Analysis of CY 2024 Medicare Physician Fee Schedule Proposed Rule

On July 13, 2023, CMS released a proposed rule on *CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program* (CY 2024 PFS).

In this proposed rule, which makes payment and policy changes under Medicare Part B effective on or after January 1, 2024, CMS proposes changes to the Medicare Shared Savings Program; to expand access to and coverage of home-based care and caregiver supports; to expand reimbursement for services to address health-related social needs; to make additional adjustments to Evaluation and Management Visit coding and documentation; and to implement provisions of the Consolidated Appropriations Act, 2023, which extend telehealth services through 2024, among other proposals. In all, CMS received over 22,000 comments. We expect a final rule to be released in November 2023.

This document synthesizes comments on key provisions in the CY 2024 PFS proposed rule from health plans trade associations, provider groups/trade associations, quality groups, and patient and consumers advocacy groups.

The most common topics and themes from across all groups include:

- Physician payment broadly;
- Social determinants of health (SDOH) risk assessment;
- Caregiver training services;
- Complex Chronic Add-On Payment (HCPCS code G2211);
- Medicare Shared Savings Program (MSSP); and
- Telehealth.

Other topics and themes addressed but not as frequently include:

- Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services;
- Reimbursement for Auxiliary Services;
- Emergency Medical Services; and
- Digital Therapeutics.

The list of organizations whose comments were reviewed for this document is as follows:

- Association of American Medical Colleges (AAMC)
- American Academy of Family Physicians (AAFP)
- American College of Cardiology
- American Hospital Association (AHA)
- American Medical Association (AMA)
- American Medical Group Association (AMGA)
- Medical Group Management Association (MGMA)
- America's Health Insurance Plans (AHIP)
- America's Physician Groups (APG)
- LeadingAge
- National Association of ACOs (NAACOS)
- National Committee for Quality Assurance (NCQA)
- The Joint Commission (TJC)
- Consumers First (CF)
- Bipartisan Policy Center (BPC)
- National Association for Homecare and Hospice
- Primary Care Collaborative (PCC)
- Center for Medicare Advocacy
- Justice in Aging
- American Heart Association (AHA)
- American Psychiatric Association (APA)
- American Physical Therapy Association (APTA)
- American Podiatric Medical Association (APMA)

Physician Payment		
Type	**Organization**	**Summary**
Provider Trade Organizations /Groups	AAMC	• Encourages CMS to support efforts to have Congress pass legislation that would provide an annual inflation-based payment update based on the Medicare Economic Index (MEI).
	AAFP	• Encourages CMS to support efforts to have Congress pass legislation that would provide an annual inflation-based payment update based on the MEI.
	ACC	• Encourages CMS to support efforts to have Congress pass legislation that would provide an annual inflation-based payment update based on the MEI.
	AHA	• Urges CMS to work with Congress to eliminate the budget neutrality cut to the conversion factor for CY 2024.
	AMA	• Encourages CMS to support efforts to have Congress pass legislation that would provide an annual inflation-based payment update based on the MEI.
	AMGA	• Urges CMS to utilize all possible measures to mitigate physician payment reductions.
	MGMA	• Urges Congress to provide a positive update to the Medicare conversion factor in CY 2024 and all future years.

Social Determinants of Health (SDOH)		
Type	**Organization**	**Summary**
Health Plan Trade Association	AHIP	• Supports adding a SDOH Risk Assessment to the AWV as a payable service and agrees with CMS that the SDOH Risk Assessment should be optional for both health professionals and patients. • Recommends CMS provide guidance on which SDOH screening tools are permissible to ensure validated and vetted tools are used.
Provider Trade Organizations /Groups	AAMC	• Supports proposals to adopt new billing codes and payment to support risk assessments, community health integration (CHI), and principal illness navigation services and recommends CMS explore policy options to waive beneficiary cost sharing to ensure broad and equitable access to these services.
	AAFP	• Supports proposals to provide separate payment for screening for and addressing patients' unmet social needs within the context of the patient's usual source of longitudinal primary care,

