[illegible]

[illegible]

i. [illegible] ACP understands that CMS cannot unilaterally address the scheduled CY23 cuts, and we call on Congress 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 it. The College also urges CMS and congressional leaders to address the greater challenge of the long-standing issue of budget neutrality.

ii. [illegible] The College is pleased that CMS has implemented a four year transition to update clinical labor pricing. ACP encourages CMS to partner 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.

[illegible]

i. [illegible] methodology and strongly encourages CMS to collaborate with physician organizations, including both small and large physician practices. ACP further recommends that any updates be postponed until there has been an opportunity to examine *all* possible avenues and stakeholders have had a chance to perform a cost-benefit analysis for each, including assessing the impact to physician practices that provide care for the most vulnerable populations and the burdensome and onerous tasks that may accompany these efforts, particularly if repeated on an ongoing basis. The 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.

[illegible]

i. [illegible] The College continues to reiterate to CMS the importance of reimbursement for vaccine counseling, not just administration. ACP strongly urge the Agency to work with stake holders in creating and reimbursing for vaccine counseling codes.

ii. [illegible] 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 G0444 should be reevaluated to ensure sufficient reimbursement that supports utilization and increasing need across the beneficiary population.

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

and treatment services. The College would also recommend that CMS consider defining lasting longer than one month.

iv. [illegible]
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.

i. ACP is pleased that the CY23 PFS proposed rule includes increases in fees for 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 opportunity to point 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.

i. 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 B M B WB B M The College opposes the proposed policy to revert to synchronous direct supervision because this places an extra onus on 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. BA B B A B B M B 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 COVID-19 PHE. 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 *solely* 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 recommend that CMS permanently extend the policy to waive geographical and originating site restrictions after the conclusion of the PHE for *all* telehealth services. ACP strongly stands behind the continued coverage of audio-only services; when clinicians do not offer audio-only services, additional disparities in care are created and perpetuated. The College is disappointed that CMS will be implementing provisions of the 2021 and 2022 CAAs that establish a 6-month in person requirement for mental health telehealth services. While the College is pleased that the 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.

B B M B 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 years. The College strongly urges CMS to revise its proposal to increase payments commensurate 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 equity-related measures, the College would appreciate greater specification on the guardrails of such a measure.

ii. B W

a. The College is encouraged by the proposed changes to the CAHPS for MI(g)Hps05E01B

X. **B Y A BW M BB BW M**
B A Y A

-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 MM A A B M B M

a.

b. ACPs 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 the 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 M M

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 conversion factor 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

account for decades of disinvestment nor a nearly 10 percent inflation rate that has driven up costs for both physicians and their patients. The College has warned that these cuts are unsustainable and negatively impact the Medicare product, and as a result, we are quickly approaching a time where millions of beneficiaries could be without a dependable option for healthcare.

Though physicians are alarmed by the continued uncertainty regarding the conversion factor and the overall impact on reimbursement,

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 pandemic and rising costs due to inflation, yet physician payments have continued to fall. These are all factors that contribute to the growing disparities in access to care and physician shortages. As a result, physicians are basing decisions that has weighed heavily on their ability to accept new Medicare beneficiaries due to ever decreasing reimbursement rates. The College urges CMS to seriously consider the impacts to patient access and ensure that Medicare remains a robust, dependable option for those who need it the most.

The College recently joined 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

rate information, and result in distortions in the allocation of direct PE. We remain encouraged that those physicians who rely primarily on clinical labor rather than supplies and equipment will receive relative increases that are commensurate with their true costs.

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 accountants and financial officers. The

declined during the COVID-19 pandemic. Both proposals could have an impact on immunization rates for clinician-administered vaccines.

M

CMS is proposing to adopt most of the CPT and RUC recommended changes to several E/M code families, including hospital inpatient; hospital observation visits; consultations; and services in the emergency department, nursing facility, home, and residence. These proposals are part of the ongoing updates to E/M visits, like those finalized in the CY21 PFS final rule for office/outpatient E/M visit coding and documentation.

