American College of Physicians
Leading Internal Medicine, Improving Lives

December 20, 2023

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

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program [RIN 0938-AV07]

Dear Administrator Brooks-LaSure,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of final rulemaking regarding changes to the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP), and other federal programs for Calendar Year (CY) 2024 and beyond. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We have summarized a subset of recommendations at the onset of this letter that reflect our top priority areas. Detailed explanations for each of these recommendations are included in the main text of the letter. Additional information can also be found in our comments on the CY24 PFS proposed rule. The College is confident that these recommended changes would improve the strength of these policies and help to promote access to affordable care for Medicare patients, support efforts to improve health equity, support physicians' ability to deliver innovative care, and protect the integrity of the Medicare trust funds. The College understands that CMS is not statutorily required to provide a public comment period for a notice of final rulemaking, and we appreciate CMS taking the time to consider our feedback for CY24 and beyond. We look forward to continuing to work with CMS to implement policies that support and improve the practice of internal medicine.

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Summary of Top Priority Recommendations

- **Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation, HCPCS Code G2211:** ACP is highly pleased to see CMS implement the Medicare billing code, G2211. ACP is disappointed that G2211 will impact the conversion factor, there currently exist significant distortions in the PFS that have existed for many, many years.
- **Split/Shared Visits:** The College is very pleased to see that CMS recognizes that when the physician participates and meaningfully contributes to the MDM – even if the physician does not perform the MDM in its entirety – or when the physician meets the time threshold, then the physician should be considered to have performed the substantive portion of the visit.
- **Services Addressing Health-Related Social Needs (Community Health Integration services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services):** ACP appreciates the agency's finalizing the proposal to expand equitable access to care and link underserved communities with critical social services in the community. The College continues to recommend that CMS permit patient consent for CHI services to be obtained via telephone.
- **Social Drivers of Health (HCPCS Code G0136):** ACP is also pleased to see the implementation of CMS' proposal to include coding and payment (HCPCS code G0136) for SDOH risk assessments.
- **Principal Illness Navigation Services (HCPCS Codes G0023 and G0024):** ACP is highly supportive of CMS' proposal for inclusion of Principal Illness Navigation codes G0023 and G0024.
- **Direct Supervision via Use of Two-way Audio/Video Communications Technology, including Supervision of Residents in Teaching Settings:** The College is disappointed that CMS is not making the direct supervision flexibility permanent.
- **Updates to Supervision Requirements for Behavioral Health Services furnished at RHCs and FQHCs:** We are pleased that CMS finalized changes to the required level of supervision for behavioral health services furnished "incident to" a physician or NPP's services at RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS for CY 2023.
- **RHCs and FQHCs Conditions for Certification of Coverage (CfCs):** ACP appreciates the finalized revisions to the Conditions for Certification and Conditions for Coverage (CfCs) for Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) to include Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) as part of the collaborative team approach to provide services under Medicare Part B and to include definitions of other healthcare professionals who are already eligible to provide services at RHCs and FQHCs.
- **Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Program (OTPs)**: We are extremely pleased that CMS finalized the proposed flexibilities for OTPs' use of telecommunications through the end of CY2024.
- **Medicare Sharing Savings Program (MSSP)**: ACP is supportive of several finalized CMS policies which aim to support practices who are inexperienced with value-based payment and/or performance-based risk.
    - **Qualifying Participant (QP) Determination:** ACP is pleased that CMS did not finalize their proposal to make Qualifying Alternative Payment Model (APM) Participant (QP) determinations at the individual clinician level.
    - **Risk Adjustment Methodology:** ACP is pleased with finalized changes aimed to encourage participation by ACOs caring for medically complex, high-cost beneficiaries including the elimination of a downward adjustment for ACOs that would face a negative overall adjustment with the previous methodology.

