



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

September 6, 2022

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-1770-P. Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts.

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 CY 2023 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 29, 2022 (87 Fed. Reg. 45860). Our comments, guided by MMS policy priorities and advocacy initiatives, highlight areas of support, concerns, and recommendations. Primary areas of focus in our comments include:

- Concern over the decrease to the conversion factor and additional looming Medicare payment cuts. In light of the financial strain physician practices are already facing and persistent challenges of sustaining a physician practice, we respectfully ask that CMS use all of its authority to halt further cuts to physician payments.
- Support for CMS' efforts to significantly expand coverage for telehealth services through the addition of about 150 services that can now be provided via telehealth, including emergency department visits, critical care, home visits, and telephone visits.
- Consternation with the lack of transparency into the Geographic Practice Cost Index (GPCI) data and methodology used to derive the GPCIs. It is important that CMS provide more detailed information related to this critical component of the Physician Fee Schedule in the proposed rule. The information should be published with the proposed rule just as CMS provides the practice expense RVUs but with the specific data files.

- Support for the use of RVU-based weighting rather than MEI weights to calculate GPCIs, but concern for the use of national RVUs rather than locality RVUs. Similar concern over MEI weighting on the basis of a national average rather than a geographic region.
- Concern over the relative devaluing of the physician work expense category within the practice expense GPCI.
- Recommendation to apply the automatic Extreme and Uncontrollable Circumstances Hardship Exception in the 2022 MIPS performance period and target technical assistance to those physician practices that have received a hardship exception.
- Support for an increased focus on health equity in MIPS and the expansion of high priority measures, with a recommendation to thoughtfully define what characteristics enable a measure to be classified as related to health equity.
- Concern for the expiration of the 5 percent Advanced APM incentive payments, along with giving CMS the authority to adjust the thresholds to qualify for the incentive payments.
- Feedback on updates to the CY 2023 Quality Payment Program, including a recommendation to reduce the number of metrics and use only claims based data in order to decrease the administrative burden.

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.

The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing high quality, equitable care to all patients.

Key Recommendations:

Conversion Factor and Medicare Physician Payment Cuts

The Massachusetts Medical Society is concerned about several looming cuts to Medicare physician payment. While some of these cuts are outside the scope of this proposed rule, it is imperative understand how the proposed cuts in this rule (conversion factor reduction) operate within the larger context of physician payment, especially during this turbulent time of an ongoing pandemic that continues to impose financial stresses on physician practices. Accordingly, we ask CMS to use your authority to halt these further cuts to physician payment while we advocate for your colleagues in Congress to do the same.

The CY 2023 proposed physician conversion factor (CF) is \$33.0775. This reduction in the CF represents a decrease of 4.42% from the 2022 CF of \$34.6062. We recognize that this decrease is not a new cut—rather, it is largely due to the expiration of a 3 percent increase funded to the CF at the end of CY 2022, as required by law. The conversion factor has reduced drastically over the last several years and a CF of \$33.0775 would be the smallest of the past three decades. Such continued reduction in payment to physicians will result in substantial strain to physician practices compounded by the drastic increases in clinical labor costs. Coupled with the constraints of budget neutrality, rising inflation, and rising practice expenses, physicians are being paid notably less each year, making practice sustainability an ever more present issue.

Cuts to physician payment are harmful to patient access to care, especially in light of the ongoing COVID-19 pandemic, which has created significant financial challenges for physician practices that will persist for years to come. During the pandemic, many physician practices and health care facilities saw large decreases in patient visits due to a combination of executive orders and patient fear about their safety and exposure to the COVID-19 virus. Increasingly, physician practices are having to make tough decisions on whether they will be able to sustain their practices and stay open after the pandemic, leading to practice consolidation, which is detrimental to patient access and affordability. For example, a survey by Harvard Medical School and developed through a partnership of clinicians, researchers, and public and private entities in Massachusetts found that 20-40% of practices reported consolidating, selling, or closing their practice in 2020 (this statistic was driven mostly by independent practices, including primary care).¹

Workforce challenges are also affecting physician practices, increasing the cost and effort to maintain an adequate clinical and office staff, especially as the nation reels from historic rises in inflation. All of that aside, it was already difficult for physician offices to maintain staff, since many front office staff, medical assistants, registered nurses, and technicians are finding new jobs that have lower health risk or less stress. Additional Medicare pay cuts threaten the ability of practices to provide competitive pay for their staff. This workforce challenge has led to understaffed physician practices, often resulting in reduction in hours, fewer patients seen, and less coordination of care with a negative impact on patients and the quality of their health care experience. Lower physician payment also threatens to push providers toward employment by hospitals or larger health systems (instead of smaller, more accessible and affordable practices), which generally bear higher cost burdens for patients. The CY 2023 conversion factor reduction further threatens our physicians' ability to sustain their practices and to continue delivering care to their patients—and it will undoubtedly undermine patients' access to health care.