Social Determinants of Health (SDOH)		
Type	**Organization**	**Summary**
		including through a SDOH Risk Assessment and create new coding and payment for community health integration services.
	AHA	• Supports reimbursement for the time and effort associated with SDOH screening, but requests clarifying guidance on what constitutes a "standardized, evidence-based screening assessment."
	AMGA	• Supports CMS's proposal to reimburse providers for administering a SDOH assessment.
	APG	• Recommends that CMS finalize the new code, GXXX5, for evidence-based SDOH Risk Assessment, and incorporate it into MSSP beneficiary assignment and other methodologies.
	MGMA	• Urges CMS to thoroughly vet and test the SDOH risk assessment tool used in services addressing SDOH and be mindful of the potential impact these codes may have on payment rates across the board due to budget neutrality requirements.
	NAACOS	• Supports codes for health and well-being coaching services on a temporary basis and for SDOH risk assessments on a permanent basis to the Medicare Telehealth Services List effective January 1, 2024. • Supports separately paying for services that address HRSNs, including community health integration services, principal illness navigation services, and SDOH risk assessment.
Quality Groups	NCQA	• Supports addition of an SDOH Risk Assessment as a reimbursable element of the Annual Wellness Visit to enhance patient-centered care. • Applauds reimbursement of social needs screening and recommends that results be documented in the clinical record via LOINC code. • Supports reimbursement for Community Health Integration Services, Principal Illness Navigation and caregiver training services.
	Joint Commission	• Supports adding a SDOH Risk Assessment to the AWV.
Consumer/ Patient Groups	Consumers First	• Supports the addition of a new standalone code to reimburse clinicians for delivering a SDOH risk assessment.
	LeadingAge	• Supports the creating of new codes for community health integration (CHI), SDOH risk assessment, and principal illness navigation services (PIN). • Supports the inclusion of all care management codes as eligible for initiating visits and note that the same provider may not provide all services, so flexibility should be allowed in general supervision of delivery of CHI/PIN services.

Social Determinants of Health (SDOH)		
Type	**Organization**	**Summary**
		• Does not agree with the proposed disallowance of consecutive use of part B home health services and community health integration.

Caregiver Training Services (CTS)		
Type	**Organization**	**Summary**
Health Plan Trade Association	AHIP	• Supports the proposal to establish payment for services to educate and involve caregivers in patient treatment plans; and supports the delivery of caregiver services via telehealth.
Provider Trade Organizations /Groups	National Association for Homecare and Hospice	• Supports codes for caregiver training services, but is concerned that the services are provided without the patient present, as the patient's presence would aid in demonstrating caregiver competency. • Recommends CMS limit practitioner payment for caregiver training services to beneficiaries that are not under a Medicare home health plan of care or not eligible for Medicare home health services, unless in medically underserved areas where there is a lack of home health agencies.
	PCC	• Supports the establishment of Caregiver Education, Community Health Integration (GXXX1, GXXX2), and Principal Illness Navigation (GXXX3, GXXX4) codes.
Quality Groups	Joint Commission	• Supports CMS' proposal to cover training services for caregivers.
	NCQA	• Supports reimbursement for Community Health Integration Services, Principal Illness Navigation and caregiver training services.
Consumer/ Patient Groups	Center for Medicare Advocacy	• Recommends caregiver training services not replace or substitute for existing Medicare Home Health Aide coverage.
	LeadingAge	• Supports the activation of caregiver training services codes for the PFS and support extension of codes for delegation of training by non-billing staff.

	Justice in Aging	• Supports reimbursement codes for caregiver training services, but recommends the definition of caregiver be aligned with existing statutes and initiatives.

