TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

September 6, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: 2023 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule (CMS-1770-P)

Submitted via Federal eRulemaking Portal at www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of our more than 56,000 Texas physician and medical student members, the Texas Medical Association (TMA) writes in response to the 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies as published by the Centers for Medicare & Medicaid Services (CMS) in the July 29, 2022, *Federal Register*.

TMA is the largest state medical society in the nation and is committed to improving the health of all Texans. TMA charters 110 county medical societies. It is the mission of TMA to stand up for Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

The proposed rule estimates the 2023 Medicare physician fee schedule conversion factor to be $33.0775. This is a crucial concern for Texas physicians since it represents a decrease of $1.53, or almost 4.42%, from the 2022 conversion factor of $34.6062. Yet again, the reduced conversion factor is exacerbated by already low Medicare payment for physician services and is financially disastrous for physician practices.

In addition to immediately addressing the forecasted cuts in 2023, TMA calls on Congress and policymakers to provide stable and predictable Medicare physician payments. The currently scheduled reductions to Medicare physician payments, if allowed may compromise the ability for some Texas physicians to treat Medicare patients. **Physicians and the patients in their care deserve a reliable Medicare physician payment system that keeps up with inflation and practice costs.**

TMA wholeheartedly endorses the Medicare payment policy principles developed by the American Medical Association (AMA) and other medical societies that urge Congress to ensure financial stability and predictability for physician practices. Financial stability is afforded through a baseline positive annual update that reflects inflation in practice costs. Further, budget neutrality requirements should be eliminated, replaced, or revised to allow for appropriate changes in spending growth.

Specific to the Merit-Based Incentive Payment System (MIPS), TMA remains concerned that continued proposed changes contribute to physician regulatory compliance challenges which lead to physician burnout. TMA pleads with the agency to tweak MIPS requirements only as needed or when doing so significantly reduces the burdens physicians bear while navigating the MIPS program.

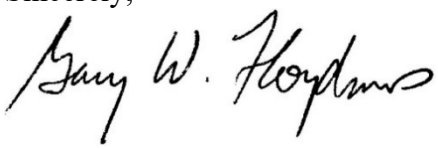
Attached to this cover letter TMA offers our detailed comments, recommendations, and suggestions to improve the Medicare program. In summary, TMA:

- Calls on CMS to work with the AMA RVS Update Committee (RUC) to value all services.
- Work with AMA and the RUC to remove any distortions from the resource-based relative value scale (RBRVS) currently in use by Medicare.
- Recommends that CMS permanently continue telehealth flexibilities and pay for telehealth services at parity with in-person service rates after the COVID-19 public health emergency (PHE) and the 151-day extension authorized by the Consolidated Appropriations Act concludes.
- Recommends that CMS defer to state laws and rules that govern a health professional's scope of practice/licensure, including any delegation and supervision requirements applicable under state laws.
- Urges CMS to not unfairly favor health visits with telemedicine-only companies with imbalanced pricing incentives.
- Calls for payment policies to be fair for all physician specialties. Budget neutrality requirements unfairly pit certain physician specialties against others by creating a system of "winners" and "losers."
- Encourages CMS to work with Congress and AMA to ensure that physicians are paid appropriately for time spent caring for patients regardless of delivery type. TMA recommends that CMS apply the evaluation and management (E/M) office visit increases uniformly across all services and specialties and not hold specific specialties to a different standard from others.
- Concurs with phasing in the revised geographic practice cost index (GPCI) values over two years as doing so helps mitigate disruptive impacts.
- Calls on CMS to work with the AMA to develop an appropriate current procedural terminology (CPT) code rather than introduce GAUDX.
- Ask CMS to pause consideration of other sources of cost data for use in the Medicare Economic Index (MEI) until AMA has completed an extensive effort to collect practice cost data from physician practices.
- Regarding the Medicare Shared Savings Program, TMA recommends:
    - CMS reconsider advance incentive payments (AIPs) for participants that are federally qualified health centers, rural health clinics, or critical access hospitals that might be designated as high-revenue entities.
    - Recoupment of AIP funds be phased over the five-year agreement, period allowing accountable care organizations (ACOs) more time to earn shared savings from the model.
    - Should an ACO prematurely terminate its agreement, recoupment of AIP funds should be limited to unspent funds at the time of termination.
    - The health-equity adjustment be a minimum of 10 points.
- Regarding the electronic prescribing of controlled substances (EPCS), TMA:

    - Does not support CMS modifying the determination period from the previous year to the current year to determine small prescribers.
    - Believes the 70% threshold is reasonable but encourages CMS to phase in the threshold beginning with 50% in year one of compliance, 60% in year two, and 70% in year three.
    - Fully supports the proposal to postpone EPCS enforcement for the next two years. However, we are concerned about monetary or other punitive penalties in 2025.
    - Emphatically asks CMS not to impose penalties for noncompliance.
    - Urges CMS to seek to understand why a small minority of controlled substance prescribers do not use EPCS, and to help those prescribers move to compliance in a nonpunitive fashion.
- TMA has pleaded with the agency in previous comments to modify MIPS requirements only as needed. CMS should maintain consistency in MIPS requirements if the agency earnestly hopes to encourage physician participation in this overly complicated program.

Thank you for the opportunity to comment. TMA stands ready to provide you and others within the agency with our policy expertise and any additional assistance you may find useful. If you have any questions, please do not hesitate to contact Robert Bennett, TMA vice president of medical economics, at Robert.Bennett@texmed.org.

Sincerely,



Gary Floyd, MD
President
Texas Medical Association

COMMENTS OF THE TEXAS MEDICAL ASSOCIATION

Attention: 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

Determination of PE RVUs (section II.B.)

Summary

The agency proposes to accept 85 percent of the AMA Relative Value Scale Update Committee's (RUC) direct practice expenses (PE) cost recommendations. CMS proposes to accept American Medical Association RVS Update Committee (RUC) recommendations that increase the value of evaluation and management (E&M) services and immunization administration, though the agency also proposes to decrease RUC recommendations for other services.

This is the second year of transition for clinical staff wage increases in 2023. This transition is required to be budget neutral and, as such, increases for some services are offset by decreases for others.