ACP was heavily involved in the development of these recommendations via the CPT/RUC process. If finalized, the College strongly believes that these revisions will lead to a significant reduction of administrative burden given the streamlined descriptors. Furthermore, these revisions will allow for better recognition of the resources involved in these visits, and hospital-based specialties like those within internal medicine may see a much-needed increase compared to prior years. For these reasons,

As proposed, CMS will create three new G codes (GXXX1, GXXX2, and GXXX3) to describe prolonged services for hospital, nursing facility, and home visits, since the Agency believes the CPT reporting guidelines for prolonged service 993X0 will lead to duplicative payment and confusion regarding total time spent per patient. For CY23, CMS also proposes to make CPT codes 99358 and 99359 invalid for Medicare purposes as the Agency asserts it would cause confusion and invite duplicative billing. In response to the CY21 PFS final rule, the College expressed concerns recommended would upend the work done by the CPT Editorial Panel and the RUC to clarify the code descriptor for 99417. Rather than doing so, CMS finalized policy for payment of 99417 with a substitution to report G2212 (*Prolonged service office or other outpatient)* instead.

T for prolonged E/M services create the same issues.

proposed rule, the Agency is deciding not to propose the RUC-recommended 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 service, CMS 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.

Split (or Shared) Visits

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 concerns from the College and other

internal processes or information systems to track visits based on time, rather than MDM. Although proposing a delay in the transition, 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 inpatient observation E/M visits to take effect for CY23 and allows for a one-year transition for physicians and other practitioners to get accustomed to the new changes and adopt their workflow in practice.

In response to the CY22 FFS final rule, ACP and nearly twenty other organizations expressed concerns that the substantive portion would be defined only as more than 50 percent of the total time spent, we cautioned against the implications for physician and advanced 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 and not move forward with the transition set to take effect in 2023.

Additionally, allowing only one year to educate the 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.

s in collaborating

90- - expanded to address concerns about potential underreporting (i.e., the sensitivity analysis), the patterns were similar to what was observed in the main analysis (10-day global periods = 7 percent; 90-day global periods recommendation that CMS should start the updates with the 10-day periods, which will also prove more manageable.

Beginning with the 10-day global period will additionally allow CMS and stakeholders to examine the challenges regarding the possible separate reporting of E/M codes, as well as the relevant impact to practice expense and physician work. It would further permit time for the specialties to begin doing a self-examination of the 90-day global periods and figuring out how to address the potential overvaluation via the CPT/RUC process. M A M B W W W B B W M B B B M B B M B M B B M B B M A M B A B M *only* B M B A Y M M *actually* B In considering these comments, the College welcomes the opportunity to discuss further with CMS representatives.

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M In the CY97 PFS final rule, CMS established a long-standing policy that all diagnostic tests, including audiology tests, must be ordered by the physician. In the CY98 PFS final rule, the Agency clarified that *only* the physician can approve routine hearing evaluations and since audiologists were not authorized, they were unable to meet the order requirement for these services. In response to stakeholder feedback, CMS is now proposing to revise its policy by removing the order requirement under certain circumstances for certain audiology order services furnished by an audiologist.

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Y M B W A B A B A B M

M In CY19, the last year for which incidence data are available, colorectal cancer accounted for the 4th highest rate of new cancer cases and the 4th highest rate of cancer deaths in the United States.

The College understands that CMS believes it does not have the statutory authority to waive the audio-visual standard that informs the belief that by their nature, audio-only services cannot meet the requirement that the service be analogous to in-person care by being a substitute for face-to-face care. However, older age groups, the Black population, and beneficiaries in rural communities are already faced with significant hurdles in accessing healthcare, for a variety of reasons. In realizing the continued coverage of audio-only E/M services, *and*

For reasons of retaining and improving patient access, supporting health equity, and providing appropriate compensation, This discretion should rest with the physician and CMS should trust their clinical decision-making rather than remove coverage altogether. In determining appropriate valuation, ACP is cognizant of the concept that furnishing a service via audio-only may not require the same resource inputs as a visual or face-to-face services. However, if there is too big a delta between audio-only and audio-visual or face-to-face care, then audio-only will not be utilized and patients will be without the benefits. To address these factors,

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

CMS received several requests to add emotional/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 Category 3 basis 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. Emotional/behavior health is in crisis and

Proposed New G Codes to Replace Existing Prolonged Services CPT Codes

- As discussed earlier, the AMA has formed a joint CPT/RUC Telemedicine Office Visits

widely documented in the literature.[1] [illegible]

[illegible] The College believes that there are many positive aspects of both phone and video visits that benefit patients (i.e., access to other family members, transportation issues, ability to check medications, etc.) and sees no solid rationale or clinical application for requiring a physician to see a patient in person for a mental health exam. This requirement is not based on medical necessity, and the College is opposed to imposing regulations that do not improve patient safety or outcomes. This policy would additionally hamper many psychiatrists who are currently serving patients outside of their locality from continuing to care for many of their patients, unless the in-person visit could be local for the patient and conducted in partnership with a primary care physician. If CMS' imposition of this requirement is based on fraud and abuse concerns for audio-only visits, the Agency should consider the many informatics solutions that could be implemented to eliminate such concerns.