    - **Certified Electronic Health Record (CEHRT) Threshold:** ACP is incredibly disappointed that against the recommendations of ACP and others, CMS finalized the policy requiring reporting of the Promoting Interoperability performance category for all MSSP participants.
    - **Medicare Clinical Quality Measure (CQM):** ACP is supportive that CMS finalized their proposal that ACOs reporting Medicare CQMs will be eligible for the health equity adjustment to their quality performance category score when calculating shared savings payments.
    - **Hybrid Model:** The College is pleased to see the highlighting of a potential hybrid model within the MSSP. ACP strongly encourages CMS to continue to engage with patients, physicians, and other health care professionals when moving forward with the design and implementation of a hybrid approach to paying for primary care in the MSSP.
- **Medicare Diabetes Prevention Program (MDPP)**: ACP is pleased to see the increased MDPP flexibilities included in this final rule, such as alternatives for in-person weight measurements and the elimination of the cap on the number of services that may be provided virtually.
- **Updates to the Quality Payment Program (QPP)**
    - **APMs:** ACP continues to urge Congress to pass legislation that would extend the APM Incentive Payment and replace these differential CF updates with an inflation-based update for all physicians.
    - **Traditional MIPS:** ACP is grateful that CMS did not finalize the proposed change to raise the performance threshold from 75 points to 82 points. ACP is pleased that CMS did not finalize an increase to the data completeness threshold for the 2027 performance period.
- **Performance Measures**
    - <u>New Quality Measures Proposed for the CY24 Performance Period</u>
        - *Preventive Care and Wellness (composite)*: ACP is disappointed with the finalization of the preventive care and wellness composite and urges CMS to remove this measure from MIPS.
        - *Gains in Patient Activation (PAM) Scores at 12 Months*: ACP remains concerned about the broad applicability of the measure as well as the feasibility and implementation burden the measure would pose.
    - <u>Quality Measures Proposed for Removal in the CY24 Performance Period</u>: ACP is disappointed CMS finalized the removal of Q107 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment and Q110 Preventive Care and Screening: Influenza Immunization; these measures are evidence-based, methodologically sound, and clinically meaningful. ACP is pleased that CMS finalized the removal of Q111 Pneumococcal Vaccination Status for Older Adults, Q324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients, and Q391 Follow-Up After Hospitalization for Mental Illness (FUH).
- **MIPS Value Pathways (MVPs) Development and Maintenance**
    - <u>Value in Primary Care MVP</u>: ACP is incredibly disappointed that CMS finalized their proposal to consolidate the previously finalized Promoting Wellness and Optimizing Chronic Disease Management MVPs into the single consolidated "Value in Primary Care" MVP.
- **Transforming the Quality Payment Program /Advancing CMS National Quality Strategy Goals**
    - <u>Increasing Alignment Across Value Based Programs</u>: ACP supports CMS' Universal Foundation initiative.

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation, HCPCS Code G2211
ACP is highly pleased to see CMS implement the Medicare billing code, G2211. The G2211 code will improve Medicare beneficiaries' access to high-quality, continuous care and help sustain the physician practices beneficiaries rely on for comprehensive health care.

Primary care office visits include the provision of patient-centered, integrated, and community-aligned services to achieve better health and better care at lower costs. Evidence clearly demonstrates that primary care O/O E/M visits are more complex, comprehensive, and impactful than other E/M visits. ACP goes into greater depth in the forthcoming section, Request for Comment About Evaluating E/M Services More Regularly and Comprehensively, but we strongly believe the existing CPT and RUC methodologies and processes for describing and valuing E/M services do not adequately account for the complexity and intensity of E/M visits. G2211 is intended to be billed with codes for O/O E/M visits to better account for the unique and inherent complexity of services provided through longitudinal patient care that is based on a physician or clinician's ongoing relationship with a patient. While the revisions to the O/O E/M codes better account for the work in these services, the CPT and RUC processes focus on the "typical" patient prohibits the capture of added complexity beyond the typical. Accordingly, the College believes there remains a gap in office-based coding in the PFS that can be filled by implementation of G2211.

ACP is confident G2211 will help capture the added complexity of primary care O/O visits and support the provision of longitudinal care. The increased complexity of care provided by internal medicine and family medicine physicians is consistent with their expanding role in managing multiple chronic problems, working with limited evidence, balancing multiple guidelines, and coordinating care with multiple physicians.