Complex Chronic Add-On Payment (HCPCS Code G2211)		
Type	**Organization**	**Summary**
Provider Trade Organizations /Groups	AAMC	• Recommends that CMS provide further clarification on how the utilization assumptions were derived for an add-on payment for HCPCS code G2211 and more specific education and guidance to providers regarding when this code should be reported.
	AAFP	• Urges CMS to fully implement the G2211 add-on code in 2024.
	ACC	• Suggests that CMS delay implementation of G2211, more clearly define its purpose and usage parameters, and reduce its estimated utilization more than proposed to mirror the experience of transitional care management services more closely.
	AHA	• Supports implementation of G2211 for longitudinal care for complex patients to ensure clinicians have the added resources necessary to adequately cover the costs of providing care.
	AMA	• Concerned about the lack of clarity regarding the use of add-on code G2211 and urges CMS to further refine assumptions to prevent unwarranted reductions in the Medicare conversion factor.
	AMGA	• Concerned the G2211 add-on code will lead to additional across-the-board cuts, which illustrate the flaws inherent to the physician fee schedule's budget neutrality requirements.
	APG	• Recommends that CMS finalize an add-on payment for HCPCS code G2211 and urges CMS to monitor the impact and seek opportunities to mitigate the redistributive effect within the PFS.
	MGMA	• Urges CMS to provide further clarity and guidance surrounding the utilization of HCPCS code G2211.
	NAACOS	• Urges CMS to fully implement the G2211 add-on code in 2024.
	PCC	• Urges CMS to fully implement the G2211 add-on code in 2024.
Consumer Groups	Consumers First	• Supports CMS' proposal to implement the G2211 and make it separately payable under the PFS, starting January 1, 2024.

Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**

Health Plan Trade Association	AHIP	• Supports CMS's proposal to align the ACO and regional risk score growth cap for MSSP.
		• Supports an expanded MSSP assignment window but urges CMS conduct further analysis to ensure that the proposed Assignment methodology changes do not have unintended consequences.
		• Supports the creation of a permanent option under the MSSP that features full risk; and believes key components of a full-risk MSSP track could include 100% shared savings and loss rates and options for capitated payments.
		  ○ Participation in any new higher risk option under the MSSP should be voluntary and that CMS should not require or mandate progression by providers into higher risk tracks.
		  ○ Providers should be permitted flexibility to advance to higher risk and more advanced payment approaches at their own pace.
		• Urges CMS to balance the burden of reporting with the potential benefits, and consider the impact of how expanding the MIPS Promoting Interoperability requirements will affect scoring and whether there is a need to weigh the category at zero for certain entity types to minimize burden and avoid diluting incentives.
		• CMS should develop a financial model that incentivizes providers to participate by supporting specialty integration and sufficiently investing in providers.

Provider Trade Organizations /Groups	AAMC	• Supports the permanent adoption of the new Medicare CQMs reporting option to allow MSSP ACOs to meaningfully report quality performance. • Supports capping regional score growth and eliminating the negative regional adjustment. • Urges CMS to support legislative efforts to continue the bonus payment and eliminate high participation thresholds for clinicians in AAPMs to encourage participation in AAPMs. • Recommends CMS calculate QP thresholds at both the APM entity and individual level and allow either to satisfy QP determinations to encourage AAPM participation by both primary care providers and specialists. • Recommends that CMS not require MSSP ACOs to fulfill the MIPS Promoting Interoperability reporting requirements.

Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**
		• Believes there are two primary features that would improve a higher risk/reward track in the MSSP: payment-based participation incentives and meaningful policies to promote health equity. • These could include creating a 100% financial risk option, offering primary care capitation payments above current levels of primary care spending and payment incentives for team-based care.

	AAFP	• Urges CMS to calculate QP determinations at both the individual and APM Entity levels and apply the more favorable score.
		• Supports CMS' proposal to establish the new Medicare CQM collection type for ACOs.
		• Strongly opposes requiring MSSP ACOs to fulfill the MIPS Promoting Interoperability reporting requirements.
		• Generally supports proposed MSSP methodology changes but urges CMS to ensure that this does not have the unintended consequence of assigning beneficiaries to clinicians in specialty care or non-primary care settings.
		• Supports capping regional score growth and eliminating the negative regional adjustment.
		• Supports changes to Advance Incentive Payments and encourages CMS to consider expanding AIP access to existing ACOs that meet specific parameters and allow ACOs to keep a portion of shared savings each year.
		• Urges CMS to implement a hybrid payment participation option in the MSSP that provides prospective population-based payments for primary care
		  ○ Payments could either go directly to primary care practice or through ACO
		  ○ CMS must consider ways to support independent practice participation

	ACC	• Supports establishing Medicare CQMs, as its members participating in ACOs have faced challenges with the requirements to report all payer measures, including for patients not directly seen by specialists, which can in turn impact the ACO's performance. • Believes there should be a transitional delay for the MIPS PI reporting requirement as January 1, 2024 is too early to require ACOs to begin reporting the MIPS PI quality measures and other requirements. • Supports capping regional score growth and eliminating the negative regional adjustment. • Supports proposed changes to MSSP assignment methodology.

Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**
		• Does not support the MSSP shared governance modification as ACOs should have the flexibility to request an extension if needed which will allow for continued participation in MSSP. • Does not support modifications to Advance Incentive Payments and encourages CMS to consider proposals that would reduce extra steps for ACOs and instead allow for increased flexibility.

	American Heart Association	• Favors modifications to MSSP that:
		  ○ improve health equity through accommodations for and support of ACOs that serve a high proportion of underserved individuals,
		  ○ encourage greater model participation,
		  ○ incentivize movement into advanced APMs as ACOs gain experience and sophistication, and
		  ○ reduce complexity and administrative burden including alignment where possible across programs

	AHA	• Recommends that CMS retain its current data completeness threshold of 75% while using experience from CY 2024 and CY 2025 reporting to inform whether and when to adopt further increases. • Opposes CMS' proposal to lengthen the reporting period for the Promoting Interoperability category from 90 to 180 continuous days beginning with the CY 2024 reporting period. • Supports CMS' proposal to add a Medicare CQM reporting option. • Opposes CMS' proposal to conduct QP determinations at the clinician level.
	AMA	• Opposes CMS's proposal to require all MSSP participating clinicians meet the MIPS Promoting Interoperability measures. • Urges CMS to calculate QP determinations at both the individual and APM Entity levels and apply the more favorable score. • Supports CMS' proposal to establish the new Medicare CQM collection type for ACOs. • Urges CMS to provide additional information on the anticipated impacts of proposed MSSP beneficiary assignment changes before finalizing . • Supports MSSP benchmarking changes and urges CMS to apply the proposed changes universally across ACOs beginning in 2024. • Generally supports proposed improved flexibilities for Advance Incentive Payments

Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**
		• Recommends that CMS takes steps to expand participation options in APMs by introducing additional voluntary risk tracks. • Urges CMS to advance voluntary models with financial structures and accompanying regulatory flexibilities that are inherently sufficient to attract participants and support and sustain innovative new methods of delivering better patient care, rather than relying on models that compare financial performance to past spending. • Supports prospective patient assignment and payments, performance measures that measure what is within physicians' control, regular and timely performance feedback, longer agreement periods, additional supports for practices serving high-needs patient populations to help address and overcome barriers to care, targeted incentives to encourage primary and specialty coordination, and automatic annual inflation-based payment updates to ensure payments keep pace with rising practice costs. • Urges CMS to drive more specialty engagement in APMs by adopting more specialty-focused and integrated models, including implementing new episode-based payment models, including models that have already been developed by physicians, rather than further miring APM participants in MIPS.
	AMGA	• Supports efforts to move toward value-based care but is concerned about the frequent modifications to the MSSP, as maintaining policy stability is key to the program's success. • Opposes the proposal to determine QPP status at the individual as opposed to group level. • Urges CMS to fully address the challenges presented by the MIPS low-volume threshold. • Supports CMS' proposal to expand the MSSP assignment window; but urges CMS to provide additional information on the anticipated impacts of proposed MSSP beneficiary assignment changes, particularly in rural areas, before finalizing. • Supports MSSP benchmarking changes and urges CMS to apply the proposed changes universally across ACOs beginning in 2024. • Opposes CMS's proposal to require all MSSP participating clinicians meet the MIPS Promoting Interoperability measures. • Strongly support CMS's efforts to maintain uniform processes, procedures, and flexibility across different MSSP tracks.

Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**
	American Psychiatric Association	• Urges CMS to work with Congress and other stakeholders to address the long-standing problems within the framework of the MIPS payment and quality system to ensure physicians can sustain their practice.
	APG	• Recommends that CMS not require MSSP ACOs to fulfill the MIPS Promoting Interoperability (PI) reporting requirements. • Recommends that CMS conduct additional analyses to ensure that the changes to MSSP beneficiary assignment methodology do not have unintended consequences. • Supports CMS's proposal to expand the definition of primary care services used for assignment in MSSP using the proposed services identified by HCPCS and CPT codes. • Supports capping regional score growth and eliminating the negative regional adjustment. • APG members generally support, but also report mixed reactions, to the possibility of adding a track to MSSP with risk greater than the current ENHANCED track. APG encourages CMS to closely assess the evaluation results from the ACO REACH model to better understand the characteristics of participants that are successful in achieving savings under the Global Risk Option and urges CMS to review these evaluation results with participants as part of a mixed-methods approach to delve into the qualitative lessons to be learned from their experiences. • Recommends that CMS continue to make Qualifying APM Participant (QP) determinations at the APM Entity level instead of the individual eligible clinician level. • Recommends that CMS streamline the number of quality measures that physicians are expected to track and report and prioritize outcome and patient-reported measures. • Recommends that CMS finalize adoption of Medicare Clinical Quality Measures (CQMs) as an alternative collection type for MSSP ACOs and as a permanent reporting alternative to all-payer eCQMs. • CMS should limit reporting of Medicare CQMs to the patients included on the list issued by the agency to ACOs that are reporting Medicare CQMs and provide clarification on how the transition to Medicare CQMs will be handled.
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Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**
	MGMA	• Opposes CMS's proposal to require all MSSP participating clinicians meet the MIPS Promoting Interoperability measures. • Supports CMS' proposal to establish the new Medicare CQM collection type for ACOs. • Opposes CMS' proposal to make QP determinations at the individual clinician level. • Urges CMS to work with Congress to reinstate the APM incentive payment at 5%. • Supports CMS' proposal to expand the MSSP assignment window; but urges CMS to provide additional information on the anticipated impacts of proposed MSSP beneficiary assignment changes, particularly in rural areas, before finalizing. • Appreciates CMS contemplating the inclusion of a higher risk track in MSSP would offer increased savings and improved patient care in future rulemaking and urges CMS to work closely with stakeholders to design a new risk track through a transparent and collaborative process.
	NAACOS	• Urges CMS to view the Medicare CQM option as a permanent option that is in place until digital quality measurement and reporting is feasible for all ACOs. • Urges CMS to conduct additional analyses before implementing proposed changes to MSSP beneficiary assignment. • Supports MSSP benchmarking changes and urges CMS to apply the proposed changes universally across ACOs beginning in 2024. • Supports proposed changes to Advance Incentive Payments and encourages CMS to further expand eligibility criteria. • Strongly opposes CMS proposals to align CEHRT requirements for MSSP ACOs with MIPS and we urge CMS to reconsider this policy. • Encourages the agency to finalize a policy where QP determinations can be made at both the APM entity and individual level. • Urges CMS to implement a higher risk track in MSSP which it refers to as "Enhanced Plus," which would offer a bridge between the Enhanced risk track and the ACO REACH model.

	PCC	• Urges CMS to develop MSSP hybrid primary care payment option with the following principles in mind:
		  ○ Ensure that investment reaches primary care
		  ○ Enable all MSSP tracks to participate

Medicare Shared Savings Program (MSSP)		
Type	**Organization**	**Summary**
		○ Provide greater incentives for independent practices and those serving rural or underserved communities ○ Support participation by practices that are small, independent, or new ACO models ○ Allow choice of payment approach (directly to practice or through ACO) • Believes a higher risk track in MSSP should include: ○ Strong beneficiary protections – informed by protections established in ACO REACH; ○ Safeguards to ensure investments reach primary care; and ○ Adoption of a population-based, prospective payment approach for primary care within the Enhanced Risk track • Urges CMS to consider incorporating successful features of other CMS Innovation Center Models into MSSP including better access to data, paper-based voluntary alignment, and cost-sharing relief. • Supports CMS' proposed expanded window for assignment to an ACO.
Patient Group	LeadingAge	• Supports CMS's proposal to assign MSSP beneficiaries using evaluation and management codes for NPs, PAs, and CNSs to determine where a beneficiary receives the plurality of their primary care. • Suggests that CMS: 1) pursue a statutory change to permit other provider types to be the accountable entity and coordinator of care in an ACO, 2) develop value-based arrangements that are embedded within the ACO for non-physician participating providers or organizations and 3) consider new avenues for beneficiary assignment to ACOs.