Compounding this issue, physicians are facing several, additional payment cuts at the end of this year, including an approximately four percent cut due to PAYGO (pay as you go) law adjustments required to offset the spending increases from the *American Rescue Plan Act* COVID-19 budget reconciliation bill passed in March 2021. **Given the continued financial challenges of sustaining a physician practice and additional cuts facing physicians at the end of this year, we ask CMS to use its full administrative authority to avert these payment cuts.** We also urge CMS to advocate with your colleagues in Congress to pass legislation mitigating these cuts and the harmful results they will cause to patients and physicians.

Clinical Labor Pricing Update

CY 2023 marks the second year of a four-year transition to the new clinical labor cost data that will be completed in CY 2025, much like the transition used in updating the supply and equipment price updates that were completed in CY 2022. **Going forward, CMS should update pricing data on a more frequent basis for all direct PE inputs so that adjustments will not be so dramatic. The actual increase in clinical labor costs for physician practices is not recognized in the updated conversion factor, which acutely impacts our physician members. Accordingly, we call on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2023 and all future years.**

¹ Song Z, et al. "Economic and Clinical Impact of Covid-19 on Provider Practices in Massachusetts." *NEJM Catalyst Innovations in Care Delivery*. <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0441>

The MMS would like to highlight that the total direct practice expense pool increases by 30 percent under this proposal, which would result in a significant budget neutrality adjustment. Practice expense comprises 44.8 percent of the physician payment and the pool of this payment is fixed by statute; therefore, increasing payment for clinical labor shifts funds that were

previously directed to supplies and equipment. As the overall size of the practice expense component is static, a larger proportion of that 44.8 percent is now clinical labor. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality requirement within the practice expense relative values. The scaling of direct expenses, to 50 cents on every dollar fully recognized as direct costs, puts a huge and unfair burden on specialties that require expensive supplies and other direct costs to care for their patients. While the increase in clinical labor is appropriate, it is not appropriate that physicians and other qualified health care professionals, notably from a few small specialties, are negatively impacted by the change.

Geographic Practice Cost Indices (GPCI)

MMS is concerned with the lack of transparency into the GPCI data and methodology used to derive the GPCIs, which limits our ability to accurately assess CMS' calculations and understand their impact. We urge CMS to provide more transparency into the GPCI calculations in general, including a more detailed description of the step-by-step methodology and the specific data files used to derive the geographic practice cost indices (GPCIs). In addition to the RVUs by county, we urge CMS to make available the source data for the work GPCI by county, plus the source data for each component of the practice expense GPCI and all budget neutrality adjustments and calculations. Prior to 2020, CMS provided such data. It is important that CMS provide more detailed information related to this critical component of the PFS in the proposed rule to allow impacted stakeholders to fully understand and appreciate the impact of proposed changes. The information should be published with the proposed rule just as CMS provides the practice expense RVUs but with the specific data files.

While MMS agrees with CMS' proposal to use RVU-based weighting rather than the MEI weights to calculate the GPCIs, we strongly urge CMS to apply the locality RVUs, not the national RVUs, when performing this calculation because of the variability in RVU distribution among localities. To do so would be a simple adjustment to the current methodology and would provide the most precise and accurate information at the locality level. In doing so, the GAF factor calculation would more accurately reflect locality payments.

CMS is proposing significant changes in methodology to the Work GPCIs. In the proposal, no criteria were listed in the review of current data other than data existence and data sufficiency. Without further explanation, two additional occupation groups were added to the previous seven occupation groups which increased the existing 100+ occupation codes by an additional 60. No impact analysis of such a change is evidenced other than the comment that it was insignificant because the final Work GPCIs represent only 25% of the actual geographic differences. This methodology also uses national median wages to input missing data where more geographically oriented inputs such as MSA or state median wages would provide a higher degree of accuracy and precision. The large number of occupation codes used in the methodology creates unnecessary complexity and no transparency. Although we agree that the healthcare provider

dataset should not be used for developing the GPCI due to circularity, it can and should be used to validate the proposed GPCIs and to identify a much smaller subset of professions that would act as more reliable proxies than what has been proposed. MMS urges CMS to apply a smaller number of professions to the Work GPCI, which would result in a more reliable and accurate proxy for physician work, and we also ask CMS to provide more information about the correlation between physician work and the proxy professions in order to allow us to verify accuracy.

Medicare Economic Index (MEI) and Practice Expense (PE) Data Collection

The MMS supports the AMA recommendation to delay implementation of the MEI cost share weight proposal, as the AMA is currently collecting practice cost data. As such, MMS strongly urges CMS to collaborate with the AMA on a new data collection effort that will ensure consistency, accuracy, and reliability in physician payment.