TMA Response

We appreciate that CMS followed the vast majority of RUC recommendations and urge CMS to fully adopt all RUC recommendations. **TMA calls on CMS to work with the RUC to value all services.**

Potentially Misvalued Services Under the PFS (section II.C.)

Summary

CMS has the authority to examine potentially misvalued services in several categories. In addition, through an annual public nomination process, the agency receives public nominations for review of potentially misvalued codes by Feb. 10 of each year with display of these nominations on a public website.

For 2023, the agency received public nominations for home-based physician visit codes (CPT codes 99344, 99345, 99349, 99350) as misvalued. The nominator expressed concern that there is no payment for transportation costs incurred when it is medically necessary for a physician to drive to the home of the patient for a face-to-face E/M Visit. Further, physicians are not compensated for opportunity losses incurred by seeing fewer patients because of the time spent commuting to patients' homes.

Separately, the agency received a public nomination for certain cataract surgery codes (CPT codes 65820, 66984, 66989, 66991) as misvalued, as well as certain retinal procedure codes (CPT codes 67015, 67036, 67039, 67040, 67041, 67042, 67043, 67108, 67113). The nominator noted that there is currently no established non-facility payment rate for these global 90-day surgical procedures.

Further, an interested party nominated add-on CPT code 20931 (allograft, structural, for spine surgery only) as a potentially misvalued service with respect to the physician's labor for spinal surgeries. This involves the use of biomechanical synthetic cage devices versus structural allograft bone as it relates to CPT codes for anterior cervical discectomy and fusion.

TMA Response
It is TMA's policy to strongly support AMA development of a Medicare resource-based relative value scale (RBRVS) that is free of the distortions imposed by the federal government. Rather than modify codes through the fee schedule, we instead call on CMS to work with the RUC to value these and other services. **CMS should work with the AMA and the RUC to remove any distortions from the RBRVS currently in use by Medicare.**

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D.)
Summary
CMS proposes adding interim services to the Medicare Telehealth Category 3 Services list through year-end 2023 until data can be analyzed and reviewed to determine continued coverage or deletion. In March 2022, the Consolidated Appropriations Act included a provision to extend payment for Medicare telehealth services for 151 days after the public health emergency (PHE). The Act also removed the geographic site restriction so that patients can continue to be seen in their own homes. The agency proposes continuation of those flexibilities as extended under the Act.

Other provisions proposed by CMS include:

- Delay in-person requirements for tele-mental health services until 152 days after the expiration of the PHE;
- Extend the originating site and geographic restriction flexibilities;
- Allow qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists to provide telehealth services;
- Continue payment for specified services furnished via audio-only technology;
- Replace use of a "95" modifier for telehealth services with place of service (POS) codes after the 151-day extension of telehealth flexibilities expires;
- Redefine POS code "02" as "Telehealth provided other than in a patient's home" in addition to POS "10" code (telehealth provided in a patient's home); and
- Allow immediate availability for direct supervision through virtual presence for a subset of service.

TMA Response
TMA appreciates the continued telehealth flexibilities. The ability for Medicare patients to be seen virtually while staying in their own homes helps patients who need telehealth most. Many Medicare patients suffer from comorbidities due to chronic conditions that present mobility and transportation challenges. TMA, therefore, continues to advocate for the removal of the originating site geographic restrictions.

Additionally, TMA recommends that CMS permanently continue telehealth flexibilities and pay for telehealth services at parity with in-person service rates after the COVID-19 public health emergency and the 151-day extension authorized by the Consolidated Appropriations Act concludes.

Because scope of practice laws are generally governed by states (as a critical component of regulating health and welfare), **TMA recommends CMS defer to state laws and rules that govern a health professional's scope of practice/licensure, including any delegation and supervision requirements applicable under state laws.** This is important to maintain consistent quality in patient care and prevent confusion. Scope of licensure/practice, including any delegation and supervision requirements, have been carefully tailored at the state level to account for each state's licensure requirements. It is imperative that CMS ensure that any future Medicare telehealth

coverage policies do not expand the scope of practice for nonphysician health care professionals. **Additionally, CMS should not unfairly favor health visits with telemedicine-only companies with imbalanced pricing incentives.** Patients should be encouraged to seek care from their own physicians for continuity of care.

TMA supports payment policies that pay physicians for their time and resources to deliver care. Physicians must have the flexibility to decide whether to see their patients via telehealth or in person without unnecessary and disconnected pricing incentives. Physicians already are required to meet the same standard of care with a telemedicine visit as with the same service provided in-person and can determine the visit type most suitable for the care rendered. Most patients have experienced the convenience of telehealth and will continue to demand it for appropriate visit types.

Telehealth services can also increase access for underserved populations in urban and rural areas as a *supplement to, but not replacement for,* face-to-face care**.** These flexibilities should also be a permanent fixture of the Medicare Advantage Part C and D plans.

Evaluation and Management (E/M) Visits (section II.F.)

Summary

Over the past several years, CMS has engaged in a multi-year effort to update coding and payment policies for evaluation and management (E/M) visits to better reflect the current practice of medicine, reduce administrative complexity, and to promote more accurate payment. CMS updated office and outpatient E/M visits in 2021.

In this 2023 regulation, CMS proposes updates to other E/M services for inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest-home visits, home visits, and cognitive impairment assessments. These proposals are predominantly consistent with AMA RUC recommendations and allow physicians to code the E/M visit based on time spent with the patient or the level of medical decision-making.

In 2022, CMS proposed and subsequently finalized a new policy allowing physicians and nonphysician practitioners to bill for split (or shared) visits for both new and established patients, and for critical care and certain nursing and skilled nursing facility E/M visits. The "billing practitioner" is the clinician who furnished the "substantial portion" of the E/M visit. In this 2023 proposed rule, CMS proposes to delay this policy. Instead, CMS will continue to permit the substantial portion of the E/M service to be defined as either history, exam, medical decision making or more than half of total time.

CMS also proposes to delete observation CPT codes since they were merged into the existing hospital care CPT code set. The agency also proposes Medicare-specific codes for prolonged services.

CMS seeks feedback on the global surgical codes as they relate to the agency not incorporating the higher E/M service rates that were finalized in 2021 for office and outpatient E/M visits.

