Conversion Factor

(clinical labor, equipment prices, and medical supplies) simultaneously at least once every five years.

accuracy of the overall PE methodology. We appreciate CMS contracting with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs to implement updates under the PFS. It is essential that CMS and the RAND Corporation work with medical societies and organizations to ensure all aspects of these efforts are well-informed from the perspective of physicians, patients, and those charged with facilitating the provision of high-quality care.

ACP supports CMS's suggestion to establish a cycle of timing to update inputs every four years but questions why these updates would be limited to supply and equipment costs. Advancing shared goals of stability and predictability must include consideration of clinical labor alongside supply and equipment costs. If recurring updates to all PE costs do not occur uniformly, there is the unintended consequence of distortions in allocations, and true costs will continue to differ drastically from payment under the PFS. CMS should focus not only on supply and equipment costs but also on methodological refinements that update all PE costs. We also urge CMS to consider how failures to update PE costs routinely impact independent physician practices that are typically less resourced than large health systems, resulting in an increasing share of physicians being employed and shifting the dynamics in medicine.

We also strongly recommend CMS consider PE costs not currently captured under the PFS, such as AI-related medical services. The AMA's Digital Medicine Payment Advisory Group (DMPAG) is actively considering how AI medical services fit into the CPT code set, creating a terminology and taxonomy that charts a path to payment for AI-related medical services and procedures. Just as the DMPAG and medical societies are overcoming the limitations in the existing landscape, CMS must work to ensure resource costs are appropriately and adequately captured. ACP strongly urges CMS to consider these future developments in the context of its work with the RAND Corporation. It is essential that CMS, commercial payers, and others do not stifle innovation or these efficiencies but also appropriately contextualize and value the physician's work and intensity.

Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078,

January 1, 2025, unless Congress acts. There are significant concerns about maintaining access to care using Medicare telehealth services with the expiration of the statutory flexibilities that were successively extended by legislation following the PHE for COVID-19. Millions of patients have utilized interactive communications technology for visits with clinicians for a broad range of health care needs for almost five years. Patients have grown accustomed over several years to broad access to telehealth services. It is critical that Congress mitigate the negative impact of the expiring telehealth flexibilities, preserve access, and assess the magnitude of potential reductions in access and utilization.

ACP supports the expanded role of telehealth as a method of health care delivery that can enhance the patient-physician relationship, improve health outcomes, increase access to care from physicians and members of a patient's care team, and reduce medical costs. Telehealth can be an option for patients who lack access to in-person primary or specialty care due to various social drivers of health such as a lack of transportation or paid sick leave, or insufficient work schedule flexibility to seek in-person care during the day. Current telehealth flexibilities have been instrumental in improving access to care for patients across the U.S. ACP was pleased that the Consolidated Appropriations Act of 2023 extended many of these flexibilities through the end of CY 2024, helping ensure access to care. With these flexibilities set to expire, ACP has strongly urged Congress to pass the following bills.

S. 2016/H.R. 4189, , would permanently expand access to essential telehealth services, including expanding originating sites, lifting geographic

, G0446
, and G0447 , may be undervalued as their respective intensities may be lower than what is warranted for these services. ACP will work to ensure these codes undergo additional review to recognize the intensity of these services.

ACP also agrees with CMS's proposal to maintain the current 15 minutes of clinical labor time for HCPCS code G0442. It would not be typical for the clinical staff to administer the questionnaire, clarify questions as needed, and record the answers in the patient's electronic medical record in the RUC-recommended 5 minutes. For G0443, we support CMS's proposal to accept the RUC-recommended direct PE inputs without refinement.

As CMS considers how best to implement and maintain payment for preventive services and develop new payment policies in future rulemaking to address this issue more comprehensively, we urge CMS to work alongside medical societies and the RUC to ensure consistent access and adequate payment for these services.

Annual Depression Screening (HCPCS code G0444)

ACP supports CMS's proposal to adopt the RUC-recommended work RVU of 0.18 for HCPCS code G0444 . Like CMS's proposal for HCPCS code G0442, we agree with CMS's decision to maintain the current 15 minutes of clinical labor time, as it is not typical for the clinical staff to administer the questionnaire, clarify questions as needed, and record the answers in the patient's electronic medical record in the RUC-recommended 5 minutes. We believe that the current 15 minutes of clinical labor time would be more typical to ensure the accuracy of this screening procedure.