For nearly 50 years, the MEI has served as a measure of practice cost inflation and as a mechanism to determine the proportion of payments attributed to physician earnings and practice costs. The MEI measures changes in the prices of resources used in medical practices including, for example, labor (both physician and non-physician wages), office space, and medical supplies. These resources are grouped into cost categories and each cost category is assigned a weight indicating the proportion of a physician's practice costs. CMS uses these costs to measure changes in costs over time. It is important to note that CMS has collaborated with the AMA since the inception of the MEI and AMA has consistently supplied the physician earnings and practice cost data to CMS.

The current MEI weights are based on the AMA's Physician Practice Information Survey (PPI). This survey was last conducted in 2007/2008 using 2006 data. As noted above and below, the AMA is actively engaged in a process to collect this data again in 2022-2023 for the purpose of providing more updated information to CMS in order to better inform the MEI weights.

In the proposed rule, CMS proposes to update the MEI weights using 2017 data from the U.S. Census Bureau's Service Annual Survey (SAS), but the SAS data was not designed for the purpose of updating the MEI and has serious gaps as a result. The new data proxies and methodologies applied by CMS to cover these data gaps has resulted in errors that will ultimately lead to inaccurate payment.

<u>MEI Cost Category</u>	<u>Current Weight</u>	<u>Proposed Weight</u>
Physician Work	50.9%	47.3%
Practice Expense	44.8%	51.3% Professional Liability
Insurance	4.3%	1.4%

Moreover, according to the AMA, the proposed shift in payment weights from physician work to practice expense favors many non-physician entities, such as Diagnostic Testing Facilities (+13%), Portable X-Ray Suppliers (+ 13%) over other physicians, such as Emergency Medicine (-8%) and Anesthesiology (-5%) and primary care (-1-2%).

In addition to the proposed specialty redistribution, there is a substantial geographic redistribution in the proposed reweighting of the practice expense category within the geographic practice cost index (GPCI) that includes employee compensation, office rent, purchased services and equipment/supplies. For instance, CMS proposes to significantly reduce the weight of office rent from 10.2% to 5.9% which would lead to substantial reductions in payment to most physician practices in most Massachusetts regions, particularly small practices. While small practices and

large practices in Massachusetts may report differing proportions of practice expense dedicated to office space, which may be due to economies of scale, these expenses should be studied further with more accurate data collection directly from physician practices. According to our observations and information, rent is undervalued, particularly for small practices. Both small and large practices report that the purchased services category is considerably over-weighted. Furthermore, large variation exists in the practice expense weights between geographic regions.

CMS should refrain from basing policy on the assumption that the distribution of the types of RVUs are consistent throughout the nation or even across an entire state. The most recent locality RVU file produced by CMS shows a range of work RVUs as a % of total RVUs from a low of 33% (San Mateo, California Locality) to a high of 59.5% (Vermont). **Accordingly, the MMS recommends that the MEI weighting be adjusted by geographic region in order to ensure the most accurate payment rates.**

The 2017 SAS Medicare Revenue reported for Offices of Physicians was \$78.8 billion. In 2017, Medicare paid \$69.1 billion for clinician services delivered by over 1 million clinicians in all settings.² Since CMS is using actual numbers from the SAS estimate to determine percentage differences in expenses and there is a significant difference between actual and estimated Medicare revenues, we question the accuracy of the SAS estimated expenses.

Additionally, MMS is concerned with using other data sources to disaggregate data from the SAS because the inputs are different and not designed to be used in the way CMS is proposing. For example, in the Work component, using the BLS OEWS estimates to determine the percentage of employed physicians in the SAS is not appropriate because they are derived from different samples. In other words, the 63.2% ratio of physician total mean hourly wage cost to total mean hourly wage costs derived in step 2 of the proposed methodology from the BLS OEWS survey may be different from the SAS survey. Likewise, estimating physician practice owner compensation using the AMA Physician Practice Benchmark Survey and applying it to the 2017 SAS is not appropriate because it assumes they were obtained from the same survey sample, and it is assumed that net revenue minus expense would be equally proportioned among physician and non-physician owners. Using multiple data sources with the assumption of similar samples amplifies the likelihood and magnitude of error. For instance, CMS estimates \$20.9 billion in compensation for physician owners represents just 10% of total compensation for all physicians, yet nearly half of physicians in the U.S. are owners. Similar problematic methodology is used in the Practice Expense component as the Work component.

For these reasons, MMS believes it would be inattentive to proceed with the proposed rebasing of the MEI without further validation of direct physician practice data from the upcoming AMA physician practice surveys; therefore, we urge CMS to postpone the updates to the MEI weights until the new AMA survey data are available and to collaborate with the AMA on new data collection efforts.