Given the magnitude of the proposed changes to the E/M codes, which represents around 20 percent of allowed charges in the fee schedule, the agency is required to impose a budget neutrality adjustment of negative 1.55% to the 2023 Medicare conversion factor.

TMA Response

TMA appreciates CMS' efforts to pay properly for E/M services but remains concerned that, due to budget neutrality requirements, these favorable improvements negatively impact certain physician specialties that do not predominately utilize E/M codes. **TMA calls for payment policies to be fair for all physician specialties. Budget neutrality requirements unfairly pit certain physician specialties against others by creating a system of "winners" and "losers."**

TMA encourages CMS to work with Congress and AMA to ensure that physicians are paid appropriately for time spent caring for patients regardless of delivery type. TMA recommends that CMS apply the office visit E/M increases uniformly across all services and specialties and not hold specific specialties to a different standard from others.

Geographic Practice Cost Indices (GPCI) (section II.G.)

Summary

CMS is required to develop separate geographic practice cost indices (GPCIs) to measure relative cost differences among localities compared to the national average for each of the three fee-schedule components (work, practice expense, and malpractice). Every three years, the agency is required to review and update the GPCI values.

In this regulation, the agency proposes revised values based on 2017-2020 data from the Bureau of Labor Statistics; Occupational Employment Statistics wage data; 2015-2019 data from the American Community Survey; and 2020 premium data based on state insurer rate filings.

The agency proposes to implement half of the GPCI adjustment in 2023 and the other half in 2024. However, the GPCI values proposed for 2023 reflect the 1.0 GPCI floor that was extended through the end of 2023.

TMA Response

TMA concurs with phasing in the revised GPCI values over two years as doing so helps mitigate disruptive impacts. TMA supports geographic adjustments for Medicare payments that are fair and accurate based on variations in local economic conditions. To ensure accurate adjustments, CMS should:

- Find and apply the most accurate and current available data for use in GPCI calculations, including better data on commercial office costs, current information on medical liability costs, and data to accurately measure the existing variations in costs of medical supplies; and
- Update all factors including locality definitions and boundaries. CMS should work with Congress and seek federal funding to hold harmless and prevent cuts to localities that could be affected adversely.

Further, it is TMA's policy to support the collection and evaluation of the most current valid and reliable data and its use in calculating accurate geographic practice cost indices and in determining geographic payment areas. Further, TMA believes variation among geographic payment areas should be minimized and equitable access to medical care services should not be diminished by geographic practice cost indices that are unreasonably low in rural areas.

Non-Face-to-Face/Remote Therapeutic Monitoring (RTM) Services (section 11.1)

Summary

CMS proposes adding two Healthcare Common Procedure Coding System (HCPCS) codes that allow certain qualified nonphysician health care professionals to furnish remote therapeutic monitoring (RTM) services.

TMA Response
While TMA agrees that remote therapeutic monitoring has value and the use of nonphysicians helps to increase beneficiary access, CMS must clarify that state scope of practice/licensure requirements and state delegation and supervision laws still apply. For example, Texas only allows delegation of certain medical acts under the supervision of a physician. Texas also has very specific laws on what therapeutic services fall within a health care professional's license, certification, or other authorization. CMS' proposal should be carefully tailored so it does not supersede these state protections.

In addition, TMA recently adopted principles for augmented intelligence in health care. The following principles may be helpful to CMS as remote therapeutic services are provided.

> TMA Policy: Augmented Intelligence in Health Care
>
> The Texas Medical Association supports the use of augmented intelligence (AI) when used appropriately to support physician decision-making, enhance patient care, and improve public health. Augmented intelligence should also be used in ways that reduce physician burden and increase professional satisfaction. Sufficient safeguards should be in place to assign appropriate liability inherent in augmented intelligence to the software developers and not to those with no control over the software content and integrity, such as physicians and other users.
>
> The Texas Medical Association adopts the following principles for augmented intelligence in health care:
>
> 1. Augmented intelligence should be the preferred health care term over artificial intelligence as it should be used to augment care by providing information for consideration. Augmented intelligence, whether assistive or fully autonomous, is intended to co-exist with human decision-making and should not be used to replace physician reasoning and knowledge.
> 2. Physicians should not be mandated to use augmented intelligence.
> 3. Augmented intelligence must not replace or diminish the patient-physician relationship.
> 4. Algorithms developed to augment user intelligence must be designed for the benefit, safety, and privacy of the patient.
> 5. Sellers and distributors of augmented intelligence should disclose that it has met all legal and regulatory compliance with regulations such as, but not limited to, those of HIPAA, the U.S. Department of Health and Human Services, and the U.S. Food and Drug Administration.
> 6. Use of augmented intelligence, machine learning, and clinical decision support has inherent known risks. These risks should be recognized and shared among developers, distributors, and users with each entity owning responsibility for its respective role in the development, dissemination, and use of products used in clinical care.
> 7. Users should have clear guidelines for how and where to report any identified anomalies. Additionally, as with all technology, there should be a national database for reporting errors that holds developers accountable for correcting identified issues.
> 8. Before using augmented intelligence, physicians and all users should receive adequate training and have educational materials available for reference, especially in instances where the technology is not intuitive and there are periods of nonuse.

9. Physicians should inquire about whether the AI used is a "continuously learning system" versus a "locked system." A locked system is more appropriate for clinical care, although a hybrid system may be appropriate as long as the clinical output is based on locked training sets.
10. Algorithms and other information used to derive the information presented as augmented intelligence to physicians and other clinicians should:
    i. Be developed transparently in a way that is accessible, explainable, and understandable to clinicians and patients and details the benefits and limitations of the clinical decision support, and/or augmented intelligence;
    ii. Have reproducible and explainable outputs;
    iii. Function in a way that promotes health equities while eliminating potential biases that exacerbate health disparities;
    iv. Use best practices for user-centered design that allows for efficient and satisfactory use of the technology;
    v. Safeguard patient information by employing privacy and security standards that comply with HIPAA and state privacy regulations; and
    vi. Have a feedback loop that allows users who identify potential safety hazards to easily report problems and malfunctions as well as opportunities to report methods for improvements.
11. Medical students need to learn about the opportunities and limitations of augmented intelligence as they are prepared for future medical practice.
12. Recognizing the rapid pace of change in augmented intelligence, it is important to continually assess and update TMA's principles at regular intervals (JR 8 2022).