ACP is disappointed that G2211 will impact the conversion factor, there currently exist significant distortions in the PFS that have existed for many, many years. **The College believes it could be argued that the impact from G2211 would be substantially outweighed by addressing the fact that the majority of visits in the global period are not being furnished but are paid for, nonetheless.**

As evidenced by the 2019 RAND report, the vast majority (ratio = 0.04) of expected post-operative visits for procedures with 10-day global periods are not delivered. Among procedures with 90-day global periods, the ratio of observed to expected post-operative visits provided was 0.38. In an additional analysis of the 2019 claims data, RAND's adjustment to work RVUs, physician time, and direct PE inputs resulted in a 2.6% net reduction in RVUs across all PFS services. At the 2019 conversion factor, this reduction equals $2.5 billion in Medicare allowed amounts. Though several factors impact what the true cost savings would be, at a minimum, the conversion factor would increase, and payments could be redistributed across all physicians' services.

ACP understands that there are several important distributional implications with this revaluation approach. The College is careful to not diminish these, but the resounding point is that the overvaluation of procedures with 10-day and 90-day global periods leads to overpayment by Medicare, inflated beneficiary cost-sharing burden, and distorted incentives for practitioners to overprovide these services, with further implications for Medicare payments and beneficiary costs and health. The College commends CMS for initiating discussions regarding the global periods and we strongly encourage the agency to improve the accuracy of valuation of these global periods and redistribute potential savings to Medicare by moving forward.

Split/Shared Visits
The College is very pleased to see that CMS recognizes that when the physician participates and meaningfully contributes to the MDM – even if the physician does not perform the MDM in its entirety – or when the physician meets the time threshold, then the physician should be considered to have performed the substantive portion of the visit. ACP believes this would best account for the physician's contributions in collaborating with the AP, particularly when involved in cases with greater complexity. The recommended approach also encourages APs to work to the top of their license, consulting with the physician when the situation is particularly difficult. In these situations, the physician is performing the key component of the visit and has meaningfully contributed, though not necessarily spending more than half of the total time.

Community Health Integration (CHI) Services (HCPCS Codes G0019 and G0022)
ACP appreciates the agency's finalizing the proposal to expand equitable access to care and link underserved communities with critical social services in the community. This closely aligns with the principles and recommendations in ACP's 2022 policy paper on Reforming Physician Payments to Achieve Greater Equity and Value in Health Care, as well as our 2022 policy paper on Addressing Social Determinants to Improve Patient Care and Promote Health Equity.

CHI services help address unmet social drivers of health (SDOH) needs that affect a patient's diagnosis and treatment. To ensure these needs are considered across the continuum of patient care, we recommend that these services be documented in the medical record. For purposes of data standardization, the College recommends that physicians and other practitioners be encouraged to use the ICD-10 codes from categories Z55-Z65 in the medical record and on the claim. ACP additionally agrees that a substantial portion of the work involved in furnishing these services and the SDOH risk assessment could be done in person, but some could also be performed over the phone. For this reason, the College continues to recommend that CMS permit patient consent for CHI services to be obtained via telephone.

Social Drivers of Health (HCPCS Code G0136)
ACP is also pleased to see the implementation of CMS' proposal to include coding and payment (HCPCS code G0136) for SDOH risk assessments. By providing for separate coding and payment for these services, physicians and other practitioners will be able to better account for the time and resources spent on assessments that ultimately impact patient care. Since SDOH needs undoubtedly impact patient care, the College also supports the agency's recommendation to make the SDOH assessment optional in a patient's annual wellness visit.

Principal Illness Navigation Services (HCPCS Codes G0023 and G0024)
ACP is highly supportive of CMS' proposal for inclusion of Principal Illness Navigation codes G0023 and G0024. In alignment with the Administration's shared commitment to improving care management and coordination, these codes support physicians and other trained auxiliary personnel in improving critical transitional care for patients with serious illnesses. In the College's recent paper Beyond the Discharge, ACP highlighted the impact of care coordination efforts on improving the quality of patient care, particularly for those with multiple chronic conditions.

Direct Supervision via Use of Two-way Audio/Video Communications Technology, including Supervision of Residents in Teaching Settings

The College is disappointed that CMS is not making the direct supervision flexibility permanent and is instead proposing to cease defining direct supervision to allow the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications after December 31, 2024. Disappointingly, CMS is also proposing to revise regulatory text so that, after December 31, 2024, the presence of the physician (or other practitioner) will not include virtual presence through audio/video real-time communications technology. We recommend that CMS retain current policies in the CY 2025 PFS rule.

There are a number of robot-assisted surgeries that are performed with the surgeon sitting at the console manipulating robotic arms (attached to the surgical instruments) with the use of hand and foot controls. These procedures are much more invasive than supervising residents via real-time two-way audio/video communications.