Telehealth and Other Communications Technologies

The MMS appreciates CMS' efforts to respond to the challenges presented by COVID-19 and to provide crucial flexibilities for telehealth policies provided during the Public Health Emergency (PHE). These expanded policies allow patients to safely maintain access to the care they needed during the PHE.

² Report to the Congress: Medicare and the Health Care Delivery System (June 2019).

The flexibilities and enhancements that have been granted during the COVID-19 PHE have accelerated the utilization of telehealth in Massachusetts and across the United States. COVID-19 telehealth policy changes have ensured that Massachusetts residents have access to critical health

care services while supporting necessary precautions to limit exposure to COVID-19, reduced the stress and burden of traveling to appointments (including the cost of tolls, parking, and time lost from work), allowed continued social distancing, and preserved personal protective equipment for the health care workforce. Telehealth, including audio-only services, has been a powerful tool to increase equitable access to care for all residents of the Commonwealth and promote the principles of health equity and health justice.

Telehealth utilization grew immensely during the pandemic. Telehealth appointments have improved patient compliance with appointments and reduced no-shows—one Massachusetts health system reported that telehealth show rates had been 89% during the first half of 2020 versus the show rate of 80% for in-clinic-only visits during the previous year. Moreover, a study by an MMS member, published in the *Journal of the American Academy of Dermatology*, shows that compared to visit rates in-clinic, telehealth visits “had significantly lower no-show rates, with the greatest reductions seen for Black or African American, LatinX, and primary non-English speaking patients.”³

Telemedicine’s ability to improve show rates extends beyond increased access to necessary care: these efficiencies also translate to high-value, lower cost care. Since telehealth changes will be subject to Medicare Physician Fee Schedule budget neutrality provisions, it is important to note that expanding and making permanent telehealth flexibilities will not add substantial cost. For example, a report by the Taskforce on Telehealth Policy (convened by the National Committee for Quality Assurance, Alliance for Connected Care, and the American Telemedicine Association) found that “the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded.”⁴ The authors argue that telehealth may improve costs because of fewer missed appointments that improves compliance, fewer costly Skilled Nursing Facility patient transfers to hospitals/emergency departments, and increased use of transitional care management that cuts readmissions; however, they note that additional data after the PHE would be helpful for a fuller assessment on long-term cost of telehealth.

Due to the success of telehealth since the start of the PHE, the MMS urges CMS to continue to strengthen telehealth policies and make permanent many of the flexibilities granted during the COVID-19 PHE. We support CMS’ proposal to continue paying for telehealth services that were scheduled to be covered only through the end of the COVID-19 Public Health Emergency (PHE) for an additional 151 days beyond the end of the PHE. We urge CMS to continue its current coverage and payment policies for telephone visits and audio-visual telehealth services until the joint CPT/RUC Telemedicine Office Visits Workgroup determines accurate coding and valuation, as needed, for office visits performed via audio-visual and audio-only modalities. Additionally, we

³ Franciosi EB, Tan AJ, Kassamali B, O’Connor DM, Rashighi M, LaChance A, Understanding the Impact of Teledermatology on No-Show Rates and Healthcare Accessibility: A Retrospective Chart Review, *Journal of the American Academy of Dermatology* (2020), doi: <https://doi.org/10.1016/j.jaad.2020.09.019>.

⁴ NCQA Taskforce on Telehealth Policy (TTP): Findings and Recommendations, <https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealthpolicy/taskforce-on-telehealth-policy-ttp-findings-and-recommendations/>

urge CMS to lift the frequency limit on subsequent nursing facility visits delivered through telehealth, as physicians already must provide the required regulatory patient visits in-person. At

a minimum, no limitation should be applied to the frequency of subsequent nursing facility visits for at least 151 days after the PHE ends.

Specific telehealth recommendations are listed below:

I. Extension of Telehealth Services Beyond the PHE

During the COVID-19 PHE, MMS supported CMS' significant expansion of the Medicare Telehealth List through the addition of about 150 services that can now be provided via telehealth, including emergency department visits, critical care, home visits, and telephone visits. CMS also created two new categories of interim telehealth services. Codes in Category 3 of the Medicare Telehealth List are covered on an interim basis through the end of 2023 to allow data to be developed after the PHE has ended that could help CMS determine whether these services should be permanently added to the Medicare Telehealth List or not. An additional category of services was only slated to be available via telehealth until the end of the PHE.

In March 2022, the Consolidated Appropriations Act included several provisions extending the telehealth policies that have been in place during the PHE for an additional 151 days after the PHE ends. The law also delayed the requirement for Medicare patients to see a physician in person 6 months prior to receiving their first telehealth service for a mental health condition and extended the availability of audio-only telehealth services. Consistent with these provisions, CMS proposes to similarly extend Medicare telehealth coverage for the codes that were only going to be on the telehealth list through the end of the PHE for an additional 151 days after the PHE ends. The MMS strongly supports this proposal and urges that it be finalized.