Behavioral Counseling & Therapy (HCPCS codes G0445, G0446, and G0447)

The College appreciates CMS's proposal not to adopt the RUC-recommended direct PE inputs for G0445

, G0446 (
, and G0447 .
Given the insufficient survey responses, ACP agrees that these changes are not substantiated. Low survey response rates are not unusual for RUC surveys, particularly among the primary care community, and we strongly urge CMS to consider this reality alongside future developments to the valuation process, given the potential for these under-representations to distort the RBRVS, with significant downstream consequences. ACP has regularly raised concerns about this and refers CMS to the College's comments on the CY 2024 PFS proposed rule and CMS's
.

Payment for Caregiver Training Services (CTS)

The College supports policy changes designed to improve the workforce of caregivers through comprehensive training and reimbursement. Adequately trained caregivers are essential to promoting

the health and safety of patients. Overall, the College believes that these proposed codes could be beneficial to both caregivers and patients. Still, we want to guarantee that the agency has a robust plan to educate caregivers about these new codes. This would ensure the adequacy and accuracy of payment for CTS. If these codes are finalized as proposed, CMS should closely monitor the uptake and utilization to guarantee that caregivers are supported and trained as intended.

We urge CMS to further partner with subspecialty and local physician organizations to focus on alignment and care coordination. The College has been highly supportive of the Guiding an Improved Dementia Experience (GUIDE) Model and the Patient-Centered Medical Home (PCMH) model of care, which focus on comprehensive care coordination and care management, as well as caregiver education and support. These models also work closely with subspecialists to improve patient experience and better manage complex, chronic conditions.

If these codes were finalized, ACP would also be concerned about their impact on private practices and implementation challenges. CTS could pose a cost concern in these practices, thus negatively impacting uptake and utilization.

RFI for Services Addressing Health-Related Social Needs (Community Health Integration (CHI) (G0019, G0022), Principal Illness Navigation (PIN) (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health (SDOH) Risk Assessment (G0136))

ACP appreciates CMS's initiative to introduce new G codes for CHI and SDOH risk assessment. CHI services are crucial in addressing unmet SDOH needs that significantly impact a patient's diagnosis and treatment. ACP recommends thoroughly documenting these services in the medical record and encourages using ICD-10 codes from categories Z55-Z65 for data standardization. Additionally, ACP recommends that CMS permit patient consent for CHI services via telephone, recognizing that some aspects of these services can be effectively performed over the phone.

ACP also supports introducing HCPCS codes for PIN services and PIN-Peer Support. These services are vital in guiding patients through complex health care systems, particularly those in underserved communities. ACP recommends that CMS consider the unique challenges practitioners face in these settings and provide clear guidelines to facilitate the effective delivery of PIN services. Additionally, ACP appreciates CMS's focus on clinicians in geographically isolated or underserved communities and recommends seeking feedback to better understand barriers and opportunities related to coding Z codes on claims for CHI, PIN, and SDOH risk assessment.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

ACP strongly supports CMS's proposal to refine its current policy for payment for the O/O E/M visits complexity add-on code, HCPCS code

The College supports CMS's efforts to align APCM services with other Medicare programs and initiatives, such as the MSSP and the QPP, including MIPS and Advanced APMs. This alignment reflects ACP's longstanding advocacy for integrated and streamlined health care delivery that reduces administrative burdens and enhances patient care continuity and access. The proposal to create a low-burden way for practitioners to furnish APCM services by appropriately recognizing how they may meet APCM billing requirements as part of these programs and initiatives is commendable. ACP appreciates CMS's initiative to seek feedback on duplication within the APCM service elements and practice capabilities they should consider addressing.

ACP also supports CMS's proposal to pay for APCM services under codes GPCM1, GPCM2, and GPCM3, as this will help primary care practices expand their services to meet patients' needs better. ACP suggests that bundling reimbursement for care management services into a monthly billable code that is not based on time is a positive step, addressing that E/M codes do not capture much of the care provided between patient visits. However, ACP recommends allowing consent for APCM services to be covered under the global consent used for E/M codes, as obtaining individual consent for nearly all patients would be logistically and ethically challenging. We also recommend CMS explore the option of offering yearly consent provided by the patient. Additionally, ACP suggests increasing the reimbursement of GPCM 2 from $50 to $65 and GPCM 3 from $110 to $125. GPCM 1 reimbursement must be increased to $56. Many practices have robust and effective transitional care management (TCM) programs and utilize the existing TCM codes to reimburse for the services. Under the proposed rule, for a patient with chronic conditions, the practice would be billing the APCM code whether that patient received TCM services that month or not. However, significantly more resources would be used for the patient receiving TCM services. The practice could not bill APCM that month for that patient and only bill TCM; then, the practice would not be receiving reimbursement for any other care management or interprofessional consultation services the patient receives. Alternatively, ACP suggests not including TCM services in the APCM bundle due to the significant resources required for TCM services and the

