistics, Bureau of health Workforce, HRSA (March 31, 2023) <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>.

⁶ AAMC, The complexities of physician supply and demand: projections from 2019-2034 (June 2021) can be found here <https://www.aamc.org/media/54681/download>.

⁷ https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023v3.pdf.

provide additional services while still garnering the support needed from their teaching physicians.

Additional Recommendations

Furthermore, the MMS recommends that CMS:

- reimburse physicians and other qualified health care professionals (QHPs) for furnishing remote monitoring services to new and established patients;
- remove the requirement of 16 days of monitoring for the Remote Therapeutic Monitoring Treatment Management (RTMTM) services;
- remove RTMTM services from its clarification, as CPT guidelines do not require 16 days of monitoring to report these services;
- reconsider the limitation that only one physician or other QHP may report CPT codes 99453 and 99454, or CPT codes 98976, 98977, 98980, and 98981, during a 30-day period;
- allow patients to receive RPM *and* RTM services if they are reported by separate physicians or other QHPs for separate and distinct episodes of care; and,
- clarify that a physician or other QHP can report remote monitoring services separately from the global service period even if the service is related to the diagnosis and episode of care for the global procedure as long as the work described is distinct.

5. SERVICES ADDRESSING HEALTH-RELATED SOCIAL NEEDS

Community Health Integration (CHI) Services

The MMS supports CMS' proposal to further incentivize screening for Social Determinants of Health (SDOH) and referral to community support systems to improve health outcomes and reduce avoidable inpatient, emergency department, and long-term care utilization. The MMS urges CMS to waive patient cost-sharing for CHI services, exclude these services from budget neutrality, expand the types of services that qualify as initiating visits, finalize the provision of these services under general supervision of a physician, and better define the services and personnel who can provide the service.

MMS recommends that, to ensure that these services are accessible to the patients who need them the most, CMS should explore all authorities, including working with the states and with Congress, to **waive patient cost-sharing for these services**. Under current policy, Medicare beneficiaries would be subject to a 20 percent co-insurance requirement to receive CHI services. Particularly for Medicare patients who are experiencing a health-related social need (HRSN), a majority of which are driven by financial hardship, out-of-pocket expenses can lead to delaying or foregoing these services. While [research](#) in this area is still growing and mixed for some interventions, there is promising evidence that well-designed and funded interventions lead to reduced health care utilization and costs. The Medicare program should reinvest these savings into waiving patient cost-sharing. Importantly, we believe CMS can also ensure greater access to these services by partnering with states to provide coverage of these services in their state Medicaid plans or coverage of cost-sharing for dual-eligible beneficiaries. Waiving patient cost-sharing would remove a significant barrier to uptake of care management services, including CHI.

If patient cost-sharing is not waived, the MMS recommends requiring patient consent during the CHI initiating visit. Unfortunately, patient cost-sharing is a barrier to care for other care management services that CMS has previously established as beneficiaries are not accustomed to out-of-pocket costs for this type of care. Obtaining patient consent will help ensure patients are aware of their cost-sharing responsibilities, and we believe providing this clarity to patients outweighs the additional burden imposed on physician practices to obtain informed consent.

CMS should not apply budget neutrality to the CHI services as these codes establish a new benefit for beneficiaries. CMS believes there is a gap in the current care management code set for integration of community services provided by auxiliary personnel, including community health workers or peers. As this is a new service being provided by a new set of personnel who were not previously eligible to provide billable services under Medicare, we believe this service falls outside the scope of budget neutrality as a change in law or regulation.

At a minimum, the MMS urges CMS to maintain a low utilization assumption for these services. The uptake of these codes has historically been low and increasing the utilization assumption would result in a greater budget neutrality cut that physician practices cannot absorb given the proposed 3.36 percent reduction to the Medicare conversion factor and projected 4.5 percent increase in practice costs as measured by the MEI.