Telehealth		
Type	**Organization**	**Summary**
Provider Trade Organizations /Groups	AAMC	• Supports the extension until December 31, 2024, of the COVID-19 telehealth flexibilities provided for in the CAA, 2023. • Supports the removal of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services furnished via telehealth through December 31, 2024.

Telehealth		
Type	**Organization**	**Summary**
		• Supports CMS' proposal to pay the same amount for in-person services when a practitioner is providing telehealth to the patient at home, beginning January 1, 2024. • Recommends that CMS not require the Medicare enrollment application to include practitioners' home addresses when providing telehealth from their homes if there is a valid reassignment relationship between the remote practitioner and a Medicare-enrolled practice with a physical office location where care is delivered in-person to patients. • Supports CMS' proposal to add HCPCS GXXX5 to the Telehealth Services List on a permanent basis. • Urges CMS to advance long-term solutions that preserve patient access to telehealth services. • Urges CMS not to require physicians include their home address on Medicare enrollment paperwork related to rendering telehealth services. • Supports CMS' proposal to pay telehealth services billed with POS 10 at the non-facility rate.
	AAFP	• Supports CMS' proposal to add HCPCS GXXX5 to the Telehealth Services List on a permanent basis. • Urges CMS to advance long-term solutions that preserve patient access to telehealth services. • Urges CMS not to require physicians include their home address on Medicare enrollment paperwork related to rendering telehealth services. • Supports CMS' proposal to pay telehealth services billed with POS 10 at the non-facility rate.
	ACC	• Supports the extension of Direct Supervision via Two-way Audio/Video Communications Technology.
	American Heart Association	• Supports temporary addition of the codes for CY 2024 to facilitate collection of more, better data and research relating to best practices for implementing telehealth.
	AHA	• Supports CMS' ongoing study into creating a long-term structure for the efficient delivery of telehealth services. • Supports CMS' proposed additions to the eligible telehealth services list. • Supports CMS' proposed simplification of the process to add codes to the list of eligible telehealth services and the streamlining the telehealth categories into "permanent" and "provisional" designations.

Telehealth		
Type	**Organization**	**Summary**
		• Supports reimbursement at the non-facility rate for telehealth visits to the patient's home, but disagrees that telehealth provided to locations other than the patient's home should be reimbursed at the facility rate. • Supports the proposed extension of virtual presence to satisfy direct supervision requirements by interactive telecommunications technology. • Continues to support CMS' ongoing efforts to reimburse audio-only services. • Concerned with the requirement, and the potential privacy issues it poses to publish providers home addresses on sites like Medicare Care Compare without their knowledge or consent.
	AMA	• Supports CMS's proposals to continue paying for telehealth services provided nationwide and to patients in their homes, as well as the continuation of payment for the CPT codes for audio-only visits and all Medicare telehealth services covered in 2022 through the end of 2024.
	AMGA	• Agrees with CMS's proposal to reimburse telehealth provided to patients in their homes based on the "non-facility" rate and supports all proposals to extend telehealth flexibilities.
	APA	• Supports the codification of the Consolidated Appropriations Act, 2023, extensions of telehealth capabilities, including the delay of in-person requirements for tele-mental health, the allowance of audio-only tele-mental health care, and the allowance for RHCs and FQHCs to be reimbursed for rendering telehealth services. • Urges CMS to permanently remove a mandatory in-person visit requirement for Medicare beneficiaries prior to initiating or maintaining tele-mental health care with a psychiatrist, contributing to equitable access to crucial, safe, and effective telepsychiatry. • Supports the maintenance of codes billed with POS 10 ("Telehealth Provided in Patient's Home") paid at the non-facility rate, constituting the same level of coverage as if the care had been provided in-person and urges CMS to permanently maintain payment for telehealth provided to patients' homes at the same rate as if the service had been delivered in person to maintain quality of and access to care in rural and other under-resourced settings. • Recommends that the ability for residents to deliver telehealth services under virtual supervision be applied permanently, which is a key retention tool and will help curb the drastic workforce shortage facing psychiatry. • Does not support the proposed rule to only allow virtual supervision in cases where the patient, resident, and teaching physician are in three different locations.