In previous comments to CMS, ACP advocated for the permanency of direct supervision flexibility based on our belief that doing so would support the expansion of telehealth services and protect frontline healthcare workers by allowing for appropriate social distancing measures. While social distancing may no longer be a chief concern, the College still believes that clinicians should feel empowered to supervise clinical staff virtually, at their discretion, regardless of whether there is a PHE, as we previously stated.

The College remains concerned that the expiration of the direct supervision flexibility means that supervision will be required to happen synchronously, which the College continues to oppose. Such a requirement places an extra onus on the preceptor/supervisor to be in the same vicinity as the supervisee (i.e., the resident or fellow the physician is supervising). ACP strongly believes that direct supervision does not have to be synchronous and there is no reason to require synchronous direct supervision.

Updates to Supervision Requirements for Behavioral Health Services furnished at RHCs and FQHCs

We are pleased that CMS finalized changes to the required level of supervision for behavioral health services furnished "incident to" a physician or NPP's services at RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS for CY 2023. ACP is similarly pleased that CMS finalized revisions to regulations at §§ 405.2413 and 405.2415 to reflect that behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or another practitioner).

RHCs and FQHCs Conditions for Certification of Coverage (CfCs)

ACP appreciates the finalized revisions to the Conditions for Certification and Conditions for Coverage (CfCs) for Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) to include Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) as part of the collaborative team approach to provide services under Medicare Part B and to include definitions of other healthcare professionals who are already eligible to provide services at RHCs and FQHCs. These changes will help resolve lingering questions and the lack of clarity on the eligibility of certain health care professionals to provide services in these contexts. ACP is also appreciative of revisions to the CfCs that include MFT and MHC services to indicate that RHC and FQHCs can offer these services under their Medicare certification. These changes will advance access to behavioral health services and better support whole-person care, inclusive of patients' emotional and mental well-being.

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

We are extremely pleased that CMS finalized the proposed flexibilities for OTPs' use of telecommunications through the end of CY2024. These flexibilities, which permit audio-only periodic assessments for patients receiving buprenorphine treatment via OTPs when audio-video communication capabilities are not available to the Medicare enrollee and if SAMHSA and DEA requirements are met, will ensure continued accessibility to these services beyond the COVID-19 public health emergency.

Medicare Sharing Savings Program (MSSP)

ACP is supportive of several finalized CMS policies which aim to support practices who are inexperienced with value-based payment and/or performance-based risk. Policies providing up to seven years in upside-only tracks for ACOs inexperienced with performance-based risk, allowing ACOs currently in upside-only tracks (Tracks A and B) to remain in upside-only for the duration of their agreement, and making the Enhanced Track optional each address previously expressed concerns of feasibility and sustainability of these programs. For a meaningful and advantageous move to value-based payment, CMS and other payers must invest in practices upfront and throughout the infrastructure and learning processes.

Qualifying Participant (QP) Determination

ACP is pleased that CMS did not finalize their proposal to make Qualifying Alternative Payment Model (APM) Participant (QP) determinations at the individual clinician level. CMS will continue to make these determinations at the APM Entity/group level for the 2024 performance period.

Risk Adjustment Methodology

ACP is pleased with finalized changes aimed to encourage participation by ACOs caring for medically complex, high-cost beneficiaries including the elimination of a downward adjustment for ACOs that would face a negative overall adjustment with the previous methodology. Due to the impacts of finalized changes including new codes added to the Primary Care calculation and an extended 24-month lookback window, CMS projects a 2.9% increase in beneficiary participation which supports ACP and CMS' shared interest in increasing access while shifting to value.

Certified Electronic Health Record (CEHRT) Threshold/ Promoting Interoperability

ACP is incredibly disappointed that against the recommendations of ACP and others, CMS finalized the policy requiring reporting of the Promoting Interoperability performance category for all MSSP participants. While this policy has been delayed to 2025, along with public reporting requirements for this data, ACP remains unsupportive. The reporting of this category will add significant physician burden and directly conflicts with the transition away from MIPS that APM participation is suggested to provide. In order to successfully transition to value-based payment, CMS must properly incentivize participation in APMs including the MSSP program. This finalized proposal vehemently goes against that goal.