We also urge CMS to better define the role of the auxiliary staff permitted to perform CHI services. To ensure patients understand the role of the community health worker (CHW) or other auxiliary staff providing CHI within the care team, we urge CMS to clarify that these staff should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. CHWs or peers should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team. CHWs or peers should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide. They should also fully disclose potential conflicts of interest to those whom they service, including employment arrangements. As mentioned above, we believe CHI services provided by nurses, social workers, or clinical staff would be more appropriately billed using the PCM codes.

Social Determinants of Health (SDOH) Risk Assessment

The MMS supports CMS' proposal to further incentivize screening for SDOH and referral to community support systems to improve health outcomes and reduce avoidable inpatient, emergency department, and long-term care utilization. **The MMS urges CMS to waive patient cost-sharing for SDOH risk assessment services, exclude these services from budget neutrality calculations, and mitigate potential negative implications of collecting SDOH data.**

Similar to the arguments above related to CHI services, SDOH Risk Assessments should not require patient cost-sharing nor should they mandate the application of budget neutrality. Furthermore, however, CMS should address the potential negative implications of collecting SDOH data, as formally documenting SDOH risks in the medical record is a somewhat new undertaking, and SDOH data could be considered as a pre-existing condition or become part of an evaluation of the patient record in other contexts where we do not yet fully know the possible impact of these social risks and needs, even if resolved. Patients should consent to being screened,

understand the possible social risks that the given screener may detect (e.g., transportation insecurity, homelessness, victim of domestic abuse, etc.), and be aware that their screening results will appear in their medical record. A possible approach to mitigate potential negative implications might be to outsource screening and social care to organizations specializing in detecting social risks and offering referrals or interventions. With the consent of the patient, the minimum social care data required to improve the care of the patient could then be accessed by, or communicated to, the physician and documented in the patient's medical record, if appropriate. Additionally, regulations should be considered to protect social risk and needs data outside of covered entities (e.g., community-based organizations). Regardless of how the data is collected, to protect patients from discrimination and other unintended consequences of collecting this data, consideration should be given to recording the minimum social care data required.

We also urge CMS to permit SDOH risk assessments to be billed with emergency department (ED) E/M visits, in addition to office/outpatient E/M visits. CMS states that ED visits would not typically serve as SDOH risk assessment initiating visits because the practitioners furnishing the E/M services in those settings would not typically be the ones to provide continuing care to the patient. However, research has shown that individuals with SDOH needs have a higher rate of ED visits.⁸ For this reason, screening can help physicians in these settings to formulate targeted interventions to facilitate referrals for patients (e.g., initiating primary care) with an unmet social need. In addition, expanding this service to the ED allows for the potential to reduce repeat ED use for patients by connecting them to navigation or community health integration services, improving their health outcomes and reducing costs to the Medicare program.

The MMS recommends allowing a SDOH risk assessment tool to be administered as part of the patient's pre-visit preparation or patient intake. As physician offices have moved away from paper forms to electronic records and patient portals, they often ask patients to complete or update their information up to three days prior to the visit to ensure the information is properly recorded and reviewed prior to the E/M visit to ensure the patient's clinical and, in this case, non-clinical needs are addressed during the visit. Because CMS proposes that this service would be available to all Medicare beneficiaries, many patients will need only a standard screening tool to rule out any unmet social needs. This could be completed prior to the visit and free up time for physicians to do a deeper dive with those patients who are identified as having a HRSN that is unaddressed. Allowing screening to be done in advance of a visit would also allow personnel to line up referral options in advance of the E/M visit so that they can be discussed more efficiently at the time of the visit. Additionally, screening is like a test and test results that may impact a visit are often available in advance of the visit. At the same time, however, we acknowledge that disparities in access to mobile devices and broadband can exacerbate issues, as those without access might miss out on crucial opportunities, such as access to an SDOH assessment ahead of their office visit. They must be afforded the option to complete the assessment in the office, but this may impact physicians' ability to do a deeper dive. Therefore, we