Telehealth		
Type	**Organization**	**Summary**
	APTA	• Supports CMS' proposal to extend the virtual direct supervision flexibility through 2024 and recommends that CMS consider making the flexibility permanent as it relates to physical therapists. • Have received several concerns from physical therapists (PTs) that FQHCs and RHCs are extremely cautious in the provision of PT services in these settings and urges CMS to not require a higher standard of supervision than is necessary.
	APMA	• Supports allowing any site in the US where the beneficiary is located at the time of the telehealth service, including an individual's home, to serve as an originating site for services furnished via telehealth. • Urges CMS to work with Congress to permanently remove the Section 1834(m) geographic and originating site restrictions to ensure that all patients can access care where they are, where clinically appropriate and with appropriate beneficiary protections and guardrails in place. • Supports the proposal to pay claims billed with POS 10 (Telehealth Provided in Patient's Home) at the non-facility MPFS rate and to pay claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) at the MPFS facility rate. • Supports the proposal to remove the telehealth frequency limitations for the duration of CY 2024 for the following services: subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. • Appreciates ongoing payment for telephone E/M services through 2024 and asks that this be made a permanent policy.
	MGMA	• Supports CMS making conforming regulatory changes to implement the CAA, 2023 and urges CMS to permanently institute coverage and payment for audio-only service. • Supports CMS reimbursing telehealth services using the POS 10 code at the higher non-facility rate through 2024.
	National Association for Homecare and Hospice	• Agrees with CMS that Principal Illness Navigation services can be delivered via telehealth.
	Justice In Aging	• Recommends that caregiver training services be allowed via telehealth.