We are pleased that CMS finalized lengthening the performance period for this category from 90 days to 180 days. We are also pleased that the revised definition of CEHRT was finalized to be consistent with the "edition-less" approach to health IT certification as proposed in the ONC HTI-1 proposed rule.

Medicare Clinical Quality Measure (CQM)

ACP is supportive that CMS finalized their proposal that ACOs reporting Medicare CQMs will be eligible for the health equity adjustment to their quality performance category score when calculating shared savings payments. ACP also supports the finalization of CMS' proposal to revise § 425.512(b) to specify that, for performance years 2024 and subsequent performance years, we will calculate a health equity adjusted quality performance score for an ACO that reports the three Medicare CQMs or a combination of eCQMs/MIPS CQMs/Medicare CQMs in the APP measure set, meeting the data completeness requirement at § 414.1340 for each measure, and administers the CAHPS for MIPS survey (except as specified in § 414.1380(b)(1)(vii)(B)).

Hybrid Model

The College is pleased to see the highlighting of a potential hybrid model within the MSSP. ACP, alongside other groups interested in appropriate payment for primary care, have outlined various principles that we believe would promote success in such program. These principles include that:

- Equity considerations must be embedded in the hybrid payment option.
- There will be added value for the Medicare beneficiary.
- The option must result in increased investment in primary care.
- The option must be fully voluntary.
- The option must be available rapidly and in all geographies.
- Implementing this option will create additional value for Medicare.

ACP strongly encourages CMS to continue to engage with patients, physicians, and other health care professionals when moving forward with the design and implementation of a hybrid approach to paying for primary care in the MSSP. To promote the widest participation, the model's design must provide primary care practices with assurance that they will share directly in additional financial incentives. Meaningful participation of primary care clinical leaders in ACO governance is one powerful means to that end and should be incorporated into the model. We thank CMS for the acknowledgment of the value of prospective population-based payment and look forward to working with the Agency on developing this model further.

Medicare Diabetes Prevention Program (MDPP)

ACP is pleased to see the increased MDPP flexibilities included in this final rule, such as alternatives for in-person weight measurements and the elimination of the cap on the number of services that may be provided virtually. The conversion to a hybrid payment structure, which pays for attendance on a fee-for-service basis and diabetes risk reduction (i.e., weight loss), is also welcome. ACP supports the finalization of the new G-code for MDPP services provided virtually. Alongside the aforementioned flexibility extensions, this new G-code will allow for improved data collection on the effectiveness of virtual services.

Updates to the Quality Payment Program (QPP)

APMs

ACP continues to urge Congress to pass legislation that would extend the APM Incentive Payment and replace these differential CF updates with an inflation-based update for all physicians.

Traditional MIPS

ACP is grateful that CMS did not finalize the proposed change to raise the performance threshold from 75 points to 82 points. This change could have led to a higher number of MIPS-eligible clinicians facing penalties and a potential payment reduction of up to nine percent.
Furthermore, **ACP is pleased that CMS did not finalize an increase to the data completeness threshold for the 2027 performance period**. The data completeness criteria will be maintained at 75% for the 2026 performance period.

Performance Measures

New Quality Measures Proposed for the CY24 Performance Period

Preventive Care and Wellness (composite)

ACP is disappointed with the finalization of the preventive care and wellness composite. ACP urges CMS to remove this measure from MIPS. ACP does not support the combination of individual MIPS preventive measures into a composite measure. The benefit of this measure is questionable. There has long been an argument in the performance measurement community about the value of composite measures in both assessing performance and identifying areas for improvement. While composite measures gained favor because they offer the promise of providing a clearer picture of overall performance, they should not be used alone. Rather, they should be a complement to individual measures when profiling and creating incentives for improvement. Each one of the measures assess important aspects of prevention and detection of disease (i.e., addressing influenza immunization, pneumococcal immunization, breast and colorectal cancer screening, body mass index screening, tobacco use screening and cessation intervention, and screening for high blood pressure with follow-up). While all of them were reviewed by ACP's Performance Measurement Committee (PMC), four out of seven measures were supported by the PMC. The most common reasons that the other three measures were not supported included concerns related to evidence, feasibility, and unintended consequences.