<u>Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order (section II.K.)</u>

Summary

Medicare requires physician supervision for most diagnostic tests, but in 1998, CMS amended policy to accept certain tests furnished by audiologists, psychologists, and physical therapists who are board-certified in electrophysiology. As a result, audiologists are authorized to provide diagnostic services, such as hearing and balance assessment, independently of physician supervision to the extent that they are legally authorized to perform these services under state laws.

In this 2023 regulation, CMS proposes to allow Medicare beneficiaries to have direct access, when appropriate, to an audiologist without a physician referral by creating a new Healthcare Common Procedure Coding System (HCPCS) code – GAUDX – for audiologists to use when billing for certain audiology services. The service(s) encompassed by the new HCPCS code would be personally furnished by the audiologist, allowing beneficiaries to receive care for non-acute hearing or assessments unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. The agency proposes to permit audiologists to bill for this direct access (without a referral) once every 12 months.

TMA Response

TMA supports the use of Current Procedural Terminology (CPT) coding as developed by the American Medical Association (AMA). CPT codes offer physicians and providers a uniform language for coding medical services and procedures to streamline reporting and to increase accuracy and efficiency. As such, TMA is concerned with the development of any HCPCS codes. **Rather than introduce GAUDX, TMA calls on CMS to work with AMA to develop an appropriate CPT code**. Also, CMS should make it clear to the extent that it moves forward with

this proposal that state licensure, delegation, and supervision laws control what services an audiologist may perform.

Rebasing and Revising the Medicare Economic Index (MEI) (section II.M.)

Summary

CMS proposes to revise the weights for the different cost components of the Medicare Economic Index (MEI), which is primarily based on 2006 data. The agency proposes to move away from using America Medical Association (AMA) data and primarily use data from the Census Bureau's Service Annual Survey for the new weights. These proposed changes lead to considerable changes in the weights that calculate physician practice expense. Due to the considerable changes, CMS does not propose to implement these changes in 2023 and instead seeks public feedback.

TMA Response

While TMA appreciates the agency's efforts to use updated and more accurate data, we are ultimately concerned that the proposed changes would negatively impact physician specialties with high work relative values as well as low practice costs.

Since the AMA is actively engaged in an extensive effort to collect practice cost data from physician practices, we join AMA in asking CMS to pause consideration of other sources of cost data for use in the MEI until AMA has completed these efforts.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers (section III.D.)

Summary

For 2023, CMS proposes two updates to expand Medicare coverage for colorectal cancer screening. These updates align with United States Preventive Services Task Force (USPSTF) recommendations.

CMS proposes to expand Medicare coverage for certain colorectal cancer screening tests by reducing the minimum-age payment limitation to 45 years. CMS also proposes to expand the regulatory definition of colorectal cancer screening tests to include a follow-on screening colonoscopy after a Medicare-covered, non-invasive, stool-based colorectal cancer screening test returns a positive result.

TMA Response

TMA fully supports proposed changes that expand Medicare coverage for colorectal cancer screening and concur that these proposals expand access to quality care and improve health outcomes for patients through prevention and early detection services, and effective treatments. We agree these proposals are consistent with recent evidence and consensus among medical societies and USPSTF.

TMA continues to support the elimination of coinsurance for this procedure as this is sound policy that will reduce the financial burden facing Medicare beneficiaries whose screenings result in a diagnostic procedure. Elimination of coinsurance also will promote utilization of colorectal cancer screenings that save lives.

It has been TMA's longstanding policy to support state and national legislation for coverage of colorectal cancer screening under which patients and physicians have the option to utilize a variety of tests – such as fecal occult blood test, fecal immunochemical test, stool DNA test, flexible sigmoidoscopy, colonoscopy, double-contrast barium enema, CT colonography (virtual colonoscopy), or other appropriate techniques – in accordance with the most recently established

national guidelines and in consultation with interested specialty societies and scientific organizations for the ages, family histories, and frequencies referenced in these guidelines.

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

Summary

In 2020, CMS established a Medicare Part B benefit category for opioid use disorder (OUD) treatment services furnished by opioid treatment programs (OTPs).

In this regulation, and to account for annual inflation, CMS proposes to modify the pricing of the drug component for the methadone weekly bundle and the add-on code for take-home supplies of methadone. Furthermore, CMS proposes to increase payment for OUD episodes of care bundled services. The agency also proposes to expand access to OTPs by allowing mobile units to furnish OTP services and bill for bundled OTP services.

TMA Response

TMA continues to support multi-dimensional strategies to optimize safe and evidence-based treatments of pain. We also continue to support OTPs and appreciate the agency updating for inflation payment for methadone.

TMA supports improved access to substance-use disorder treatment, especially through co-location of physical health, mental health, and substance-use services, and through wider availability of evidence-based medication-assisted treatments.

Medicare Shared Savings Program (section III.G.)

Summary

While more than 11 million people are currently receiving care under the Medicare Shared Savings Program (MSSP), trends indicate that the number of beneficiaries assigned to accountable care organizations (ACOs) has plateaued, and higher spending populations and communities of color are increasingly underrepresented. Further, physicians and other health care providers cite significant barriers to MSSP participation, such as lack of capital for technology and care management investments that are integral to accountable care success. Aggressive timetables that force inexperienced groups to enter performance-based risk before they are ready also thwart interest in the program. In its proposed changes, CMS attempts to promote agency goals to advance growth and sustainability of MSSP – currently the largest value-based purchasing program in the country – while addressing health equity and representation among underrepresented populations.

TMA Response

TMA appreciates CMS' proposals to improve and encourage participation in MSSP. Of note, this includes a more conservative glidepath to at-risk agreements; implementation of advance investment payments (AIPs) for ACOs in all geographies that care for underserved populations; modifications to quality performance thresholds that will benefit low-revenue ACOs; and attempts to ensure fair, accurate, and sustainable benchmarking and risk-adjustment policies.

Looking forward, TMA hopes to see more opportunities to engage specialists in Medicare value-based purchasing programs. A recent *JAMA* article, "Primary Care Spending in the United States, 2002-2016," states that specialty care represents more than 18% of the professional medical spend in the U.S. compared to just 4% for primary care. Clearly, physicians in all specialties will be required to participate in value-based care models if CMS is to achieve its goal of moving all Medicare beneficiaries in such models by 2030.