Telehealth		
Type	**Organization**	**Summary**
Consumer/ Patient Groups	LeadingAge	• Supports continued extension of the COVID-19 PHE telehealth flexibilities, extension of the definition of direct supervision beyond December 31, 2024, and continuing to allow outpatient therapy by institutional providers via telehealth through 2024. • Supports removing frequency limitations to align with other telehealth-related flexibilities.
Other Interest Groups	ATA	• Supports providers' ability to offer Medicare telehealth services and believes all practitioners should have the option to utilize virtual care when clinically appropriate and be reimbursed for the services rendered. • Urges permanent coverage of therapy codes even though physical therapists, occupational therapists, and speech therapists are not currently permitted by statute to provide telehealth services after CY2024. • Urges CMS to continue seeking stakeholder feedback on telehealth reimbursement rates in future fee schedule rules to ensure these reimbursement rates are appropriate as technology continues to advance. • Urges CMS to make direct supervision via telehealth a permanent option. • Urges CMS to permanently allow providers to bill practice addresses rather than home addresses.
	BPC	• Urges CMS to issue guidance to clarify parameters for tele-behavioral health services administered in a behavioral health crisis. • Supports CMS's proposal to reimburse telehealth service at the non-facility versus the facility rate for 2024; however, for the longer-term BPC recommends a differential payment be developed by CMS between the non-facility rate and the facility rate. • Recommends CMS maintain guardrails around the continuation of audio-only telehealth services, including limiting their use to established patients and requiring that audio-only visits be patient-initiated. • Recommends CMS allow audio-only telehealth visits when a beneficiary is not capable of accessing two-way video due to lack of broadband, digital literacy, or resources to purchase internet access.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Service		
Type	**Organization**	**Summary**
Provider Trade Organizations	AAMC	• Supports CMS's proposal to allow FQHCs and RHCs to furnish RPM and RTM services, but opposes the 16-day monitoring requirement to bill these services.
	AAFP	• Appreciates CMS' clarifications and agrees that RPM and RTM services should not be reported if they are related to a diagnosis for a global procedure.
	AHA	• Disagrees that RPM and RTM services should be limited to established patients. • Encourages CMS to evaluate alternative options for clinical use cases that may not require 16 days of monitoring in a 30-day period. • Supports concurrent billing for RPM/RTM with CCM, TCM BHI, PCM and CPM services, however, concurrent billing for RPM and RTM should also be allowed. • Disagrees that RPM and RTM services should need to address an episode of care that is separate and distinct from global service in order to be separately billed.
	AMA	• Recommends that CMS modify its clarifications for remote monitoring services, as it believes that many of the statements in the Proposed Rule that are intended only to clarify CMS policy on reporting of remote monitoring services create new restrictions on the use of these codes.
	ATPA	• APTA believes that multiple providers should be able to bill RTM in the same time period if the services are for distinct therapeutic purposes and are not duplicative • APTA agrees that a single provider should only be able to bill RTM services once in a time period • APTA appreciates the inclusion of RTM in G0511.
	APMA	• Does not agree with the restriction that, for either RPM or RTM, only one practitioner can bill CPT codes 99453 and 99454, or CPT codes 98976, 98977, 98980, and 98981, during a 30-day period. Consistent with the PCM precedent, CMS should remove its restriction that only one practitioner can bill the RPM or RTM codes for a patient during a 30-day period.
	MGMA	• Appreciates CMS' efforts to increase access to RMS, but is concerned that certain clarifications will inhibit medical groups' abilities to utilize these services to their full extent. • Appreciates the flexibility provided during the PHE in allowing new patients to receive RPM services and believes that rolling back this flexibility is short-sighted and dangerous.
Other Interest Groups	ATA	• Urges CMS to clarify billing processes for RHCs and FQHCs. • Does not support CMS reinstating the 16-day data requirement for all beneficiaries.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Service		
Type	**Organization**	**Summary**
		• Urges CMS to reconsider its policy regarding concurrent billing of RPM and RTM services in general and is supportive of the ability for various specialties and specialists to monitor and bill for different illnesses.
	BPC	• Recommends CMS create a separate code to provide necessary access to RPM and RTM services • Recommends that CMS allow FQHCs and RHCs to bill separately for RPM and RTM services • Recommends HHS should use its existing authority to recommend a diverse set of billing codes so there are more options for number of minimum days of data collection required, as opposed to one requirement of 16-days of data in a 30-day period.

Reimbursement for Auxiliary Service		
Type	**Organization**	**Summary**
Other Interest Groups	BPC	• Urges CMS to clarify that peer support/recovery specialists and community health workers can be considered "auxiliary personnel" incident to and under the direct supervision of the billing physician.
Provider Trade Organizations /Groups	AHA	• Supports expanding reimbursement for HRSNs services provided by auxiliary staff such as community health workers and care navigators and encourages CMS to work with Congress to waive cost-sharing requirements for the HRSNs codes in the final rule.
	AMA	• Urges urge CMS to better define the role of the auxiliary staff permitted to perform community health integration services.
Consumer Groups	Consumers First	• Supports the creation of two new G codes allowing primary care physicians and other clinicians to partner with CHWs and other auxiliary personnel to receive payments for community health integration services. • Encourages CMS to continue to refine and modify the frequency and time descriptors associated with the billing of CHI services to ensure the reimbursement for these services adequately accounts for time required for primary care clinicians and auxiliary personnel to meet the needs of the patients they serve.

Emergency Medical Services (EMS)		
Type	**Organization**	**Summary**
Other Interest Groups	BPC	• Urges CMS to expand data collection and the testing of new payment and service delivery models for EMS providers.

Digital Therapeutics		
Type	**Organization**	**Summary**
Provider Trade Organizations /Groups	APA	• Urges FDA and CMS to collaborate on a clear, practical definition of digital therapeutics and apply a rigorous standard of evidence of safety and effectiveness prior to codifying reimbursement for these products.
Other Interest Groups	BPC	• Urges CMS to issue a standalone call for input on digital therapies, separate from the annual PFS, to ensure the broadest participation in the comments process.