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Changes to the Medicare Telehealth Services List/Requests to Add Services to the Medicare Telehealth Services List

The College supports the streamlined, more straightforward process for the additions, deletions, and

The College is pleased to see that CMS proposes to continue to permit practitioners to use their practice locations instead of home addresses when providing telehealth services from the home through CY 2025. The College supports patients' and doctors' safety and privacy. We are pleased that CMS has considered this in the proposed rule and urge CMS to make this flexibility permanent.

Digital Mental Health Treatment (DMHT)

CMS is proposing Medicare payment to billing practitioners for DMHT devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. In previous comments to Congress, ACP highlighted that the number of individuals in need of mental or behavioral health services significantly increased during the COVID-19 pandemic and thereafter and that there have been significant, worsening shortages in available mental health clinicians across the country. CMS acknowledges that there has been limited access to behavioral health care due to clinician shortages ("[g]iven nationwide behavioral health workforce shortages combined with increasing demand for behavioral health care services, some Medicare beneficiaries may have limited access to these services"). Indeed, the latest available data from HRSA substantiates this problem and suggests it will only continue to worsen. Specifically, HRSA Workforce Projection data for behavioral health care workers indicate the total supply of this workforce is projected to decrease by 10% between 2024 and 2036, while the demand is projected to increase by 45%, resulting in only 53% adequacy by 2036.

ACP also previously highlighted that as the number of patients in need of treatment for mental health care has risen, the use of telehealth to access mental and behavioral health services has also increased and has proven to be an effective method of treatment. According to the Commonwealth Fund, "telemental health has a robust evidence base," and "numerous studies have demonstrated its effectiveness across a range of modalities (e.g., telephone, videoconference) and mental health concerns (depression, substance use disorders)." Digital behavioral health treatments improve the ability of the primary care and behavioral health workforce to deliver this much-needed care to more people regardless of their physical proximity to clinicians or treatment centers. Furthermore, major entities such as the

supports research and innovation to further integrate behavioral health into the primary care setting, and these devices can be helpful tools for comprehensive, whole-person care. If finalized, practitioners must be educated on these codes and the specific situations in which they can be used. Additionally, we want to ensure that DMHT devices are safe and beneficial for clinicians and patients. These devices do not always provide better health outcomes, and only high-quality, safe, and effective devices should be used.

We look forward to how DMHT devices are used to enhance care and are encouraged by CMS's development of these codes.

Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions

The College is extremely encouraged by CMS's proposal of six new G codes for all practitioners to bill for interprofessional consultations, and we are hopeful that this further promotes BHI. Access to behavioral health care remains limited for patients nationwide, and we urge CMS to continue expanding and

ACP policy supports lifting barriers that impede access to medications to treat opioid use disorder, including buprenorphine, naltrexone, and methadone. The ACP supports the proposed changes in section III.F.2 to permanently extend telecommunication flexibilities for periodic assessments, including the use of audio-only communications when two-way audio-video technology is not available to the beneficiary. We also support allowing OTPs to use audio-visual telecommunications under certain circumstances to initiate methadone treatment for any new patient for whom the OTP determines that an adequate patient evaluation can be accomplished via an audio-visual telehealth platform. These policies may help broaden access to OUD for beneficiaries facing transportation, scheduling, and other access barriers, as well as help achieve health equity for communities experiencing racial and ethnic disparities in OUD treatment access.

The ACP supports CMS's efforts to adjust payment rates to encourage higher uptake of SDOH risk assessments to better identify unmet health-related social needs and provide harm reduction and/or recovery support services. Generally, ACP supports policy and reimbursement interventions to enable physicians and other clinical care team professionals to address SDOH and identify unaddressed health-related social needs, like food insecurity, homelessness, and housing instability. CMS should provide financial, technical, and policy support to health care teams, including those providing care in OTPs, to assess SDOH-related risks during the patient visit.

Eligibility Requirements and Application Procedures

ACP supports CMS's proposal to update the antitrust language in the ACO application procedure and streamline the process of sharing ACO applications with the Federal Trade Commission (FTC) and the Department of Justice (DOJ) to hamper anti-competitive practices.

