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Summary of Top Priority Recommendations	4
PFS Detailed Recommendations	12
Regulatory Impact Analysis	12
Conversion Factor	12
Clinical Labor Pricing Update	13
Rebasing and Revising the Medicare Economic Index (MEI); Strategies for Updates to Practice Exp Collection and Methodology	
Potentially Misvalued Services Under the Physician Fee Schedule, and Valuation of Specific.Codes	16
Immunization Administration (CPT Codes 90460, 90461, 90471, 90472, 90473, and 90474)	16
Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS of and G0444)	
Chronic Pain Management and Treatment Bundles (HCPCS GYYY1 and GYYYY2)	18
Behavioral Health Services	18
Evaluation and Management (E/M) Visits, including Valuation and (SpS) hared) Visits	

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A MSM

i.

- i. w Ms ACP understands that CMS cannot unilaterally address the scheduled CY23 cuts, and we callCongress to reinstate the positive adjustment, waive the 4 percent PAYGO requirement, and make a significant time and monetary investment into ensuring that those who need care are able to receive. College also urges CMSand congressional leads to address the greater challenge of the long-standing issue of budget neutrality.
- ii. BB BBA The College is pleased that CMS has implemented a four year transition to update clinical labor pricin/gCP encourages CMSptartner with physician organizations to determine how to update the cost data more frequently and fairly compensate physicians for rising rates of clinical labor, including the impact of inflation and increased needs for clinical staff due to demand.

MBA WBMBA B BY ABM M B Y M B A i.

methodology and stronglencourages CMS to collaborateth physician organizations, including both small and large physician practices P further recommends that any updates be postponed until there has been an opportunity to examineossible avenues and stakeholders have had a chance to perform abconstit analysis for each including ssessing the impact to practices that provide care for the most vulnerable population and the burdensome and one rous tasks that may accompany these efforts, particularly if repeated on an ongoing batter College also strongly recommends CMS work with congressional leaders to address the fundamental challenges with the PFS system, incorporate specialty society input, and maintain transparency and open communication.

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B B BBM B M

The College continues **te**iterate to CMSthe importance of reimbursement for vaccine counseling, not juadministration. ACP strongly urge the Agency to work with stake holders in creating and reimbursing for vaccine counseling codes.

ii. M B A M BM M The College supports the proposed modifications to G0442 and G0444 as part of an effort to allow physicians to efficiently furnish the service, absent minimum time requirements. ACP would further recommend that CMS take an additional look at whether G0442 and G04441s he reevaluated to ensure sufficient reimbursement that supports utilization and increasing need across the beneficiary population.

iii. B B A M M ACP agrees and supports the proposed revisions the chronic pain management codes. The College believes it would be beneficial to allow separate payment for pain management

and treatment services. The College wo**als**brecommendthat CMS consider defining lasting longer than one month.

iv. **WB WB M** access to behavioral health services

- i. ACP is pleased that CMS has revised its policy to permit audiologists to furnish certain diagnostic tests. The College is confident that these revisions will broaden patient access to these services and remove the administrative burden associated with the requirement that physicians must approve audiology tests.
 - B M WB M
- i. ACP is pleased that the CY23 PFS proposed rule includes increasety/ifefæcflor dental surgeries performed in hospital operating rooms. However, for reasons stated through this letter, ACP strongly cautions CMS against adding any such services that affect budget neutrality. The College also wishes to use this opportten/thp/int out that the (unfortunate) reality of these concerns only further underscores the need to address budget neutrality and the derivatives that constrain the collective efforts of medicine.
- Y MB W A BA BA BM
- ACP is very pleased that CMS has taken steps to update Medicare coverage and payment policies to make it easier to get colorectal cancer screenings and help improve access to earlier treatment.
- i.

on-making, we caution CMS against increasing

administrative burden.