⁸ See e.g., McCarthy ML, Zheng Z, Wilder ME, Elmi A, Li Y, Zeger SL. The Influence of Social Determinants of Health on Emergency Departments Visits in a Medicaid Sample. *Ann Emerg Med.* 2021 May;77(5):511-522. doi: 10.1016/j.annemergmed.2020.11.010. Epub 2021 Mar 11. PMID: 33715829; PMCID: PMC9228973 and https://www.cdc.gov/pccd/issues/2020/19_0339.htm.

believe that the requirement to furnish the SDOH risk assessment tool on the same day as the E/M visit may be an impediment to expanding this service.

Additionally, we agree with CMS that these services could be conducted via telecommunications as appropriate and not necessarily in-person. Self-administered, online screening with automated detection of negative and positive screening results, which are reviewed by the physician or practitioner, is efficient and should be allowed.

Regarding the duration of the visit, we believe the time required to administer the screening that adheres exactly to questions on a screener should be fairly easy to estimate. However, for screenings with positive results, further time may be required for post-screening questioning and assessment (e.g., asking additional questions to understand the correct referral or intervention). We do not yet know enough to gauge the amount of time that might be appropriate for the latter and it may vary with complexity of the patient and their needs.

Regarding the domains to be screened, we feel the domains selected should be those where the evidence supports the best return on investment related to health outcomes.

Regarding the risk assessment tool, we believe that specifying a set of allowed, evidence-based, standardized screening instruments should help reduce data variability and improve interoperability. Screening tools that can be self-administered online and support the automated detection of negative and positive screening results are optimal for integrating this service into the clinical workflow.

6. DIABETES SERVICES

The MMS supports Medicare coverage of the HbA1c test for diabetes and prediabetes screening purposes. Previously, HbA1c was approved for managing, but not screening for diabetes even though it has long been used as an effective screening method. The United States Preventive Services Task Force updated their 2015 and 2021 final recommendations statements to include the HbA1c test for diabetes screening purposes. The MMS is pleased to see this proposed change to ensure Medicare coverage remains current with the latest clinical standards and believes this change will lead to more frequent and earlier screenings, and therefore more effective diabetes treatments and clinical outcomes for Medicare beneficiaries. Importantly, covering this test would improve referrals to Medicare's Diabetes Prevention Program (MDPP) given the HbA1c test is already a qualifier for that program. Furthermore, the majority of commercial payers already cover the HbA1c test for screening purposes, so covering this test for diabetes screening will bring Medicare coverage in closer alignment and thereby improve equity of access for Medicare beneficiaries.

We support CMS' proposal to cover HbA1c tests for screening purposes and urge the agency to finalize this change as proposed. We further urge the CMS to expand on this proposal by waiving the patient deductible for HbA1c tests in order to further encourage the test for screening purposes and reduce cost barriers for Medicare beneficiaries, particularly those from historically minoritized and disenfranchised communities. Additionally, we support the proposal to expand frequency limitations for screenings to remove barriers and allow clinicians and patients to decide the appropriate interval for screening based on that individual's clinical history and circumstances. Regular screening for diabetes is critical to early and effective diagnosis and treatment and improved outcomes. Accordingly, we support removing regulatory barriers, including frequency limitations, for diabetes screening services.

The MMS also supports regulatory changes that mitigate barriers and improve access to Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services while ensuring services are appropriately performed via telehealth given the patient's individual needs and the latest clinical standards, guidelines, and best practices. In this case, we believe these flexibilities are appropriate and will not adversely impact patient safety or quality outcomes, while expanding access to these critical services which help to prevent obesity, diabetes, heart disease, and other diet-related conditions. Accordingly, we strongly support the proposed changes to expand telehealth flexibilities for DSMT and MNT services.

7. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MMS strongly opposes increasing the current MIPS performance threshold for the 2024 period, and we urge CMS to maintain the current threshold to prevent undue penalties. Maintaining this threshold is particularly important given the cumulative impact of five years of hardship exceptions in addition to disruptions caused by the COVID-19 pandemic.

Estimates show that nearly 54% of MIPS eligible clinicians could face penalties averaging -2.4% and up to -9% if the proposed 82-point threshold is implemented. We are alarmed by the financial strain these penalties could pose for physicians, especially in light of the proposed 3.36 percent reduction to the Medicare conversion factor. The resulting higher MIPS penalties would further jeopardize the stability of physician practices and impede patient access to care.

Increasing the performance threshold has distinct repercussions for smaller practices and certain specialists, and it could exacerbate health inequities. Studies indicate that physicians with a higher proportion of patients dually eligible for Medicare and Medicaid, as well as those caring for medically and socially vulnerable patients, could receive lower MIPS scores as a result. Such dynamics could result in transferring resources from physicians serving disadvantaged patients to those caring for more affluent patients.

The MMS strongly urges CMS to alleviate the MIPS administrative burdens on physicians during the 2024 performance period. To do so, we offer the following:

- overhaul the costly and burdensome MIPS and MIPS Value Pathways programs. The number of reporting requirements should be reduced, and CMS should rely more on clinical data registries;
- revise the CMS termination plan for Qualified Clinical Data Registries, which should be the alternative to MIPS because these registries help physicians improve patient care outcomes; and,
- refrain from making multiple changes to the QPP every year as it is extremely costly, burdensome, and hinders a physician's ability to navigate the program and make practice adjustments to meet the ever-changing program requirements.

8. ALTERNATIVE PAYMENT MODELS (APMs)

MMS urges CMS to work with Congress to continue the APM bonus incentive payment that expires at the end of 2023 and reinstate it at the 5% level.

MMS further recommends that CMS require hospitals to share admission, discharge, and transfer information with community physicians to ensure coordination and continuity of care.

We urge CMS to provide multiple types of Alternative Payment Models (APMs) to allow more physicians to innovate and participate. At least 30 different physician-led APMs were developed by physician organizations and submitted to CMS' Physician Technical Advisory Committee (PTAC). While all the models were approved by PTAC, CMS failed to implement any of them. Studies show that physician-led APMs are higher quality and lower cost.

9. MEDICARE SHARED SAVINGS PROGRAM (MSSP) AND ACCOUNTABLE CARE ORGANIZATION (ACO) REFORMS

The MMS supports the improvements in the proposed rule that are focused on alleviating potential unintended consequences for specific categories of ACOs by helping to better address the needs of certain patient populations and secure the continued participation of legacy ACOs while fostering greater participation in the program.

Specifically, we support the proposal to postpone the transition to electronic clinical quality measures (eCQMs) adoption due to logistical considerations. We appreciate CMS allowing participants to continue to use the CMS Web Interface for reporting quality measures. We also support aligning the financial benchmark risk adjustment methodologies across performance and benchmark years.

However, we oppose proposals that would counteract CMS' and Congress' objective to encourage more physicians to participate in APMs. In particular, we strongly oppose CMS' proposal to mandate that all MSSP participating clinicians, regardless of their ACO track, meet the Merit-based Incentive Payment System (MIPS) Promoting Interoperability (PI) measures. CMS should instead be actively seeking opportunities to alleviate regulatory burdens for ACOs that have already taken the responsibility to be accountable for outcomes and costs. Moreover, we believe this proposal to require APM participants to participate in MIPS violates the statute and Congressional intent. It will only serve to further disincentivize APM participation.

CONCLUSION

As always, the Massachusetts Medical Society appreciates the opportunity to provide comment and work with CMS on our shared goal of providing the highest quality health care to patients. Should you have any questions, please contact Casey Rojas, Federal Relations & Health Equity Manager, at crojas@mms.org or 781-434-7082.

Sincerely,

Barbara S. Spivak, MD

President, Massachusetts Medical Society