II. Payment Policy

CMS states that it decided not to add three CPT codes for telephone visits to Category 3 and confirms that the telephone visit codes will now be covered on the Medicare Telehealth List for 151 days after the PHE ends rather than on an interim basis through 2023. CMS questions the statutory authority to extend telehealth coverage for these services and believes that telehealth services are statutorily required to be analogous to in-person care such that the telehealth service is a substitute for a face-to-face encounter, but also that the audio-only CPT codes are inherently non-face-to-face. Section 1834(m)(2) of the Social Security Act, which CMS cites in the proposed rule as the basis for this belief, pertains only to the "Payment Amount" for telehealth services. In Section 1834(m), the only reference to which services may be covered when provided via telehealth is in 1834(m)(4)(F)(i), the definition of telehealth service, which includes "any additional service specified by the Secretary." No provision in the statute prohibits defining telephone visits as telehealth services. **Accordingly, we urge CMS to include telephone visits in Category 3.**

During the COVID-19 PHE, physicians gained tremendous experience with delivering telehealth services, including audio-only services. The MMS urges CMS to continue its current coverage and payment policies for telephone visits and audio-visual telehealth services until the AMA's joint CPT/RUC Telemedicine Office Visits Workgroup has an opportunity to do its work to assess the

available data and ascertain the appropriate next steps to determine accurate coding and valuation, as needed, for office visits performed via audio-visual and audio-only modalities.

CMS is also proposing that, following 151 days after the PHE ends, Medicare telehealth services would revert to being paid at the “facility” rate instead of the “non-facility” rate. Section 1834(m)(2) of the Social Security Act, however, requires the Secretary to “pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.” If the physician is based in a non-facility setting, therefore, such as an office, the statute requires that the services provided using a telecommunications system be paid at the non-facility rate. **Accordingly, MMS believes it necessary for CMS to continue to pay the nonfacility rate when a physician is providing services in a non-facility setting.**

CMS reiterates in this proposed rule its plan to allow telehealth services for the diagnosis, evaluation, and treatment of mental health conditions to continue to be payable after the 151-day period following the end of the PHE, including audio-only services. Accordingly, the MMS requests more information about how physicians and other health professionals should plan to report these codes in a way that the administrative contractor would know that the audio-only service was for a mental health condition.

III. Telehealth Visits for Patients in Nursing Facilities

MMS believes that CMS should lift the frequency limit on subsequent nursing facility visits delivered through telehealth as physicians already must provide the required regulatory patient visits in person. At a minimum, no limitation should be applied to the frequency of subsequent nursing facility visits for at least 151 days after the PHE ends.

IV. Opioid Treatment Program (OTP) Telecommunications Flexibilities

Massachusetts needs greater intervention to prevent overdose deaths in the Commonwealth. The state is on track for its fourth consecutive year with greater than 2,000 reported opioid-related overdose deaths. Recent Massachusetts Department of Public Health data shows that racial disparities in overdose deaths are widening, with Black, non-Hispanic men making up the largest increase in opioid overdose death rates in 2021, at sixty-three percent. Recent reports have also highlighted significant gender disparities in access to treatment, with women less likely to access treatment despite increased substance use. Data from 2020 showed a 15% increase from the previous year in the number of women who experienced fatal opioid overdoses, according to Massachusetts DPH. These developments underscore the imperative of the Commonwealth’s continued investments to address this issue with a focus on equity.

Given the severity of the opioid crisis in the Commonwealth, the MMS supports the proposal to allow the OTP intake add-on code to be furnished via telehealth for the initiation of treatment with buprenorphine, including use of audio-only communication technology when audio-video is not available to the patient, and we urge that this proposal be finalized. The MMS further recommends that OTPs continue to be allowed to furnish periodic assessments using audio-only communication for patients who are being treated with buprenorphine, methadone, or naltrexone following the end of the COVID-19 PHE.

As mentioned above, the MMS strongly supports continuing the greatly increased Medicare coverage for telehealth services, including audio-only services, that was implemented during the COVID-19 PHE. One of the conditions for which these telehealth flexibilities has been exceptionally important for patient care is treatment of opioid use disorder (OUD). Many barriers to care impede patients with OUD from initiating and continuing a treatment plan, including pervasive stigma, prior authorization requirements and other insurance plan barriers, shortages of physicians and other health professionals to provide the needed treatment services, and lack of access to transportation, childcare and other support services that make regular OTP and office visits feasible.