- v. Y B B YB BB M B WENE B M The College opposes the proposed policy to revert toynchronous direct supervision cause this places an extra onush the preceptor/supervisor to be in the same vicinity as the supervisee (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.
- vi. BAB B A B B M M B B B M

 The College is very pleased that CMS is proposing to implement provisions of the 2021

 al health

telehealth services furnished on or after the end of the COMIDHE. However, the College is disappointed that CMS did not broaden the scope of services for which geographic restrictions do not apply to include telehealth services furnished only for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, but also all other telehealth services as approved at the time, effective for services furnished on or after the end of the PHE. The College continues to recommented the policy to waive geographical and originating site restrictions after the conclusion of the PHE fat/ telehealth services ACP strongly stands behind the continued coverage of audionly services; when clinicians do not of the college is disappointed that CMS will be implementing provisions of the 2021 and 2022 CAAs that establish a fmonth in person requirement for mental health telehealth siees. While the College is pleased that CAA will extend certain telehealth services for 151 days after the end of the PHE, ACP questions why these extensions would be limited to 151 days and would not be made permanent.

BB M B B

i. ACP does not believe the proposal to maintain the \$3 fee appropriately accounts for the cost of furnishing the service, nor the fact that costs have risen yet the collection fee has remained the same for several yearsheCollege strongly urges CMS to revise its proposal to increase payments mmensurate with the costs of performing the service.

- a. While the ACP is pleased with the prospect of expanding the definition of a high priority measure to include health equityelated measures, the College would appreciate greater specification on the ardrails of such a measure.
- ii. **B W**

a.The College is encouraged by the proposed changes to the CAHPS for MI(gTAxS05E01B

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-or-

b. The College believes it is crucial that other stakeholder feedback is sought, particularly from other clinicians not involved in the development of MVP as well as patients.

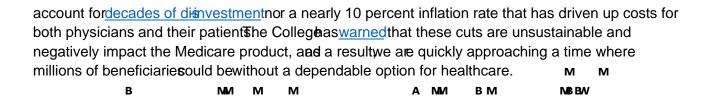
iv. B $\mathbf{M}\mathbf{M}$ AAB \mathbf{M} BM

a.

- b. ACHs calling on Congress to intervene to provide CMS with the statutory authority.
- ii. M
 - a.ACP expresses disappointment that the QP threshold will not be frozen and is proposed to increase to 75 points for the 2023 performance.year
 - b.For futureperformance thresholds, ACP suggests using the mean or median from 2021 performance year data when it becomes available.
- iii. BW M B
 - a. The College expresses agreement with many of the concerns mentioned regarding the expiration of APM Incentive.
 - b. The expiration of this incentive will significantly impact the entrance to and retention of APMs.
 - c. The limited incentives currently available may not be enough to maintain participation once the APM incentive payment expires.
 - B B M
- A MBM

Conversion Factor

M B For CY23, the proposed conversion factor is \$33.08 (rounded), representing a decrease of \$1.53 (or roughly 4.5 percent), as compared to the CY22 convection of \$34.61. This decrease is a result of budget neutrality adjustments, as required by law, as well as the required statutory update to the conversion factor for CY23 of zero percent and the expiration of the three percent increase to physician payment



Though physicians are alarmed by the continued uncertainty regarding the conversion factor and the overall impacton reimbursement, M B B MM

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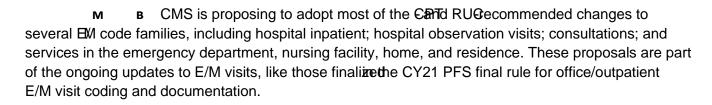
B An MGMA report conducted in 2019 found that over 67 percent of medical practices reported that Medicare payments would not cover the cost of delivering care to beneficiaries. Since its release, the healthcare community has endured a global pandandicising costsdue to inflation, yet physician payments have continued to falliese are all factors that contribute to the growing disparities in access to care and physician shortages. As a result, physicians are discission that has weighed heavily on their ability to accept new Medicare beneficiaries due to exterceasing reimbursement rates. The College urges CMS to seriously consider the impacts to patient access and ensure that Medicare remains a robust ependable option for those who need it the most.

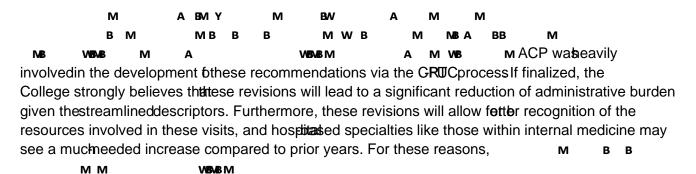
A M A M B A BMM A B The College recent vined over 100 organizations in expressing conceu [(co)-6(n2G [(792 re W*n BT 792 re 757 rg 0.0196 0.388 0.757 RG [(d)14(ecades)10(o)-7(f)12(d))

independent practices, and this subset of the population is not equipped with the same resources as large health systems; that is, small and independent practices often have one administrative staff person as compared to large health systems that have a host of accossinated financial officers. The

declined during the COVID9 pandemic. Both proposals could have an impact on immunization rates for clinicianadministered vaccines.

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w MNA BB M A B A A M WB M M As proposed, CMS will create three new G codes (GXXX1, GXXX2, and GXXX3) to describe prolonged services for hospital, nursing facility, and home visits incethe Agency believes the CPT reporting guidelines for prolonged service 993X0 will lead to dupltioze payment and confusion regarding total time spent per patient. CY23CMS also proposes to make CPT codes 99358 and 99359 invalid for Medicare purposes as the Agencyassers it would cause confusion and invite duplicative billing. In response to the PFS final rule, the Collegexpressed concerns

recommended would upend the work done by the CPT Editorial Panel and the RUC to clarify the code descriptor for99417. Rather than doing so, CMS finalized policy forprogramment of 99417 with a substitution to report G2212Prolonged service office or other outpatient) instead.

Т

for prolonged E/M services creatite same issues.

proposed rule, the Aency is deciding not to propose the RttCommended work RVU of 3.50 because it believes this service is appropriately valued more highly than the analogous office/outpatient E/M visit code, CPT code 99205. In the interest of supporting access to this extMS is instead proposing an increase from the current 3.80 to 3.84 to account for the increase in physician time with use of a total time ratio.

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B M B B B A

Split (or Shared) Visits

м в For CY23, CMS is proposing to delay the split (or shared) visits policy finalized in CY22 for the definition of substantive portion until January 1, 2024. Rather than the substantive portion being defined as more than half of the total time, the substantive portion of a visit may be met by any of the following elements:

- 1. History;
- 2. Performing a physical exam;
- 3. Medical decision making; or
- 4. Spending more than half of the total time.

The Agency notes that this delay is a direct result of ongoing concernstfeocollege and other

internal processes or information systems to track visits based on time, rather than MDM. Although proposing a delay in the trantisin, CMS continues to believe it is appropriate to define the substantive portion of a split (or shared) service as more than half of the total time. This proposal, however, is intended to allow for the changes in the coding and payment policies for impressive observation E/M visits to take effect for CY23 and allows for a-system transition for physicians and other practitioners to get accustomed to the new changes and adopt their workflow in practice.

M In response to the CY22 FFS fin₩,rACP and nearly twenty other organizations expressed concerns

substantive portion would be defined only as more than 50 percent of the **tiotizel** spent, we cautioned against the implications for physiciandwanced practitioner (AP) reimbursement plans, as well as the detrimental impact on the care delivery model and the patient experience. Therefore, we urged CMS to discontinue its policy armost move forward with the transition set to take effect in 2023.

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M B WB M Additionally, allowing only one year to educenthe physician

and AP commco1 0 0 1 42r.83 2 11.04 Tf 1 0 0 1 476.83 202.01 Tm 0 g 0 G [(the ph)14(y)-3(sicia)3(n)3()] T

family.					M		MB	В	ВВ	M		ВА	В	M
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M	В		М		В	В	3	ВА	M	и в	N B	i	WENB	В
w													sin colla	borating

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expanded to addess concerns about potential underreportifige., the sensitivity analysisthe patterns were similar to what was observed in the main analysisd (a) (global periods recommendation that CMS should start the updates with the 10 day periods, which will also prove more manageable.

Beginning with the 10day global periodvill additionally allow CMS and stakeholders to examailhe challenges regarding the possible acepte reporting of E/M codes, as well as the relevant impoact practice expense and physician work. It would further permit time for the specialtiles gion doing a self-examination of the 90-day global periods antidguring outhow to address the potential overvaluation via the CPRUC process. M A M B W W

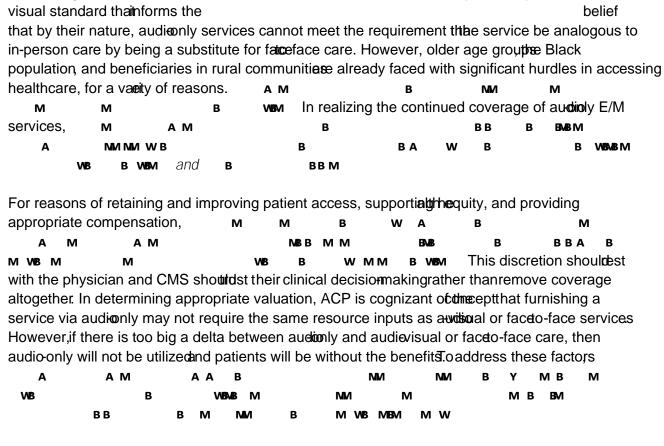
M B ABMM BM B B A MB MM B MB B

M In the CY97 PFS final rule, CMS establists doing standing policy that all diagnostic tests, including audiology tests, must be ordetegethe physician the CY98 PFS final rule, the Agency clarified that only the physician can approve routine hearing evaluation and since audiologists were not authorized they were unable toneet the order requirementor these services. In response to stakeholder feedback, CMS is w proposing to revise it policy by removing the order requirement under certain circumstances for certain audiologists.

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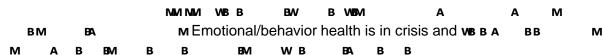
M In CY19, the last year for which incidence data are available; ectal cancer accounted for the thin highest rate of new cancer cases and the thin highest rate of cancer deaths in the United States.



The College understandhat CMS believes it does not have the statutory authority to waive the audio

Emotional/behavior Assessment, Psychological, or Neuropsychological Testing and Evaluation Services

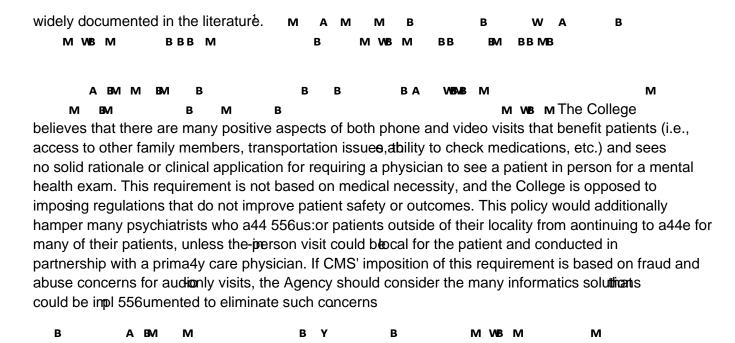
m CMS received several requests to authorional/behavior, psychological, or neuropsychological testing and evaluation services, including those described by CPT codes 97151 97158, to the Medicare Telehealth Services List permanently on a Category 2 basis. These services are currently on the Medicare Telehealth Services List temporarily for the duration of the PHE. In considering this request, the Agency is proposing to include these services for temporary inclusion on a Category 3 basis. These services were not originally included on a Categorise after the initial assessment, but CMS noted there is likely to be a clinical benefit when furnished via telehealth, so they meet the criteria for temporary inclusion. B A M B M



Proposed New G Codes to Replace Existing Prolonged Services CPT Codes

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 $\mathbf{m}\,\mathsf{As}\,\mathsf{discussed}$ arlier, the AMA has formed a joint CFRUCT elemedicine Office Visits

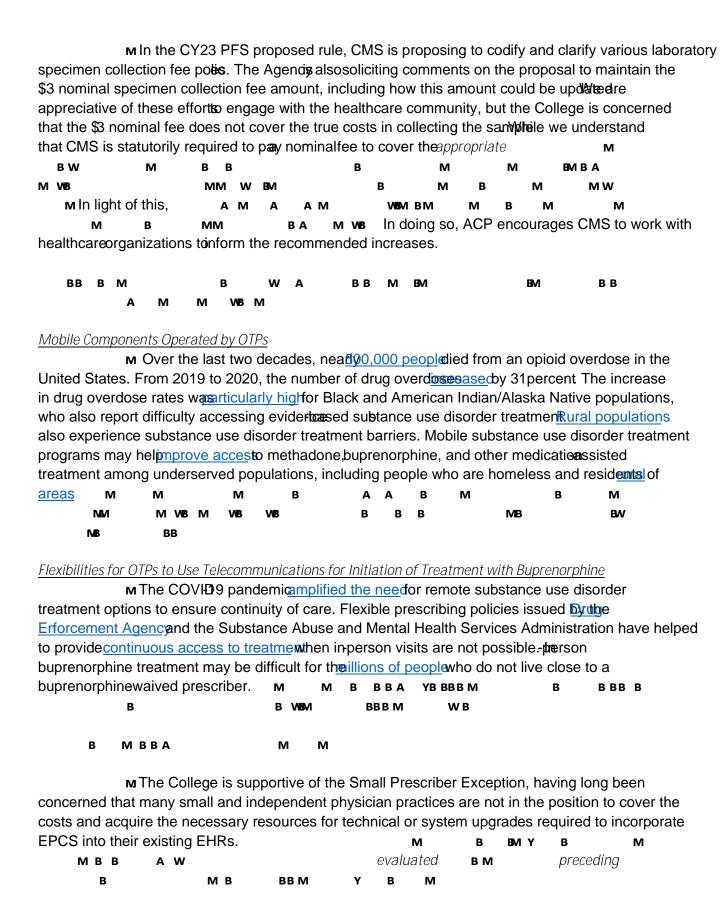


If these services can be effectively delivered via telehealth for 151 days after the end of the PHE, there appears to be no reason why they a4nnot be effectively delivered via telehealth thereafter, for the long term. Therefore, we question the bitrary 151 day limit to an average of these services and urge CMS toontinue to work with Congress and stakeholdets cover these services permanently.

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¹ UscherPines L, Sousa J, Jones M, et al. Tel 55(h)-4(e)4(alt)-3(h)-4(Us)-17(e)4(Am)-9(o)-2(n)-4(g Sa)-3(f)4(e)4(ty)] TJ E



м м в м This would allow the Small Prescriber Exception to align with all other

The College is

The College is Isoconcerned that proposed approaches to advancing the use of standardized data, achieving FHIR based electronic clinical quality measures (eCQM) reporting framing around defining data standards and exchange mechanisms for Edd to dQMs are misdirected. While ACP agrees that the standardization of vocabulary and terminology within EHRs is needed, the College does not agree that physicians have control over the vocabutand/or terminology in their EHRs CP encourages the Agency to consider their normal with ONC and quiring EHR vendor to update and standardize their language and maintain consistency between different systems tead of misguidedly placing the responsibility of this change on physicians and their care to define Collegensists that any potential regulations require vendors to make those mandated changes available to practices free of charge, so that the functionality does not become component of for which vendors upcharge.

By M By B BB

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	M I	MM	В	Α	В	МВ	М	В			М	W		MB M	
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М		В	м		м	В		М	М		А М				

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Quality	Quality	Quality Measure Description	ACP Comments
Measure #	Measure Name		
			300,000 Americans with RA. This should
			only be apticable to physicians who are
			managing and providing medical therapy
			for RA. Most often, this measure will apply
			to rheumatologists, but primary care physicians may also manage RA.
476	Urinary	Percentage of patients with an	
110	Symptom Score	• .	unable to provide a comment at this time.
	Change 612	measurement period and with	
	Months After	a new diagnosis of clinically	
	Diagnosis of	significant Benign Prostatic	
	Benign	Hyperplasia who have	
	Prostatic	International Prostate	
	Hyperplasia	Symptoms Score (IPSS) or	
		American Urologial	
		Association (AUA)	
		Symptom Index (SI)	
		documented at time of	
		diagnosis and again 62 months later with an	
TBD	Screening for	improvement of 3 points. Percent of beneficiaries 18	ACP agrees that this measure is highly
וסטו	•	years and older screened for	ACP agrees that this measure is highly
	Health	food insecurity, housing	
	ricatii	instability, transportation	
		needs, utility difficulties, and	
		interpersonal safety.	
		•	

Quality	Quality	Quality Measure Description	ACP Comments
Measure #	Measure Name		
			ACP would also like to see the measure revised to require the AHC HRSN and oth validated instruments.
TBD	Kidney Health Evaluation	Percentage of patients aged	

Quality	Quality	Quality Measure	ACP Review Date	ACP Review Rationale
Measure #	Measure Name	Description		
				the Centers for Disease
				Control and Preventions
				(CDC) Advisory Committee
				While we support this
				measure, we suggest
				developers consider
				revising the specifications

to include excusion criteria for patient, medical, and system reasons for vaccination not given. Additionally, we note that the measure is nearly Quality Quality

Measure # Measure Name

BM MBA BB Y M BBB M BM This measure also fails to account for the binical relevance and value at the point of care, as there is no value in querying for

MACP isappreciative and supportive of belief in the importance of taking a patient centered approach to health information access and related efforts to move towards a system in which patients have immediate access to their electronic health information and can be assured that their health information will follow them as they move throughout the health are system However, the College has serious concerns abthut existing digital divide in this nation, which were not addressed within this RFI. Most patient portals are English nly, leaving most non-English speakers with no way of navigating their own health information. Lendors do not want to translate information due to liability concerns, meaning that i

MVPs and APM Participant Reporting Request for Information (from PR)

m The College agrees with many of the concerns expressed by 16 1/18 dingthe alignment between MVPs and APMs. If MVPs are going to continue 1/10 1/18 do no no no no no no no value based payment, there must be APMs for those participating in MVPs to transition I 1/18 1/18 agrees that there is a significant gap in the availability of 200224 APMs available for specialty practitioners. While CMS currently has parocess in place for interested parties to submit APM proposals the materialization of these proposals not occurred The College encourages CMS to

continue to improve the MVP. ACP looks forward to continuing productive conversations and collaboration.

Measures in Optimizing Chronic Disease Myamaent MVP PFS 2023 Proposed Rule Type of ACP Support

Summary: 10 measures ACP support: 5

ACP does not support; uncertain validity: 4

ACP does not support; invalid: 1

B M B

· Q006: Coronary ArterDisease (CAD): Support, Antiplatelet Therapy Valid

clinicians to perform this intervention during an initi

		higher proportion of marginalized patient populations.
· Q321: CAHPS for MIPS Clinician/Gr	Do not	
Survey	Support,	Clinician & Group Surveys (CAHPS)
•	Uncertain	Survey results provide important feedback and
	Validity	enhance the provider selection process for

		Asthma Cotrol Test (ACT), it is best practice.
		However, the ACT is a proprietary assessment too
		and therefore, clinicians may encounter.
Q438: Statin Therapy for the	Support,	ACP supports QPP measure :438 atin Therapy for
Prevention and Treatment of	Valid	the Prevention and Treatment of Cardiovascular
Cardiovascular Disease		Disease." The performance gap has increased
		significantly due to new United States Preventive
		Task Force (USPSTF) and American College of
		Cardiology/American Heart Association (ACC/AHA
		dinical recommendations on treatment of
		cardiovascular disease to expand therisk patient
		population. Additionally, the balance of evidence
		provides a strong foundation for the treatment of
		blood cholesterol for the primary and secondary
		prevention of aherosclerotic cardiovascular disease in adult men and women. Furthermore, measure
		specifications include appropriate exclusion criteria
		for patient intolerance. While we support this
		measure, we note that implementation of statin
		therapy alone does not garantee meaningful
		improvements in clinical outcomes. A more
		meaningful measure may examine patient adheren
		to prescribed statin therapy. Additionally, a high
		percentage of patients prescribed statin therapy for
		the management of cardiovascular disease
		exacerbations (e.g., acute MI) discontinue therapy
		without consulting their clinician. Therefore, the
		measure may unfairly penalize clinicians for lack of
		control over nonadherent patients.
• Q483: Perso©entered Primary Care		ACP does not support NQF 3568: "Per©emtered
Measure Patient Reported Octome	Support,	Primary Care Measure PROM (PCPCM PROM)" for
Performance Measure (PCPCM PRO	Not Valid	application at the actual/intended level of analysis:
PM)		ce" because it lacks validity. The ACP had concerns regarding
		whether the measure would lead to improvements
		care and a lack of evidence to indicate as much.
		There were also some problems regarding the face
		validity of the instrument and the feasibilitand
		burden to implement this in a general internal
		medicine practice.

Proposed New MVPs

M MB MB B A MM This MVP provides another option that is strongly tied to the daily practice of general internal medicine physicians and has been adapted from one of the MVPs submitted by ACP in February 2020.

Overall, we are pleased to see many of the chartiges have been proposed by CMS with regards to

indicates support for eight of them, does not support four of them with uncertain validity, and has found one of

have provided our comments on that measure in the MIPS seation the table below.

the quality measures

included in the Promoting Wellness MVP.

B M W

		organizations move towards teabrased care, these issues should be minimal in the future.
Q113: Colorectal Cancer Screening	Support, Valid	ACP supports QPP measures. Colorectal cancer screening is an important clinical area. It is critical to improve access to evidendessed tests to make a meaningful clinical impact. These eviderdessed tests should be clearly identified as not all tests have validity to support their use as standone screening tests. The ACP recommends modifying the numerator include only the types of tests that qualify as colorectal cancer screening, consistent with current guidelines. It would also be beneficial to extend the numerator time interval for performing the colonoscopy from nine years to ten years to ensure the exam is ordered and performed adequately.
Q309: Cervical Cancer Screening	Support, Valid	ACP supports QPP meas@9. ACP believes that the Cervical Cancer Screening is an important measure, given its ability to impact disease prevention. Current evidence supports this measur and it does not increase clinician burden or have a feasibility issues. The measure spectforms need clarity; the ACP recommends revising the specifications for better interpretation of the age appropriate screening tests. To avoid unnecessary screening, the ACP encourages the development of an overuse measure.
Q310: Chlamydia Screening for Women	Support, Valid	ACP support PP measure 316 ecause it aligns with recommendations from the United States Preventiv Services Task Force and the Centers for Disease Control and Prevention (CDC) and evidence supposcreening in primary care as feasible and effective.
Q400: OneTime Screening fo Hepatitis C Virus (HCV) for all Patient	Support, Valid	because a performance gap exists, it is important to screen for HCV in patients at risk because it is a treatable disease, the measure aligns with Centers Disease Control and Prevention (CDC) and United States Preventive Services Task Force (USPSTF) recommendations on screening for HCV in patients risk, and the measure specifications include appropriate exclusion criteria. Additionally, the USPSTF found little evidence on the harms of screening for HCV. While the measure is clearly specified, clinicians may encounter interoperability barriers to patient information retrieval. Also, while we support this measure, we suggest the measure developers reassess the benefit of screening all patients included in the denominator population

		during the measure update, particularly patients bo in the years 1945 965.
Q475: HIV Screening	Do not Support,	ACP does not support MIPS measure ID# 475 (NC
	Uncertan Validity	uncertain validity. To the extent the intent of this

Q128: Preventive Care and Screenir Do not Body Mass Index (BMI) Screening and Support, FollowUp Plan Uncertain Validity developed, tested and endorsed at the health plan level, and for this reason, the MAP did not support this measure for use at the individual clinician and clinician group levels. Health plans have ready act to the information required for the mesure.

ACP does not support QPP measure 128: "Preven Care and Screening: BMI Screening and Fellipw" The urgency posed the obesity epidemic underscores the need for evidence based and

clinically meaningful performance measures.

Q226: Preventive Care and Screenir Support, Tobacco Use: Screening and Cessatic Valid Intervention or only those seen during the calendar year in a facto-face visit.

ACP supports QPP measure 228 eventive Care and Screening: Tobacco use: Screening & Cessation Intervention because reduction of tobacco use slowers.

		on clinicians. While we support this measure, we suggest the developers revise the numerator specifications to clearly define "brief counseling".
Q483: PersonCentered Primary Care	Do not	ACP does not support NQF 3568: "Per@mtered
Measure Patient Reported Outcome	Support,	Primary Care Measure PROM (PCPCM PROM)" for
Performance Measure (PCPCM PRO	Not Valid	application at the actual/intended level of analysis:
PM)		
		lacks validity. The ACP had concerns regarding
		whether the measure would lead to improvements
		care and a lack of evidence to indicate as much.
		There were also some problems regarding the face
		validity of the instrument and the feasibility and
		burden to implement this in a general internal
		medicine practice.

While the College isgenerally supportive, AGP quality measures included in the two VPs, however, many of the changes that are incorporated resonate with comments we have made in the past.

MVP Reporting Requirements

m ACP continues to highlight that changestruly reinvent MIPS with MVPs, CMS must:

Scoring MVP Performance

MACP supports applying the highest of scores reported. This encourages participation and minimizes errors thatould arise during subgroup selection or assignment. There is precedent with facility-based scoring. ACP supports physicians being able to select MVP reporting when submitting MIPS data at the end of a performance period (as opposed to midway throughetformance year). This approach provides more time to make the decision and better accounts for NPI/TIN changes during the performance year, which far outweigh any drawbacks. In general, flexibility in reporting is critical to reducing burden while increing clinical relevance and patienteredness.

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Advance Investment Payments

M Due to plateaued participation in MSSP and advocacy aimed at providing greater opportunities to ACOs serving underserved populations, CMS has proposed a substantial number of changes to the incentive structure of MSSP. One such promising proposal disatiling revenue ACOs inexperienced with performance risk. While further thought may be warranted in the definition of high/low revenue ACOs as it impacts FQHCs/RHCs, this proposal seems to be a step in the right direction. Offering a one fixed payment provides a unique opportunity for certain ACOs to enter into accountable care agreements. The College is pleased to see the application of lessons learned from prior APMs applied to permanent programing.

Glide Path

M ACP is encouraged the proposal to allow ACOs inexperienced with downside risk up to seven years in one ided risk before transitioning to two ided risk. The College agrees that the quick transition into downside risk may deter participation and that these proposalse nayurage participation by those in small, rural, and/or otherwise underserved communities.

eCQM/MIPS CQMs and Health Equity Adjustment

M The College is pleased with the possal to extend the incentive for reporting eCQMs/MIPS CQMs throughromance year 2024 to align with the sunsetting of the CMS Web

М

ability to deliver innovative care and protecting the integrity of the Medicare trust funds. The College appreciates the opportunity to offer our feedback and lsdbrward to continuing to work with the Agency to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Ph.D., Director, Regulatory AffairstferAmericarCollege of Physicians, at boutland@acponline.org (202) 2614544 with comments or questions about the content of this letter.