Gains in Patient Activation (PAM) Scores at 12 Months

Though ACP expressed a recommendation against adding this measure to MIPS, CMS finalized the addition of this measure. ACP remains concerned about the broad applicability of the measure as well as the feasibility and implementation burden the measure would pose. The PMC describes some positives about the design of the measure including looking at a change score and excluding patients who would clearly not be eligible for the measure. However, PMC feels that the measure would be better if it applied to a narrower set of patients. As it is, the measure does not account for patient preference and the instances where a patient may not need activation such as a sore throat or a sprained ankle. This can be burdensome to operationalize and would be very difficult to adopt into a practice that does not already have a robust system to support patient engagement, patient activation, and patient-centered experiences. It can be difficult for physicians to integrate this into their workflow. In addition, the developers state that PAM scores are higher for people who have good to excellent health. They also acknowledge lower scores for a vast majority of patients that make up an internal medicine physician's patient population (i.e., sicker patients, patients older than 75, the uninsured, Medicaid and Medicare patients). As a result, the performance scores would likely skew lower for internal medicine physicians. Due to these concerns, ACP recommended that CMS not move forward with the proposal to add this measure to MIPS.

Quality Measures Proposed for Removal in the CY24 Performance Period

ACP is disappointed CMS finalized the removal of Q107 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment and Q110 Preventive Care and Screening: Influenza Immunization; these measures are evidence-based, methodologically sound, and clinically meaningful.

ACP is pleased that CMS finalized the removal of Q111 Pneumococcal Vaccination Status for Older Adults, Q324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients, and Q391 Follow-Up After Hospitalization for Mental Illness (FUH). These measures were not supported by the PMC for a number of reasons including reliability and validity concerns as well as unintended consequences.

MIPS Value Pathways (MVPs) Development and Maintenance

Value in Primary Care MVP

CMS finalized 5 new MVPs, and modifications to all previously finalized MVPs. There will be a total of 16 MVPs available for reporting in the 2024 performance period.

ACP is incredibly disappointed that CMS finalized their proposal to consolidate the previously finalized Promoting Wellness and Optimizing Chronic Disease Management MVPs into the single consolidated "Value in Primary Care" MVP. The combination of the two MVPs into one seems to minimize the work of internal medicine physicians and the complexities of both prevention and early identification of disease AND the management of chronic conditions. Preventive services are focused on living well and most often provided annually during physical exams or wellness visits. On the other hand, effectively managing chronic disease involves routine visits with a primary care clinician focused on improving symptoms and getting well. Given the distinction between these two critical aspects of a primary care clinician's practice, the unique challenges with the focus of each of these services, and their frequency/timing, we strongly believe this consolidation is a disservice to primary care.

Transforming the Quality Payment Program /Advancing CMS National Quality Strategy Goals

Increasing Alignment Across Value-Based Programs

CMS finalized a total of 198 quality measures in the quality measures inventory and 106 improvement activities in the MIPS inventory. Additionally, CMS finalized five new episode-based cost measures, each with a 20-episode case minimum, in addition to the existing measures.

ACP supports CMS' Universal Foundation initiative. Aligning the most important adult and pediatric performance measures across CMS programs will help to identify measurement gaps and disparities in care. However, some of the adult performance measures in the Universal Foundation are flawed and do not have testing data available. ACP strongly believes a performance measure should be tested at the level of attribution it is applied to when used in accountability and payment programs. ACP's Performance Measurement Committee (PMC) applies a RAND-modified process to evaluate measures based on five criteria: importance, appropriate use, evidence, measure specifications, and feasibility.10 ACP is hopeful that we will see a more objective process in the selection of measures for CMS programs, including the former MAP process and CBE endorsement. We are encouraged to learn of some of the

improvements that are planned which should ensure that measures receive greater scrutiny and that criteria are applied more consistently and without bias. For more detailed information on specific universal foundation measure positioning, please refer to ACP's comments on the PFS proposed rule.

Conclusion

Thank you for the opportunity to provide feedback on CMS' finalized policy regarding changes to the CY24 PFS and QPP. ACP is confident these recommended changes would improve the strength of these policies and help promote access to affordable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We look forward to continuing to work with CMS to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Ph.D., Director, Regulatory Affairs for the American College of Physicians, at boutland@acponline.org or (202) 261-4544 with comments or questions about the content of this letter.

Sincerely,

Jason M. Goldman, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians