September 6, 2022

Submitted Electronically via www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1770-P; CY 2023 Payment Policies Under the Medicare Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

The Advocacy Council of the American College of Allergy, Asthma and Immunology ("ACAAI") together with its sponsoring organization, the ACAAI, appreciate the opportunity to submit comments on the proposed changes to the 2023 Medicare Physician Fee Schedule and Quality Payment Program ("Proposed Rule"). The Advocacy Council and the ACAAI represent the interests of over 6,000 allergists-immunologists and allied health professionals. Its members provide patient services across a variety of settings ranging from small or solo physician offices to large academic medical centers.

In the Proposed Rule, the Centers for Medicare and Medicaid Services ("CMS") offer numerous proposals impacting provider payment under Medicare. Our comments are confined to the following proposed policies:

- Changes to the Medicare physician fee schedule conversion factor and related reimbursement rates;
- Treatment of telehealth as the federal government prepares for the expiration of the public health emergency;
- Expiration of the public health emergency flexibility for direct supervision;
- Creation of codes concerning Remote Therapeutic Monitoring ("RTM") services; and
- Policies concerning the Merit-based Incentive Payment System ("MIPS") program and MIPS Value Pathway ("MVPs").

Cuts to Physician Reimbursement

Due to the expiration of the statutory increase in Medicare physician fee schedule payments for 2022, as well as the budget neutrality requirement imposed on the Medicare physician fee schedule, CMS is proposing to reduce the conversion factor to $33.0775, a decrease of $1.53 (4.42%). The proposed cut to the conversion factor, in addition to other structural cuts, materially impact reimbursement to providers across the Medicare program—including

allergists. In fact, the proposed Medicare payment cuts will likely have a ripple effect beyond the Medicare program, as many commercial payers link their reimbursement rates to Medicare payment levels.

The COVID-19 public health emergency impacted the financial health of many providers, and we are concerned that the proposed cuts to provider payment will place an additional financial strain on practitioners. Therefore, we urge CMS to work with Congress to mitigate or eliminate the effects of these cuts and identify longer-term "fixes" to this annual issue. Specifically, Congress should extend the 3% temporary increase in the Medicare physician fee schedule, waive the 4% PAYGO sequester, provide an inflation-based update, and provide relief to counter the 1.5% budget neutrality cut for 2023.

Direct Supervision

When a physician uses clinical staff to aid in the furnishing of a service, Medicare rules generally require that the physician be immediately available on-site. This is known as direct supervision. In response to the COVID-19 public health emergency, CMS temporarily relaxed this direct supervision requirement, allowing the supervising physician (or other supervising practitioner) to be immediately available through virtual presence via real-time audio and video technology until the end of the calendar year in which the COVID-19 public health emergency ends. This applies to both "incident-to" services (e.g., allergy injections) and diagnostic tests (e.g., allergy skin tests).

We urge CMS to permanently adopt this policy so that allergists can continue to satisfy the direct supervision requirement through the use of real-time audio and video technology. This would facilitate greater efficiencies in the workforce and reduce the potential spread of COVID-19.

Expansion of Telehealth

In accordance with the Consolidated Appropriations Act, 2022, CMS proposes to continue allowing certain telehealth services that would otherwise not be available via telehealth after the expiration of the public health emergency to remain on the Medicare Telehealth Services List for 151 days after the expiration of the public health emergency. Medicare telehealth services performed on dates of service occurring on or after the 152nd day after the end of the public health emergency will be subject to the pre-public health emergency rules.

We continue to appreciate CMS's rapid expansion of telehealth services during the COVID-19 public health emergency. The proliferation of telehealth has allowed many Medicare beneficiaries to easily access medically necessary health care, while limiting the threat of COVID-19 infection. Accordingly, we support the continued payment of telehealth services for an additional 151 days beyond the end of the public health emergency.

Although we also support the expansion of telehealth past the 151 days, we recognized that the agency has limited authority to expand telehealth beyond the duration of the public health emergency. It is our understanding that Congress is in the process of considering permanent extensions of CMS' authority, or potentially mandating a longer-term or permanent expansion of

telehealth in the Medicare program. We encourage the agency to continue working under its current authority and with Congress to ensure that telehealth is available long-term.

Remote Therapeutic Monitoring Services

RTM services represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These include respiratory system status, therapy adherence, and therapy response. One technology used by some allergists consists of Bluetooth sensors that are attached to a patient's inhalers and an app that tracks frequency of inhaler use. This can provide the clinician and the patient with a better understanding of the patient's asthma triggers and avoidance measures. Another technology is a device that allows for in-home spirometry testing. During the COVID-19 pandemic, in-office spirometry, an important tool used to monitor patients with asthma, was restricted due to the potential aerosol exposure. Handheld Bluetooth spirometers have been validated and approved by the Food and Drug Administration and could add tremendous value in the management of chronic asthma.

Unlike remote physiological monitoring ("RPM") services—which can be provided under general physician supervision (i.e., provided by a physician's clinical staff without the physician being in the office or on-site), a physician (or non-physician practitioner) must directly supervise the clinical staff who are furnishing the treatment management of the RTM service. This creates a significant obstacle to providing RTM services and makes it practically impossible to have the service provided by third-party vendors.

For 2023, CMS is proposing to create four new Healthcare Common Procedure Coding System ("HCPCS") G codes, including HCPCS codes GRTM1 and GRTM2, which include clinical labor activities that can be furnished by auxiliary personnel under general supervision. Instead of creating four new HCPCS G-codes, which may cause confusion, CMS should simply allow for general supervision of RTM Current Procedural Terminology ("CPT") codes 98980 and 98981.

Exceptional Performance Bonus

The 2022 performance year was the last year for an additional performance threshold/additional MIPS adjustment for exceptional performance. We encourage CMS to work with Congress to extend the exceptional performance bonus.

Data Completeness

We appreciate the agency's proposal to set data completeness at 70% for the 2023 performance year. However, we oppose the increase of the MIPS data completeness requirement to 75% for the 2024 and 2025 performance years. The proposed increase in the data completeness requirement is inconsistent with the agency's goals of reducing administrative burden within the MIPS program. Further, percentage requirements of higher than 70% fail to take into account that some physicians provide care across multiple sites and that not all sites of service use the same electronic health record vendor or registry that the physician uses for MIPS reporting. CMS should not increase the data completeness requirement until health care data is integrated seamlessly across all settings of care.

Sunsetting the Traditional MIPS Program

In the Proposed Rule, CMS states that it has not yet determined the timing for sunsetting the traditional MIPS program. We believe that it is premature to consider retiring the traditional MIPS program. A rushed timeframe to retire traditional MIPS may disenfranchise clinicians without meaningful MVPs. Therefore, we urge CMS to continue to recognize MVP participation as voluntary for the foreseeable future.

Allergy/Immunology Specialty Set

CMS proposed to include two new measures in the Allergy/Immunology Specialty Set: (1) Screening for Social Drivers of Health ("SDOH") and (2) Adult Immunization Status. We do not support the inclusion of the Screening for SDOH quality measure in the specialty set due to lack of adequate specification and testing. In addition, CMS proposes to remove the following two quality measures from the Allergy/Immunology Specialty Set for traditional MIPS reporting: (1) Preventive Care and Screening: Influenza Immunization and (2) Pneumococcal Vaccination Status for Older Adults. We oppose the proposed removal of these quality measures.

We appreciate your consideration of our comments and recommendations. If you have any questions, please contact Susan Grupe at suegrupe@acaai.org.

Sincerely,

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