There is no question that availability of OUD treatment services via telecommunications, including audio-video and audio-only, has had a major impact in reducing these barriers to care, including for OTPs. Patients who experience stigma and fear going to an OTP in person can avoid that problem with telehealth. Patients who are not located near an OTP or who cannot readily get to it due to lack of transportation or other responsibilities such as caregiving or work can much more easily access care via telehealth or telephone. CMS should allow OTPs to use telehealth, including audio-only services, to initiate treatment with buprenorphine. Additionally, the expiration of the COVID-19 PHE will do nothing to change this situation with barriers to accessing periodic assessments, and it would be highly detrimental to patients to eliminate the existing flexibilities when the PHE ends.

V. Direct Supervision

During the PHE, CMS has allowed the requirement for direct supervision to be met for diagnostic tests, physicians' services, and some hospital outpatient services through real-time, interactive audio/video technology, instead of requiring a physician's physical presence. In the proposed rule, CMS is seeking comment on whether this policy should be extended beyond the end of the PHE, and, if so, whether it should only be extended for a subset of services and whether these services would require a service level modifier. **The MMS strongly supports this direct supervision policy and recommends it be made permanent.** Extending this policy will be especially important for many rural and underserved areas where patients may be unable to access important care services if the only physician available needs to deliver services or supervision in multiple locations. CMS proposes to allow these flexibilities to expire at the end of the PHE, but MMS urges CMS to authorize direct supervision via telehealth a permanent option. Physicians have the clinical experience and knowledge to best understand when and how direct supervision via telehealth is appropriate, and they should be afforded the autonomy to make that determination in accordance with relevant standards of care. Additional requirements that are not present for in-person services should be limited to those that are clinically necessary.

Medicare Payment for Dental Services

In the proposed rule, the details of extending coverage for dental care are too sparse, citing only that the proposed services will be paid for under Medicare Part A and Part B. As it relates to payment of dentists, the MMS wants to firmly express that we do not believe the Medicare Physician Payment Schedule is the appropriate fit for immediate inclusion of dental services or benefits for Medicare beneficiaries. The MMS has historically highlighted concerns with the Physician Payment Schedule relative to budget neutrality and the lack of new funding to appropriately pay for new or revalued services. The MMS believes the Medicare system will be increasingly burdened and challenged in its effort to fit dentists into a system established for

physicians, given that the current system is already facing significant fiscal and operational problems that will only be further exacerbated. While we understand and appreciate the importance of oral health to overall physical health, we have concerns about the impact of adding dental coverage in the fee schedule, which will necessarily trigger payment cuts elsewhere due to budget neutrality. If dental services and providers are added to coverage, the overall total budget should be commensurately increased, as it should with the addition of any services or providers.

As CMS proposes coverage of dental services under Medicare Part B, we want to make sure it does not disrupt the Medicare Physician Payment Schedule.

CMS should conduct a demonstration to determine the financial and operational efficiencies for Medicare patients with underlying medical conditions who require integral dental services as a condition of their covered, primary Medicare Part A service. The demonstration should be the vehicle for vetting the proposals CMS is making in the proposed rule for dental services determined to be inextricably linked to the clinical success of a covered medical service, and a funding source separate from and without impact on the Medicare Physician Payment Schedule should be used to cover these dental services. The demonstration should leverage existing evidence linking dental services to clinical quality outcomes for the Medicare Part A procedures listed and should lead to more research on the effectiveness of the dental services for the services beyond those piloted.

Outpatient Treatment for Substance Use Disorder (SUD) Treatment

CMS is soliciting comments on whether gaps in its coverage and payment policies exist for intensive outpatient SUD treatment furnished by intensive outpatient programs. In June 2021, the Legal Action Center published a paper in the journal *Health Affairs*⁵ that describes this gap in SUD treatment in the Medicare program. According to this paper, intermediate levels of SUD care are more intensive than office-based outpatient counseling, but less intensive than inpatient hospitalization. This includes intensive outpatient, partial hospitalization, and residential treatment. The authors state that this type of care is often used as a step down for people who no longer need to be hospitalized but cannot be discharged safely, or as a step up for those who need more services and supports than can be provided in the office setting. The authors also note that Medicare does cover comparable rehabilitation programs for patients with other medical conditions, such as Comprehensive Outpatient Rehabilitation Facility services, but does not have comparable programs for SUD treatment. The MMS strongly encourages CMS to fill this gap in care.