[illegible] 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 cannot be effectively delivered via telehealth thereafter, for the long term. Therefore, we question the arbitrary 151-day limit to coverage of these services and urge CMS to continue to work with Congress and stakeholders to cover these services permanently.

[illegible]

[1] Uscher-Pines 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

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J 0 0 1 208.85 Tm 0 0 0 1 0 0 Tc 0.1 Tw 0 Tz 0 TL 0 Tr 0 Ts 0.0059 Tf 1 0 0 g 0.0059t/F1 9.96 Tf s(H)-4(.)-2(ex)3vE7re W*tem /I

M In the CY23 PFS proposed rule, CMS is proposing to codify and clarify various laboratory specimen collection fee policies. The Agency is also soliciting comments on the proposal to maintain the $3 nominal specimen collection fee amount, including how this amount could be updated. We are appreciative of these efforts to engage with the healthcare community, but the College is concerned that the $3 nominal fee does not cover the true costs in collecting the sample. While we understand that CMS is statutorily required to pay a nominal fee to cover the *appropriate*

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M In light of this, A M A A M W B M B M M B M M M B A M M W B In doing so, ACP encourages CMS to work with healthcare organizations to inform the recommended increases.

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Mobile Components Operated by OTPs

M Over the last two decades, nearly 500,000 people died from an opioid overdose in the United States. From 2019 to 2020, the number of drug overdoses increased by 31 percent. The increase in drug overdose rates was particularly high for Black and American Indian/Alaska Native populations, who also report difficulty accessing evidence-based substance use disorder treatment. Rural populations also experience substance use disorder treatment barriers. Mobile substance use disorder treatment programs may help improve access to methadone, buprenorphine, and other medication-assisted treatment among underserved populations, including people who are homeless and residents of rural areas M M M B A A B M B M

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M B B B

Flexibilities for OTPs to Use Telecommunications for Initiation of Treatment with Buprenorphine

M The COVID-19 pandemic amplified the need for remote substance use disorder treatment options to ensure continuity of care. Flexible prescribing policies issued by the Drug Enforcement Agency and the Substance Abuse and Mental Health Services Administration have helped to provide continuous access to treatment when in-person visits are not possible. In-person buprenorphine treatment may be difficult for the millions of people who do not live close to a buprenorphine-waived prescriber. M M B B B A Y B B B B M B B B B B B

B B W B M

B M B B A M M

M The College is supported of the Small Prescriber Exception, having long been concerned that many small and independent physician practices are not in the position to cover the costs and acquire the necessary resources for technical or system upgrades required to incorporate EPCS into their existing EHRs. M B B M Y B M B B *evaluated* B M *preceding*

B M B B M Y B M

M M M B M This would allow the Small Prescriber Exception to align with all other

The College is

The College is also concerned that proposed approaches to advancing the use of standardized data, achieving FHIR-based electronic clinical quality measures (eCQM) reporting, and framing around defining data standards and exchange mechanisms for FHIR-based 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 vocabulary and/or terminology in their EHRs. ACP encourages the Agency to consider partnering with ONC and requiring EHR vendors to update and standardize their language and maintain consistency between different systems, instead of misguidedly placing the responsibility of this change on physicians and their care teams. The College insists that any potential regulations require vendors to make those mandated changes available to practices free of charge, so that the functionality does not become a component of for which vendors supcharge.

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Quality Measure #	Quality Measure Name	Quality Measure Description	ACP Comments
			300,000 Americans with RA. This should only be applicable 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 Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.	*ACP plans to review this measure but is unable to provide a comment at this time*.
TBD	Screening for Social Drivers of Health	Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	ACP agrees that this measure is highly

Quality Measure #	Quality Measure Name	Quality Measure Description	ACP Comments
			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 Measure #	Quality Measure Name	Quality Measure Description	ACP Review Date	ACP Review Rationale
				the Centers for Disease Control and Preventions (CDC) Advisory Committee While we support this measure, we suggest developers consider revising the specifications to include exclusion criteria for patient, medical, and system reasons for vaccination not given. Additionally, we note that the measure is nearly

Quality Measure #	Quality Measure Name

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

ACP is appreciative 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 healthcare system. However, the College has serious concerns about the existing digital divide in this nation, which were not addressed within this RFI. Most patient portals are English only, leaving most non-English speakers with no way of navigating their own health information. Vendors do not want to translate information due to liability concerns, meaning that i

