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Request for Information (RFI): Drugs and Biologicals which are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding
Appropriate Use Criteria Program for Advanced Diagnostic Imaging

Quality Payment Program
Merit-based Incentive Payment System (MIPS) Evolution
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MIPS Quality Performance Category
Removal of Two Measures from the Gastroenterology Measure Set
Connection to Community Service Provider Proposed Measure
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MIPS Cost Performance Category
Cost Performance Category Improvement Scoring
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MIPS Payment Adjustment / Performance Threshold
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Public Reporting

Medicare Physician Fee Schedule

Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List
Our societies support CMS' proposal to change the way it categorizes services on the Medicare Telehealth List by replacing the Category 1-3 designations and, instead, defining telehealth services as

Our societies continue to believe that the only difference between the physician work of telehealth office visits and telephone E/M is the absence of real-time video. The interactions among the beneficiary and physician (or other practitioner) that take place during a telephone E/M visit are similar to telehealth office visits. In both cases, the physician can assess the patient's condition, make a medical decision, and communicate that decision to the patient via telephone only or a real-time audio/visual telehealth platform. *The absence of video does not change or diminish the time, intensity, or level of medical decision making*. Additionally, no wide-spread evidence of fraud or abuse of telephone E/M has been identified since telephone E/M benefits were expanded in response to the COVID

mainly on time data, as they can miss or inappropriately devalue vital components, such as complexity and intensity, which are necessary components when determining the value of services and procedures.

Split (or Shared) Visits

We thank CMS for proposing this continued delay and urge CMS to finalize in the 2024 PFS final rule allowing physicians or

Revising and Rebasing the Medicare Economic Index (MEI)

The MEI was last updated nearly ten years ago in 2014. In the 2023 MPF final rule, CMS finalized updated MEI weights for the different cost components of the MEI for CY 2023 using a new methodology based primarily on a subset of data from the 2017 US Census Bureau's Service Annual Survey (SAS). [illegible] significant redistribution of PFS spending among specialties, CMS delayed implementation of this policy in CY 2023 to "time uncertain" and solicited comments on when and how best to incorporate these changes for future rulemaking.

In the CY 2024 PFS proposed rule, CMS announced that it will continue to delay implementation of the updated MEI weights. CMS believes continuing to delay implementation of the [illegible]

therapies. This limitation has forced specialists, excluding hematologists and oncologists, to bill such services using therapeutic drug administration codes. The advent and evolution of biologics and other immunomodulating therapies have been transformative and life-saving therapies for patients with auto-immune diseases and are cost-effective when used in appropriate patient populations.

The AMA CPT manual specifically acknowledges the applicability of chemotherapy administration codes to a broader range of treatments: Chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide antineoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as certain monoclonal antibody agents, and other biologic response modifiers. However, MACs continue to rely on unsubstantiated criteria to determine which drugs merit complex administration codes. Given the evolving landscape of biologics and monoclonal antibody treatments in various medical fields, ***our societies urge CMS to reevaluate the definition of the outdated term "chemotherapy" and align it with drug indications and toxicity.***

Language in the CPT manual further states, "The highly complex infusion of chemotherapy or other drug or biologic agents requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified healthcare professional." The complexity associated with designing, manufacturing, and storing biologics, coupled with variations over time in their structure, efficacy, and safety, requires specialized supervision by trained physicians and advanced practitioners. We believe it is important for the impacted

information from the ordering professional is not transmitted accurately or in a timely manner to the furnishing provider.

As CMS gives thoughtful reconsideration of the Program and considers recommendations to Congress, ***we encourage CMS to consider how existing CMS programs can be leverage including, but not limited to, the Merit-based Incentive Payment System (MIPS), and alternative payment models (APMs) which should be recognized as mechanisms for discouraging inappropriate resource use.***

Quality Payment Program

Merit-based Incentive Payment System (MIPS) Evolution

Our societies appreciate that CMS' proposed changes for participation in MIPS for the 2024 performance year were kept to a minimum. However, we have issues with a number of the proposed modifications and remain deeply concerned with the overall direction of the program, including the cvocourned w.8(i)-4.6puno

became known the Total Per Capita Cost (TPCC) measure's benchmark is being calculated monthly. CMS was not transparent about this change which raises additional questions about the measure's validity and usefulness and is further evidence of why confidence in the MIPS program is lac

Promoting Continuous Improvement in MIPS

In response to the request for feedback on how CMS can foster clinicians' continuous performance improvement, we encourage CMS to focus on efforts to support quality of care which may include supporting efforts to maintain achievement of high-quality care *or*

positive fecal tests. [6,7,8,9,10] Because the use of fecal testing varies regionally and across health practices, screening colonoscopies performed for positive fecal tests are excluded from the calculation of ADR. ***We urge CMS to consider excluding from the denominator of the Screening/Surveillance Colonoscopy episode-based cost measure screening colonoscopies performed following positive fecal tests given the variability in which this innovation has been adopted into practice.***

MIPS Payment Adjustment / Performance Threshold

Our societies oppose CMS' proposal to establish the performance threshold for the CY 2024 performance period/2026 MIPS payment year as 82 points, using the CY 2017-CY 2019 performance years as the prior period. While CMS' proposal to rely on a three-year-average attempts to recognize the impact of the pandemic on the MIPS program and other year-to-year fluctuations, it fails to recognize that reporting requirements and standards for the program were significantly different in the early years of MIPS. First, CY 2017 shoul

insufficient to fully transition from traditional MIPS to MVPs and should be increased to meet the goals that CMS is attempting to achieve with the full-scale adoption of MVPs.

Promoting Interoperability Category

We believe that Promoting Interoperability should only require attestation if an individual clinician or practice is using a certified EHR. The growing complexity in the number of measures and duration of reporting continues to increase the burden to participate in this category with little to no added value. In addition, the fact that CMS has added exceptions for reporting to this performance category signals the limited usefulness of the performance category or its requirements. ***We urge CMS to identify alternative ways to capture and report on this important area rather than continuing down this path.***

Public Reporting

CMS proposes modifications to its existing policy to publicly report utilization data, including expanding

Support CMS collaboration with the AMA on the new PE data collection effort to ensure consistency and reliability in physician payment.
Support CMS's interest in developing a roadmap for updates to the PE methodology that accounts for changes in the health care landscape.
Urge that any PE changes the Agency considers should be made carefully to ensure they reflect actual practice costs incurred by all types of physician practices and other service suppliers and should be phased in to minimize the redistributive impact on payment.
Thank CMS for recognizing the PPI Survey effort and postponing implementation of the updated MEI weights for CY 2024.
Encourage CMS to continue to postpone implementation of the updated MEI weights until after the AMA completes the PPI Survey update.

Urge CMS to support continuity in available quality measures in MIPS and their associated benchmarks year over year.