Immunization Administration and Payment for Preventive Vaccine Administration

The MMS urges CMS to adopt the AMA RUC's recommended work RVUs and direct PE inputs for vaccine administration services. The MMS supports CMS' proposal to annually update the payment amount for administration of Part B preventive vaccines to account for changes in the cost of administering those vaccines, and we urge CMS to consider several factors that could impact administration of COVID-19 vaccines prior to decreasing their payment rate in the year following the end of the Emergency Use Authorization (EUA) declaration. Physicians currently engage in extensive counseling regarding the COVID-19 vaccines and boosters, including their

⁵ Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20210616.166523/full/>

safety, effectiveness, and patient eligibility. Additionally, these vaccines require uniquely cold storage and are packaged in multi-dose vials. These factors lead to higher administration costs for physician practices and must be considered prior to lowering the payment amount for administration of the COVID-19 vaccine. Additionally, the MMS supports CMS' proposal to continue the additional payment of \$35.50 when a COVID-19 vaccine is administered in a beneficiary's home through 2023. Furthermore, **the MMS encourages CMS to cover all immunizations in the pharmacy benefit and in physician offices, as doing so will make it easier, and more likely, for patients to improve vaccine adherence immediately at the time of their visit.**

Colorectal Cancer Screening

The MMS greatly appreciates CMS' proposal to expand Medicare coverage of certain colorectal cancer screening tests by reducing the minimum age payment limitation from 50 to 45 years. Further, the MMS believes that coverage of colorectal screening needs to continue until the patient has a life expectancy of 5 years or less rather than at age 70. We also support expansion of the definition of colorectal cancer screening tests to include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based screening test returns a positive result. The MMS recognizes colon cancer as a leading cause of cancer deaths in the United States and supports CMS' efforts to reduce barriers to screening, prevention, and early detection of colorectal cancer. Moreover, we appreciate that these policies would advance health equity by promoting access to much-needed cancer prevention and early detection within rural, minoritized, and marginalized communities that are especially impacted by the incidence of colorectal cancer.

Other Recommendations from the CY 2023 Fee Schedule Proposed Rule

The MMS supports several other policies outlined in more detail in the AMA's comments. Specifically, MMS:

- Asks CMS to significantly improve access to Medicare diabetes prevention services, including expansion of Medicare Part B coverage of HbA1c testing to include the indication of screening for prediabetes or abnormal glucose, and approve the Medicare Diabetes Prevention Program as a permanent covered benefit.
- Requests CMS to cover validated self-measured blood pressure monitoring devices to improve hypertension control.
- Supports the RVS Update Committee (RUC) recommendations on specific services that are potentially misvalued and the continued collaboration of the RUC and CMS to identify and review potentially misvalued codes.
- Recommends that CMS finalize the recommendations for all the E/M visits and apply the office E/M visit increases to the office visits, hospital visits, and discharge day management visits included in the surgical global payment, as it has done historically.
- Urges CMS to allow physicians and QHPs to bill split or share visits based on time or medical decision-making. We strongly urge CMS not to disrupt team-based care in the facility setting and to revise the split or shared visit policy to allow the physician or QHP who is managing and overseeing the patient's care to bill for the service.

- Supports the proposal for new bundled monthly codes for chronic pain management and treatment and, further, urges them to be finalized.
- The MMS recommends that CMS provide technical and financial support resources to physicians to help them adopt EPCS and encourage Part D plan sponsors to provide positive incentives for EPCS such as waiving prior authorization.

CY 2023 Updates to the Quality Payment Program

The MMS appreciates CMS' focus on promoting improvements to the Medicare Quality Payment Program (QPP) and introducing a more clinically relevant, less burdensome approach to the Merit-based Incentive Payment System (MIPS) via the MIPS Value Pathways (MVPs). We support improvements to value-based payment mechanisms under the QPP. However, it is important to note that continuous changes to program terminology, participation and reporting requirements, and other measures can significantly add to physicians' administrative burden. These continuous changes can make it more difficult for physicians to formulate practice goals and better measure and improve their own performance, which can impact patient care. At a high-level, the MMS urges CMS to reduce physician burden by making the program simpler and more streamlined—and make the program more predictable, adaptable, and accessible across all specialties, while also striving for an optimal assessment of the quality of patient care.

Due to the continued effects of the COVID-19 PHE, **we strongly urge CMS to apply the automatic Extreme and Uncontrollable Circumstances Hardship Exception in the 2022 MIPS performance period and target technical assistance to those physician practices that have received a hardship exception due to COVID.** Additionally, we urge CMS to work with Congress to extend the \$500 million exceptional performance bonus, which expires in payment year 2024 under current law. Finally, the MMS urges CMS to reduce the performance threshold to avert more penalties and to specifically assist small practices in reporting MIPS data. The average positive payment adjustment is estimated to be 2.49 percent and the average penalty is estimated to be -1.64 percent. The maximum bonus would be 6.9 percent, and the maximum penalty would be 9 percent. CMS projects that about 7 percent of clinicians would receive a score of less than 50 points, resulting in a penalty of more than 3 percent.

To help CMS rescue the MIPS program and make it more clinically relevant and patient-centered, the MMS makes several recommendations in response to the MIPS Value Pathway (MVP) Request for Information. Among other things, we urge CMS to: work closely with the national medical specialty societies to develop MVPs that are patient-centered and focused on improving patient care, rather than the individual metrics; reduce the number of metrics in an MVP and incentivize participation in MVPs by, for example, mitigating QPP penalties through participation in an MVP; test and implement new and existing measures that are tailored to achieving the desired outcome of the MVP; adjust MVPs to reflect the higher cost of caring for low-income patients and address social determinants of health; and provide timely, actionable claims data analysis. We are concerned that MVPs as currently designed mirror many of the flaws in MIPS which, without changes, will deflate interest and financial commitment to develop and participate in MVPs.

It costs \$12,800 per physician per year to comply with the complex and ever-changing MIPS requirements, and on average, physicians spend more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits. CMS should immediately remedy these problems by redesigning MIPS through MVPs to give physicians who care for

underserved communities and who practice in all specialties and practice sizes the opportunity to be accountable for fewer, more meaningful measures of quality and cost. Everything outside of that paradigm, particularly the MVP foundation layer, is demonstrably doing harm to physicians and their patients, especially those with more complex medical needs and health-related social risks.

The MMS urges CMS to view MVPs as an opportunity to salvage the troublesome MIPS program by offering incentives to physicians to opt into a novel value-based track that holds them accountable based on aligned quality and cost measures within their control. In particular, we urge CMS to:

- promote innovative, patient-centered MVPs by focusing on the outcome of the MVP, rather than the metrics;
- incentivize MVP participation by reducing burden and the risk of penalties by creating an MVP bonus, reducing the overall number of metrics in an MVP, and aligning scoring across multiple performance categories for innovations that are applicable to multiple domains;
- test and implement new and existing measures that are tailored to achieving the desired outcome of the MVP;
- implement MVPs that have clinical relevance to physicians and patients regardless of CMS' ability to compare physicians across the same specialty and regardless of a corresponding APM;
- adjust MVP payment adjustments to reflect the higher costs of caring for low-income patients and address social determinants of health;
- adapt MVP payment adjustments to better align with APM and other value-based payment methods; and,
- provide timely, actionable claims data analysis so physicians can identify and reduce avoidable costs.

The MMS is alarmed that CMS estimates that one-third of MIPS-eligible clinicians would receive a penalty based on the 2023 proposals and urges the agency to lower the 2023 MIPS performance threshold to avoid penalizing one in three physicians and other medical professionals in a program that is already costly, burdensome, and disproportionately punitive toward small practices and practices that care for low-income patients. The COVID-19 pandemic remains a disruptive crisis to the fair and accurate evaluation of physician performance in MIPS.

The MMS supports modifying the Medicare SSP (MSSP) to recognize the challenges that ACOs face in delivering high quality care to patients with low incomes or who live in disadvantaged communities; however, we question the methodology of the proposed Health Equity Adjustment for ACOs. Several aspects have the potential to worsen disparities in care, rather than to improve health equity, so it is especially important to be clear on definitions used within this proposal. Furthermore, we urge that any Health Equity Adjustment created by CMS be available to all ACOs, not just those reporting eCQMs/MIPS CQMs, as the implicit financial penalty for serving disadvantaged patients affects ACOs regardless of the types of quality measures they report or the method they use to report them.

We share CMS's concerns that the Quality Payment Program's incentive structure beginning in performance year 2023 does not create adequate incentives for physicians to move to APMs. This

concern is compounded by the proposed cuts to the conversion factor and the expiration of MACRA's 5 percent Advanced APM incentive payments. The incentive payments not only help encourage physicians to enter risk-based ACO and Innovation Center models but also provide additional resources that can be used to expand services beyond traditional fee-for-service. Physicians who participate in ACOs often do so on the basis of this 5 percent guarantee, as they build that payment into practice planning since it notably assists with establishment of necessary infrastructure of the ACO and helps to mitigate any potential loss or lack of savings in the program. **Accordingly, we strongly encourage CMS leadership to work with Congressional leaders to support an extension of the 5 percent Advanced APM incentive payments, along with giving CMS the authority to adjust the thresholds to qualify for the incentive payments.**

The MMS further recommends CMS to do the following:

- Clarify the proposal for implementing the change in the benchmarking policy to further explain how adjustments for prior savings will be made.
- Finalize the proposal to create a more appropriate glidepath to risk, by allowing accountable care organizations (ACOs) up to seven years in upside-only tracks before advancing to risk.
- Expand eligibility for advance investment payments (AIPs) to all ACOs who care for underserved beneficiaries to combat health inequities.
- Allow existing ACOs to opt into the proposed financial methodology approaches.
- Engage with physicians and other stakeholders throughout development of an administrative benchmark concept.
- Test new concepts that would incentivize ACOs and specialists to collaborate to provide high quality, lower cost care for Medicare patients.

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,

Theodore A. Calianos, II, MD, FACS

President, Massachusetts Medical Society