Further, TMA encourages CMS to work with Congressional leaders to support extension of the 5% advanced alternative payment model (APM) incentive payment set to expire Dec. 31, 2022. This incentive is a strong tool used by ACOs to recruit new physicians. Shared savings isn't guaranteed, but the APM incentive has been.

Section III.G.2.a - Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs

Summary
Recognizing that solo and small group practices often lack capital, staff, and infrastructure to successfully participate in the Medicare Shared Savings Program (MSSP), CMS proposes advance investment payments (AIPs) for low-revenue, new-entrant ACOs serving underrepresented populations. These changes are based on the previous ACO Investment Model (AIM) offered from 2016 to 2018, in which upfront quarterly payments helped kickstart ACOs in rural and underserved communities. Under the proposed AIP rules, qualifying ACOs in any geography can receive an up-front, fixed payment of $250,000, followed by eight quarterly payments based on the number of assigned beneficiaries (capped at 10,000 beneficiaries). The per-beneficiary payment amount would vary based on a risk factor-based score and dual eligibility status among the Area Deprivation Index (ADI) ranking of the census block group. AIPs would be recouped from any shared savings the ACO earns. If the ACO doesn't achieve shared savings, CMS will not recoup the funding unless the ACO terminates during the agreement period in which it received the advance investment payments.

TMA Response
TMA is supportive of this proposal, as more than a few rural and border-region groups in Texas were able to establish ACOs because of the AIM funding and are still participating in MSSP today. TMA notes, however, that several low-revenue, physician-led ACOs entered MSSP after AIM funds were suspended – they have yet to achieve shared savings. **TMA recommends that CMS consider AIPs for existing low-revenue ACOs that have not achieved shared savings, though they may be in renewal or re-entering status.** Prospective funding would provide second-chance access to enabling infrastructure, redesigned care processes, and other resources that were not available during the gap years of 2019 and beyond. Moreover, Medicare Advantage plans typically offer monthly care coordination fees for the life of their contracts in recognition of the additional work and coordination required to care for the senior population, many with multiple chronic conditions. **TMA further recommends that CMS reconsider AIPs for participants that are federally qualified health centers, rural health clinics, or critical access hospitals that might be designated as high-revenue entities.** These organizations are crucial to providing care to underserved communities.

TMA recommends that recoupment of AIP funds be phased over the five-year agreement period, allowing ACOs more time to earn shared savings from the model. It typically takes low-revenue ACOs two to three years to achieve savings. It is discouraging for ACO participants to have nothing to show for several years of work in the program. A longer recoupment period would encourage long-term participation and reinvestment of funds into ACO operations and improvements.

TMA also recommends that should an ACO prematurely terminate its agreement, recoupment of AIP funds should be limited to unspent funds at the time of termination. Early termination is often a result when an ACO either is unable to secure operating funds, or loses participants through competition from other ACOs.

Section III.G.2.b – Smoothing the Transition to Performance-Based Risk
Summary
Proposed policies in this section are intended to provide ACOs with a more gradual on-ramp to two-sided risk, thus enabling more ACOs to join MSSP. They are also meant to encourage current ACOs to remain in the program. Beginning with performance year 2024, new entrant ACOs could operate under a no-risk arrangement for a maximum of seven years, while ACOs already participating in Level A or B of the BASIC track could remain in a one-sided model until the end of their current agreement. Further, there are limits on how long ACOs may participate in the BASIC track before progressing to the ENHANCED track. Currently, high-revenue ACOs may not participate in the BASIC track unless they meet very limited criteria. Low-revenue ACOs may enter the BASIC track Level E and remain there for up to two agreement periods. Faced with the risk of experienced, successful ACOs terminating MSSP participation instead of progressing to the ENHANCED track, the agency proposes to remove limits on the number of agreement periods an ACO can participate in BASIC track Level E, making participation in the ENHANCED track optional.

TMA Response
TMA supports this proposal noting that performance-based risk is a barrier to value-based care adoption in commercial, Medicaid, and Medicare Advantage contracting as well. These proposals allow ACOs more time to build infrastructure and modify care management processes to improve quality and reduce costs, and will surely encourage new ACO participants.

Section III.G.4 – Quality Performance Standard Reporting
Summary
ACOs must currently meet a specified quality performance threshold to receive shared savings. Beginning in performance year 2023, CMS proposes a sliding scale for quality performance that eliminates the "all-or-nothing" cutoff. As a result, ACOs that fall below the 30th/40th percentile threshold, but meet minimum quality reporting and performance requirements, could remain eligible for shared savings. A similar sliding scale is proposed for shared losses if an ACO participates in the ENHANCED track.

CMS proposes a health-equity adjustment of up to 10 bonus points applied to the ACO's Merit-Based Incentive Payment System (MIPS) quality performance score. This would reward ACOs that: 1) report all-payer electronic clinical quality measures (CQMs) or MIPS CQMs; 2) are high-performing on quality; and 3) serve a high proportion of underserved beneficiaries. This would be an upside-only reward.

TMA Response
TMA recognizes the importance of health-equity adjustments that reward ACOs serving a high proportion of underserved beneficiaries. **TMA recommends, however, that the health equity adjustment be a *minimum* of 10 points.** As a result of CMS's health-equity incentives, ACOs will likely onboard underserved beneficiaries who have not traditionally accessed the health care delivery system and are not currently included in benchmarking or risk adjustment. Health-equity adjustments will counter-balance higher costs associated with care of this new patient population.

Section III.G.5 – Financial Methodology
Summary
It is widely held that high-performing ACOs are penalized for their success. Over time, that success lowers regional costs, and in turn, ACOs' performance benchmarks and potential for shared savings. In response, CMS proposes revised benchmarking policies to: 1) incorporate a prospectively projected administrative growth factor; 2) adjust benchmarks to account for prior

savings; and 3) lessen the impact of negative regional adjustments. The prospective administrative growth factor would be a three-way blend calculated as the weighted average of the accountable care prospective trend (1/3) and the national-regional blend (2/3). The updated historical benchmark would be applied between base year three and the current performance year.