Proposed Revisions to the Definition of Primary Care Services

ACP supports CMS's proposed revisions to the definition of primary care as this will capture more of the services rendered by primary care physicians to Medicare beneficiaries. Further, this will improve capturing primary care utilization by Medicare beneficiaries and facilitate a more appropriate allocation of resources to support physicians delivering primary care.

Revised Payment Policies for Hepatitis B Vaccine Administration

CMS proposes expanding hepatitis B vaccinations to include those who have not completed a full

hepatitis B vaccinations in RHCs and FQHCs with the other Part B vaccines at 100% of reasonable cost. This streamlines the payment process for these vaccines, which should lead to a lower administrative burden and more time providing care for clinicians who administer vaccines. Allowing mass immunizers to use the roster billing process to submit hepatitis B claims should also minimize paperwork for practitioners. The College is encouraged by CMS's steps to reduce the administrative burden and expand access to preventive services.

Participant Definition

[illegible]

ACP recommends that CMS leverage administrative data, claims data, and EHRs to maintain up-to-date information on clinician affiliations and specialties. Utilizing the National Provider Identifier (NPI) and the Provider, Enrollment, Chain, and Ow0.00000mtdt ep0.004omfdd6 G[This streETtrePECOS TJ-2(c)4cLan-3(ll u)4(p)]ur)

integration between primary and specialty care. Additionally, ACP recommends that CMS design ambulatory specialty care models with features that gradually increase risk over time, ensuring these models can potentially qualify for Advanced APM status under the QPP.

Care Delivery and Incentives for Partnerships with Accountable Care Entities and Integration with Primary Care

ACP recommends that CMS consider additional model design features that incentivize primary and specialty care clinicians to enhance care coordination, such as shared savings programs and integrated care teams. ACP is pleased with the idea of encouraging specialist clinicians and accountable care entities to collaborate by establishing clear care pathways and protocols to optimize patient outcomes and ensure efficient resource utilization. ACP recommends identifying specialists engaged in care management and coordination through performance metrics and participation in care improvement activities. ACP also suggests defining clear expectations and performance metrics for specialists beyond current MVP measure sets to foster collaboration with ACOs and primary care clinicians, using levers like MIPS Improvement Activities to support closing the care loop. Additionally, ACP recommends that CMS account for variations between ACOs, such as ownership structure and regional healthcare landscapes, in the model design.

ACP is deeply concerned about increased consolidation and recommends measures to ensure integration efforts do not reduce competition or negatively impact healthcare quality and costs. Finally, ACP suggests that risk categorization of ACOs should influence incentive structures, with adjustments to accommodate different risk levels.

ACP has previously supported the medical neighborhood model (MNM) by recommending the MNM to the HHS Secretary, aiming to strengthen relationships between primary care specialists and other specialist physicians. Additionally, ACP has been a strong advocate for the PCMH model, emphasizing its potential to improve patient care and the viability of the health care delivery system. These past efforts align with ACP's current recommendations to CMS, which focus on enhancing care coordination, establishing clear care pathways, and fostering collaboration between primary and specialty care clinicians to optimize patient outcomes and resource utilization.

Health Information Technology and Data Sharing

ACP supports HHS's continued commitment to developing the policies, procedures, and technical framework to facilitate secure, seamless, and sustainable health information exchange to improve care across the entire care continuum. Effective, practical, and secure interoperability is crucial to improving the patient experience and the patient-physician relationship, reducing the burden on physicians and, in turn, improving the quality of care. The College believes that current efforts to improve interoperability, including the Trusted Exchange Framework and Common Agreement (TEFCA), still do not focus on the types of health information exchange needed for useful clinical management of patients as they transition through the health care system. Patients and clinicians need a seamless exchange of valuable, meaningful data at the point of care, the ability to incorporate clinical perspective, and the ability to query health IT systems for up-to-date information related to specific, relevant clinical questions. We

compliance threshold calculation from January 1, 2025, to January 1, 2028, would align EPCS Program compliance calculations to the date by which the NCPDP SCRIPT standard version 2017071 is retired and the new NCPDP SCRIPT standard version 2023011 is required for prescribers when electronically transmitting prescriptions and prescription-related information for covered Part D drugs for Part D eligible individuals, thereby reducing potential compliance challenges due to misaligned timelines.

ACP supports CMS's cohesive approach toward transforming the QPP. ACP is encouraged to see CMS continue to move forward with the Universal Foundation initiative in this proposed rule. While ACP has previously outlined flaws in some of the Universal Foundation measures, ACP agrees that smaller core measure sets are needed across the most common clinical conditions with the greatest impact on health outcomes. ACP believes this approach will go a long way toward streamlining reporting across public and private payer programs and, more importantly, easing the burden of measurement leading to burnout across the physician community.

ACP is pleased to see the development of new MVPs and important modifications to the maintenance process. CMS notes that if these six additional MVPs are finalized, 80% of specialties participating in the program would have applicable MVPs to report. ACP cautions that although broad MVPs are covering a specialty, e.g., gastroenterology, there are physicians who further subspecialize and to whom some or many of the measures may still not apply. CMS must work directly with the specialty groups and invested interested parties to ensure that MVPs are relevant to the practicing physicians and their patients.

As noted in ACP's comments from last year, ACP was disappointed to learn that CMS proposed consolidating the measures in Promoting Wellness and Optimizing Chronic Disease Management MVPs into a Value in Primary Care MVP through the 2024 proposed rule. As indicated, this modification was not included in the public-facing webinar. ACP appreciates the additional outreach opportunities being considered and believes that one webinar is insufficient for sharing proposed updates with the MVPs.

Prepaid Shared Savings and Health Equity Benchmark

ACP acknowledges CMS's efforts in proposing the new "prepaid shared savings" option and the Health Equity Benchmark Adjustment (HEBA) to incentivize ACOs to serve more beneficiaries from underserved communities. However, ACP recommends that CMS consider revising the allocation of prepaid shared savings. Instead of the proposed 50% to be spent on direct beneficiary services, ACP encourages CMS to allocate some of these funds directly to support primary care. Primary care is the cornerstone of health care and is crucial in improving beneficiaries' health outcomes, including those in underserved communities. By investing in primary care, ACOs can enhance preventive care, manage chronic conditions more effectively, and reduce health disparities.

ACP supports the idea of ACOs partnering with community partners to address the health-related social needs of their population. However, ACP also emphasizes the importance of strengthening primary care

infrastructure to achieve sustainable improvements in health equity. Therefore, we recommend that CMS revise the prepaid shared savings allocation to ensure a more significant investment in primary care. This approach would address immediate beneficiary needs and contribute to the long-term sustainability and effectiveness of the ACO model.

Quality Performance Category

ACP supports the 75% data completeness threshold but encourages consideration for smaller practices. We also commend the RFIs on CAHPS survey expansion and PROMs/PRO-PMs development, emphasizing the need for patient-centered measures

Measurement programs, particularly the MIPS program, include static measures, making it impossible to modify a measure as soon as new evidence becomes available. Although the numerator defines up-to-date as determined by the CDC recommendations, this definition cannot account for changing

Scoring the Quality Performance Category

ACP supports the removal of the 7-point score cap for topped-out measures in specialty sets, which should provide fairer scoring for clinicians with limited measure options. We also support the Complex Organization Adjustment for virtual groups and APM Entities, recognizing it as a necessary step to accommodate these organizations' unique challenges.

Scoring the Cost Performance Category

ACP approves the proposed cost performance scoring methodology changes, including the new cost measure exclusion policy, which will help prevent unfair penalization. Using a 75-point performance threshold based on historical scores is a balanced approach, but we emphasize the need for CMS to offer robust support for physicians adapting to these updates.

ACP appreciates CMS's decision to maintain the performance threshold at 75% for CY 2025. Maintaining this threshold provides stability and predictability for clinicians participating in the MIPS program, allowing them to adequately prepare and align their practices with the program's expectations. ACP is pleased that the data completeness threshold will remain at 75% until 2028.

Guiding Principles for Patient-Reported Outcome Measures in Federal Models, and Quality Reporting and Payment Programs Request for Information

ACP offers the following comments in response to the "Guiding Principles for Patient-Reported Outcome

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As noted in those reports and alluded to in this RFI, a PROM is distinct from a PRO-PM. A PROM is an instrument or tool to evaluate a PRO (e.g., PHQ-9 evaluates depressive symptoms and severity). However, a PRO-PM assesses the degree to which a patient's PROM score indicates better quality of care for the accountable entity.

We believe leveraging the NQF work completed in 2013 and 2021 is important, as described above. These reports detail what characteristics are necessary for a PROM to be included in a PRO-PM. While PROM selection for PRO-PMs has been studied and described, ACP has identified a significant lack of guidance regarding principles for PRO-PMs. As a result, it would be most useful to refer to the essential considerations for PROMs from previous reports. ACP urges CMS to focus its efforts on addressing the gap regarding the principles for developing PRO-PMs and considerations for including PRO