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

- The College agrees with many of the concerns expressed by CMS regarding the alignment between MVPs and APMs. If MVPs are going to continue to be used as an onramp to value based payment, there must be APMs for those participating in MVPs to transition to. The College agrees that there is a significant gap in the availability of 2022 and 2024 APMs available for specialty practitioners. While CMS currently has a process in place for interested parties to submit APM proposals, the materialization of these proposals has 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 Management 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

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

clinicians to perform this intervention during an initi

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

		Asthma Control Test (ACT), it is best practice. However, the ACT is a proprietary assessment tool and therefore, clinicians may encounter.
Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Support, Valid	ACP supports QPP measure 438 "Statin Therapy for the Prevention and Treatment of Cardiovascular 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) clinical recommendations on treatment of cardiovascular disease to expand the at-risk patient population. Additionally, the balance of evidence provides a strong foundation for the treatment of blood cholesterol for the primary and secondary prevention of atherosclerotic 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 guarantee meaningful improvements in clinical outcomes. A more meaningful measure may examine patient adherence 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 non-adherent patients.
· Q483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO PM)	Do not Support, Not Valid	ACP does not support NQF 3568: "Person-Centered Primary Care Measure PRO PM (PCPCM PRO PM)" for application at the actual/intended level of analysis: 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 feasibility and burden to implement this in a general internal medicine practice.

Proposed New MVPs

M 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 changes that 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 section in the table below.

the quality measures

included in the Promoting Wellness MVP.

B M W

		organizations move towards team-based care, these issues should be minimal in the future.
Q113: Colorectal Cancer Screening	Support, Valid	ACP supports QPP measure 113. Colorectal cancer screening is an important clinical area. It is critical to improve access to evidence-based tests to make a meaningful clinical impact. These evidence-based tests should be clearly identified as not all tests have validity to support their use as stand-alone screening tests. The ACP recommends modifying the numerator to 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 measure 309. ACP believes that the Cervical Cancer Screening is an important measure, given its ability to impact disease prevention. Current evidence supports this measure and it does not increase clinician burden or have any feasibility issues. The measure specifications 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 supports QPP measure 310 because it aligns with recommendations from the United States Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC) and evidence supports screening in primary care as feasible and effective.
Q400: One-Time Screening for Hepatitis C Virus (HCV) for all Patients	Support, Valid	ACP supports QPP measure 400: "One-Time 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 for Disease Control and Prevention (CDC) and United States Preventive Services Task Force (USPSTF) recommendations on screening for HCV in patients at 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 1945-1965.
Q475: HIV Screening	Do not Support, Uncertain Validity	ACP does not support MIPS measure ID# 475 (NQ uncertain validity. To the extent the intent of this

		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 acc to the information required for the measure.
Q128: Preventive Care and Screenir Body Mass Index (BMI) Screening and Follow-Up Plan	Do not Support, Uncertain Validity	ACP does not support QPP measure 128: "Preven Care and Screening: BMI Screening and Follow The urgency posed by the obesity epidemic underscores the need for evidence based and clinically meaningful performance measures.

		or only those seen during the calendar year in a fac to-face visit.
Q226: Preventive Care and Screenir Tobacco Use: Screening and Cessatic Intervention	Support, Valid	ACP supports QPP measure 226 "Preventive Care and Screening: Tobacco use: Screening & Cessati Intervention" because reduction of tobacco use slo

		on clinicians. While we support this measure, we suggest the developers revise the numerator specifications to clearly define "brief counseling".
Q483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO PM)	Do not Support, Not Valid	ACP does not support NQF 3568: "Person-Centered Primary Care Measure PRO PM (PCPCM PRO PM)" for application at the actual/intended level of analysis: 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 is generally supportive, ACP
quality measures included in the two MVPs, however, many of the changes that are incorporated
resonate with comments we have made in the past.

MVP Reporting Requirements

- ACP continues to highlight that changes to truly reinvent MIPS with MVPs, CMS must:

Scoring MVP Performance

■ ACP supports applying the highest of scores reported. This encourages participation and minimizes errors that could 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 through the performance 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 increasing clinical relevance and patient centeredness.

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Advance Investment Payments

■ 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 is to allow low revenue ACOs inexperienced with performance-based 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-time 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

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

eCQM/MIPS CQMs and Health Equity Adjustment

■ The College is pleased with the proposal to extend the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 to align with the sunsetting of the CMS Web

5% APM Bonus

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ability to deliver innovative care and protecting the integrity of the Medicare trust funds. The College appreciates the opportunity to offer our feedback and looks forward 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 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.