CMS also proposes expanding eligibility criteria for shared savings beginning Jan. 1, 2024. Certain low-revenue ACOs participating in the BASIC track would be eligible to share in savings even if they do not meet the minimum savings rate requirement. Eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate would receive half of the maximum sharing rate for their level of participation (20% instead of 40% under Levels A and B, and 25% instead of 50% under Levels C, D, and E). For eligible ACOs that do not meet the quality performance standard required to share in savings but meet the proposed alternative quality performance standard, the sharing rate would be further adjusted according to proposed sliding scale approach for determining shared savings.

TMA Response
TMA appreciates CMS' efforts to revise its financial benchmarking policies, including a guardrail that protects ACOs from losses under the proposed three-way blend. Concerns exist, however, regarding use of the accountable care prospective trend, which is only as reliable as its inputs. Would the financial impacts of the COVID-19 pandemic be reflected in updates for 2019 and beyond? Would trends consider the effects of rapid market consolidation in local communities or the rapid increase in Medicare Advantage enrollment? Further, while CMS has taken precautions to protect ACOs against losses related to the new methodologies, this could also impact an ACO's ability to earn shared savings.

TMA supports expansion of shared savings eligibility criteria. The proposed approach would provide payments to ACOs with the greatest need for shared savings, in particular smaller, rural ACOs which tend to be less capitalized, allowing for investments in care redesign and quality improvement activities.

Section III.G.6 – Reducing Undue Administrative Burden and Other Policy Refinements
Summary
CMS proposes several administrative simplifications beginning in performance year 2023, such as removing the CMS review requirement for beneficiary marketing materials prior to use, and reducing the frequency of beneficiary information notices from annually to once per agreement period. Also proposed for performance year 2024 is removal of the requirement for an ACO to submit narratives for communications, care management, beneficiary evaluation, and admission plans when applying for the skilled nursing facility three-day rule waiver. ACOs would instead submit attestations that they have established the relevant plans.

TMA Response
TMA supports CMS efforts to reduce administrative burdens by simplifying documentation requirements for MSSP application and beneficiary notification requirements under the prospective assignment option. These types of administrative reductions especially benefit small ACOs led and managed by small, independent physician groups.

<u>Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H.)</u>
Summary
CMS makes several proposals regarding vaccine administration services. These include:

- Adopting the RVS Update Committee's (RUC's) recommended work relative value units (RVUs) and direct practice expense inputs for vaccine administration services (CPT codes 90460, 90461, 90471, 90472, 90473, and 90474).
- Establishing a payment of $30 for the administration of influenza, pneumococcal, and hepatitis Bvaccines.
- Updating the payment for administering preventive vaccines based upon the annual increase to the Medicare Economic Index.

TMA Response
TMA appreciates CMS acknowledging and addressing insufficient payment for vaccine administration services, especially since our members have consistently expressed the inadequacies of vaccination administration payment.

State Options for Implementing Medicaid Provider Enrollment Affiliation Provision (section III.K.)
Summary
In 2019, CMS published a regulation requiring Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) physicians, providers, and suppliers to disclose any current or previous direct or indirect affiliation with a provider or supplier that:

- Has uncollected debt;
- Has been or is subject to a payment suspension under a Federal health care program;
- Has been or is excluded by the Office of Inspector General from Medicare, Medicaid, and CHIP; or
- Had its Medicare, Medicaid, or CHIP billing privileges denied or revoked.

CMS may deny enrollment based on such an affiliation if it poses an undue risk of fraud, waste, or abuse, and the agency is phasing in the requirement based in part on concerns about the potential administrative burdens imposed on physicians and the provider community.

For Medicare enrollment, physicians, providers, and suppliers must submit affiliation disclosures upon a CMS request. For Medicaid and CHIP enrollments, each state must select one of two options, offered by the agency, for implementing the disclosure requirement.

TMA Response
TMA generally supports these efforts since they improve the ability of the agency to identify and remove individuals acting improperly.

We call on CMS to adopt Option 2, as outlined in the regulation. Under Option 2, physicians and providers who are not enrolled in Medicare – but are initially enrolling in Medicaid or CHIP, or revalidating their Medicaid or CHIP enrollment information – must disclose their affiliations only upon request from the state. TMA finds this approach to be administratively less burdensome than Option 1 and in alignment with the Medicare enrollment requirements.

Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan (section 2003 of the SUPPORT Act) (section III.L.)
Summary
The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 required that Medicare Part D prescriptions for Schedule II, III, IV, and V controlled substances be prescribed electronically starting Jan. 1, 2021. However, CMS finalized policy stating the agency would postpone enforcement action until Jan. 1, 2023.

CMS now proposes to extend enforcement delay by sending letters to non-compliant prescribers during the electronic prescribing for controlled substances (EPCS) program implementation year of Jan. 1 to Dec. 31, 2023, and during the following calendar year of Jan. 1 to Dec. 31, 2024. Starting in calendar year 2025, CMS plans to begin increasing the severity of penalties for noncompliant prescribers by issuing non-compliance letters and other penalties.

CMS also proposes changes to the exception to EPCS requirements for prescribers who issue 100 or fewer controlled substance prescriptions for Part D drugs per calendar year. Currently the determination for an exception is made using prescription-drug-event claims data as of Dec. 31 of the preceding year. The proposed change would modify the exception to better align the timeframes of data used to evaluate the exception. Rather than using previous-year data, CMS proposes to use current-year data. If finalized, this change would take effect in calendar year 2023. Under this proposal, a prescriber who issues 85 prescriptions for controlled substances during the first quarter would have to comply with the 70% threshold of EPCS once that prescriber crosses the threshold of more than 100 Part D controlled substance prescriptions. The 70% threshold would include those prescriptions prior to reaching 100 Part D controlled substance prescriptions threshold. The prescriber would be subject to compliance action if he or she does not meet the 70% threshold.

TMA Response

TMA does not support CMS modifying the determination period from the previous year to the current year to determine small prescribers. We are concerned that this proposal will be overly confusing for physicians in small practices who may not maintain a running tally of Medicare Part D controlled substance prescriptions. In fact, physicians act according to patient needs and this standard of clinical care should not deviate based on the patient's public or private insurer. Therefore, physicians may be unduly subject to compliance action as they may not realize the number of Part D controlled substance prescriptions written. If CMS considers moving forward with this proposal, TMA suggests the agency, at the very least, send a notification alerting a prescriber that the 100 Part D controlled substance prescribing threshold has been crossed. Once notification is sent, that is when the 70% calculation should begin, and it should not apply to the first 100 prescriptions.

TMA believes the 70% threshold is reasonable but encourages CMS to phase in the threshold beginning with 50% in year one of compliance, 60% in year two, and 70% in year three. This would allow physicians time to adjust, set patient expectations, and ensure industry preparedness.

Regarding the CMS proposal to issue letters of noncompliance for 2023 and 2024 but impose enforcement effective Jan. 1, 2025, **TMA fully supports the proposal to postpone EPCS enforcement for the next two years. However, we are concerned about monetary or other punitive penalties in 2025.** Though Texas began requiring EPCS on Jan. 1, 2021, the state has issued waivers for physicians citing technical or financial hardships that can be renewed annually for five years. Many physicians find value in e-prescribing and have upgraded their functionality to include EPCS so that all prescriptions may be sent electronically. In fact, the 2021 National Progress Report published by Surescripts, indicates that 74% of prescribers are successfully enabled for EPCS. This high percentage of enabled EPCS prescribers should be celebrated by CMS. For the 26% who are not enabled, they either do not prescribe controlled substances, or their practice viability is in jeopardy, and they cannot add another unfunded mandate to their practice. This is particularly true in small and rural primary care practices that are the bedrock of health care in many underserved communities. While TMA recognizes the value of EPCS, **TMA emphatically asks CMS not to impose penalties for noncompliance**. Financial penalties impose unintended consequences, such as limited access to care or physicians not prescribing necessary medications to patients. **TMA urges CMS to first seek to understand why a small minority of controlled**

substance prescribers do not use EPCS and help those prescribers move to compliance in a nonpunitive fashion.

Additionally, TMA urges CMS to consider a waiver for physicians who prescribe compounded medications that qualify as controlled substances but cannot be electronically prescribed because they are not listed on the prescribing software's medication list.

Updates to the Quality Payment Program (section IV)

Summary

The agency proposes countless tweaks, updates, and changes to the Merit-Based Incentive Payment System (MIPS) such that the agency posted a ZIP file containing four documents totaling 72 pages that attempt to explain this myriad of complicated changes.

TMA Response

TMA has pleaded with the agency in previous comments to modify MIPS requirements only as needed. CMS should maintain consistency in MIPS requirements if the agency earnestly hopes to encourage physician participation in this overly complicated program. We again call on the agency to avoid changes to MIPS categories, since even minor changes require substantial retraining for physicians and their office staff.

Physician burnout is a serious consequence for physicians who also operate small businesses and must comply with a myriad of regulations. Burdensome programs such as MIPS redirect physician focus away from patient care with little or no demonstrative benefit to their patients or their practices. The proposed changes to the MIPS program are increasingly burdensome and clinically irrelevant.

Additionally, TMA is concerned about discussions that MIPS Value Pathways (MVPs) could become mandatory. This is especially concerning as the Medicare Access and CHIP Reauthorization Act of 2015 authorized CMS to create two pathways in the Quality Payment Program – the agency must not require physicians to participate in a third pathway that was not envisioned by Congress.

Rather than force physicians into MVPs, TMA again calls on CMS to focus on moving physicians to risk-based systems in voluntary, physician-led advanced alternative payment models (APMs).

Updates to the MIPS Quality Performance Category

Summary

CMS proposes to expand the definition of the term high-priority measure to include health equity measures; increase the data completeness criteria threshold from 70% to 75% for the 2024 and 2025 performance years; and add nine quality measures.

TMA Response

While, TMA is generally supportive of the measure changes and the push for data completeness, we remain concerned about annual changes to the program that add to physician burden. The data collection for the quality category is a full year, which leaves physicians little time to prepare for any changes expected to be implemented by Jan. 1. CMS should consider a phased-in approach that gives physicians time to prepare. Additionally, CMS should provide practice support as physicians acclimate to the required changes.

Updates to the MIPS Cost Category

Summary

CMS proposes to update the operational list of care episodes and patient condition groups and codes by adding the Medicare Spending Per Beneficiary Clinician cost measure as a care episode group.

TMA Response
TMA is generally supportive of the proposed changes to the MIPS Cost Category but continues to caution CMS about the complexities of a continuously changing program. TMA urges CMS to only make necessary updates to the Quality Payment Program that are proven to improve care while reducing physician cost and burden.

Updates to the MIPS Improvement Activities Category
Summary
CMS proposes adding four new activities, modifying five, and removing five existing categories from the inventory. CMS believes the new and modified categories help fill identified gaps and seek to ensure that activities reflect current clinical practice. The proposed activities related to the CMS Six Health Equity Priorities for Reducing Disparities in Health are responsive to the administration's goal of advancing health equity for all.

TMA Response
TMA appreciates CMS' efforts to address health equity and identify social determinants of health as these efforts mirror some of TMA's work. However, we do remain concerned with physician burden as the MIPS program continuously changes requiring physicians to review any previously used activities to determine continued existence and updated requirements.

Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development – Request for Information (RFI)
Summary
Within the Medicare Shared Savings Program (MSSP) and MIPS sections, CMS discusses the use and adoption of social determinants of health (SDOH) quality measures.

TMA Response
TMA steadfastly supports CMS including these measures, and the association called for their use in a letter to CMS sent earlier this year.

At TMA, we recognize that social determinants of health (SDOH) have a profound impact on patients and the physicians who care for them, especially in the wake of COVID-19. These proposed SDOH measures signal that CMS has begun to recognize and address the significant impact that social drivers of health have on health disparities, outcomes, and costs. Additionally, social drivers impact the patient-physician relationship and the economics of clinical practice.

Specifically, we strongly recommend that CMS adopt the "Screening for Social Drivers of Health" measure in the quality performance category measure set for the Merit-Based Incentive Payment System (MIPS) for the reasons cited by the agency. Likewise, we encourage CMS to apply to MIPS the same "Screen Positive Rate for Social Drivers of Health" measure. We also urge CMS to include both the "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" measures in the APM Performance Pathway (APP) measure set so they can be incorporated into MSSP.

Currently, physicians are not paid for the social drivers of health screening. For physicians taking care of patients with greater social risk, their practice costs are higher, which negatively impacts their performance scores because risk-adjusted cost benchmarks are not considered in payment,

which impedes appropriate investments in the community resources necessary to improve the health of patients.

TMA strongly supports these SDOH measures, for MIPS and MSSP, as an essential step to advance CMS' stated commitment to equity and to enact measures that matter to patients and physicians.

Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program

Summary

CMS proposes to move the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure from optional to required while maintaining the value at 10 points. CMS also proposes to expand the PDMP query to include not only Schedule II opioids, but also Schedules III and IV prescriptions. CMS offers exclusions to physicians who prescribe fewer than 100 eligible prescriptions during the 90-day performance period or to those who are unable to electronically prescribe schedules II, III, and IV medications in accordance with applicable law.

TMA Response

PDMP has been successfully implemented in most states and works well within the physician's workflow for those physicians who continue to pay for integrated access. Texas paid for integrated access for prescribers for the first two years of the program and then discontinued funding. This left physicians with an unfunded mandate for an epidemic. Physicians should not be expected to bear the ongoing costs of PDMP access. There have been significant opioid settlement funds that can easily offset the cost of integrated access.

Health Information Exchange Measure

Summary

CMS proposes to add a new Health Information Exchange (HIE) Objective option to enable exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure (requiring a yes/no response). This would be in addition to two existing options: 1) report on both support electronic referral loops by sending and receiving (and reconciling) health information; and 2) report on the bidirectional exchange measure.

TMA Response

TMA appreciates and agrees with CMS providing an additional HIE measure. This will help heighten awareness about TEFCA and the connection among qualified health information exchanges and connected networks to further expand access to patient information. However, TMA cautions CMS to monitor HIE interface fees. While HIEs charge nominal subscription fees, TMA still hears reports of electronic health record (EHR) vendors charging in excess of $5,000 for interface fees. CMS should consider an exclusion for the HIE measure when total cost of joining an HIE exceeds $1,000.

Public Health and Clinical Data Exchange Objective

Summary

CMS proposes to consolidate the current options from three to two levels of active engagement for the Public Health and Clinical Data Exchange Objective, and to require the reporting of active engagement for the measures under the objective. CMS also proposes a revision to the definition of active engagement with a public health agency (PHA).

TMA Response

TMA believes both of the public health data exchange proposals are reasonable, as long as the correlating exclusions are maintained. Not all PHAs received adequate funds to meet these technical requirements. Additionally, some EHR vendors have not made the public health connections a priority due to a patchwork of state laws that also require technical compliance. TMA urges CMS to always consider these types of issues so that physicians and other eligible clinicians are not caught between technical capabilities and regulatory compliance. Many practices do not have the resources to employ technical experts, which means the burden falls to physicians and staff who are already unduly burdened. The ability to connect to PHAs should come at no cost to physicians and with low technical effort.

Patient Access to Health Information Measure – Request for Information (RFI)

Summary

CMS recognizes that a patient's health information may be found in multiple portals and is interested in ways CMS or the Department of Health and Human Services can facilitate individuals' ability to access all their health information in one place.

TMA Response

For years and in numerous comment letters, TMA has warned that requiring each physician to maintain a portal with access for each patient fragments the information that patients need to make health care decisions. If a patient with chronic conditions sees numerous physicians, then that patient must remember log-ins and passwords for each practice. This quickly becomes overly burdensome and is neither safe nor effective for the patient. TMA has adopted the following policy on personal health records that CMS should consider:

> Personal Health Records
> 1. TMA supports the use of personal health records (PHRs) by individuals and families.
> 2. TMA supports the concept that patients should be able to use their PHR as a source of information regarding their medical status.
> 3. PHRs need standardized formats that contain at minimum core medical information necessary to treat the patient.
> 4. TMA supports legislative efforts directed at providing incentives to facilitate PHR use and maintenance.
> 5. Physicians should be able to access PHR-released information free of charge.
> 6. TMA supports interoperability of PHRs allowing access to patient health information in patient-care settings.
> 7. TMA supports ensuring that the source of information in PHRs is clearly identifiable. Primary care physicians could be incentivized to take a unique docent role as they encourage and help patients with PHR use.

Health application program interfaces (APIs) are being created and launched by various application developers as a way to compile patient information in one place from disparate sources. If CMS encourages the use of APIs, TMA strongly recommends that industry efforts to develop standardized terms of service with strong privacy provisions are supported. Application providers should be required by HHS' Office of Civil Rights to adhere to these privacy provisions, and patients should be able to rely on the provisions as acceptable. Additionally, TMA recommends that CMS work closely with Office of the National Coordinator (ONC) so patient access efforts align with the 21st Century Cures Act.

As CMS considers regulations related to patient access, evidence-based studies should be performed to identify patient engagement tools and activities that improve quality of care and to analyze the resource costs of implementing those tools. An analysis of the cost-benefit for each tool/activity should be conducted when prioritizing initiatives. Physicians are used to this type of due diligence, as that is what they expect to see from clinical trials regarding new treatments that require them to make practice changes. Although physicians have a role in engaging patients to take a more active role in their health care, the burden of that role varies widely from physician to physician and from practice to practice. It is dependent on many factors, including the socioeconomic and severity-of-illness profiles of each physician's patient population. This disparity makes it difficult to fairly incentivize physicians for the variable amount of work they would have to do to increase patient engagement. TMA recommends a strategy that provides physicians with support to incorporate within their practice the patient engagement tools and activities that are shown to improve quality of care based on evidence-based studies and cost-benefit analyses.

Telehealth Indicator

Summary

CMS proposes adding a telehealth indicator on Medicare Compare to the profile of physicians who use and bill for telehealth services. Using a six-month lookback period, CMS would identify clinicians who perform telehealth services using place-of-service code 02 (indicates telehealth) or modifier 95 appended on paid claims. Profiles would be updated bi-monthly which is the same cadence with which other information is updated on Medicare Compare.

TMA Response

TMA agrees with CMS' proposal to add a telehealth indicator on Medicare Compare for physicians who provide telemedicine services. This information would be helpful to patients and would help physicians inform their patients that telemedicine visits are available. Further, TMA agrees with the methodology CMS proposes in determining which physicians are providing telemedicine services.