<u>*Submitted Electronically*</u>

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8106
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the proposed rule for the Calendar Year (CY) 2024 Medicare Physician Fee Schedule published in the *Federal Register* on August 7, 2023. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to by Medicare as inpatient rehabilitation facilities (IRFs). In addition to the inpatient physician services provided in IRFs that are covered by the Physician Fee Schedule, AMRPA members also provide rehabilitation services across the continuum of care, including in hospital outpatient departments, physician offices, comprehensive outpatient rehabilitation facilities (CORFs), and therapy clinics. As part of this continuum of care, our members submit claims under Part B of the Medicare program for a variety of services, including physician visits, physical and occupational therapy services, speech-language pathology, and several other elements of care.

IRFs specialize in treating patients with some of the most complex and serious conditions, such as stroke, traumatic brain injury, and spinal cord injury. Continued medical rehabilitation is an essential component of recovery from these types of conditions, and it is important that CMS keep the need for rehabilitation services for complex and vulnerable patients in mind when modernizing the Medicare program.

There are a number of proposals in this year's rule that would impact access to rehabilitation services for patients in need of continued rehabilitation, and we offer comments on those proposals in the following sections of this letter. Immediately below, we provide a brief summary of our recommendations prior to our more in-depth discussion of these issues.

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Recommendations:

1. **Budget Neutrality Adjustment to Conversion Factor:** Once again, physicians, therapists, and other clinicians paid under the Medicare Physician Fee Schedule are facing significant reimbursement cuts due to the imposition of budget neutrality and the reduction of Congressional support. CMS should utilize all authorities to minimize and/or mitigate reductions to the conversion factor and ensure that patient access to care is not compromised.
2. **Billing of Split or Shared Services:** CMS' proposed policy regarding billing for split or shared evaluation and management services fails to adequately account for the unique role of physicians in providing care, and the agency has already delayed this policy multiple times. CMS should permanently rescind the transition to "time-only" billing and develop a policy that appropriately reimburses for the role of both physicians and non-physician practitioners who jointly provide these services.
3. **Telehealth Access and Expansion:** CMS should implement its revisions to the Medicare Telehealth Services List structure while ensuring that it does not institute undue barriers to covering and paying for new telehealth services on a long-term or permanent basis.
4. **Provider Enrollment Authorities:** CMS' proposals expanding the agency's enrollment revocation authorities could reach beyond reasonable stewardship of the Medicare program and potentially threaten Medicare participation and reimbursement in the absence of actionable misconduct.
5. **MIPS Penalty Thresholds:** CMS should not make the MIPS program unnecessarily more difficult by increasing penalty and data completeness thresholds while clinicians are already facing significant reimbursement cuts elsewhere in the Physician Fee Schedule.

I. Proposed Application of Budget Neutrality and Conversion Factor Cuts Threaten Access for Vulnerable Medicare Beneficiaries in Need of Medical Rehabilitation.

Over the past several years, Medicare providers paid under the Physician Fee Schedule (PFS) have faced significant disruptions in payment rates due to the ongoing impact of policy changes finalized by CMS for physician outpatient evaluation and management (E/M) visit codes. AMRPA has recognized the importance of updated valuations for these services to ensure that physicians conducting E/M visits are adequately reimbursed for their services. However, the strict budget neutrality requirement applied to the PFS combined with these E/M changes has led to drastic annual cuts to the conversion factor in recent years. Thankfully, Congress has consistently enacted legislation to mitigate some of these cuts, but the impact has still been severe on providers, especially those offering rehabilitation services. AMRPA has consistently raised serious concerns about the impact of these payment cuts on patient access to care, particularly for some of the most vulnerable beneficiaries in the Medicare program.

This year, CMS proposes yet another cut to the conversion factor of nearly 3.4%. While the overall impact of the proposed cut will affect all providers differently depending on their individual practices and service mix, we are particularly concerned about the impact on the providers of critical rehabilitation services, including physical and occupational therapists and speech language pathologists (projected to face higher than 3% aggregate reductions) and physiatrists (projected to face approximately 1.4% reductions). Other physician specialties that serve as rehabilitation physicians in IRFs or provide other services to inpatient rehabilitation patients are projected to face similar cuts as well. These types of payment reductions, especially in light of the Fee Schedule rates finalized in previous years and the ongoing economic difficulties faced by health care providers across specialties, may result in seriously damaging service cuts and patient access issues for critical rehabilitation services.

For some types of specialties, the reduction to the conversion factor may be offset by the increase in the Relative Value Units (RVUs) for certain codes, or by the ability to bill the proposed new add-on code for physician practices that bill a high volume of E/M services. However, for other vital services, including medical rehabilitation, this is simply not the case. Rehabilitation therapists, including physical therapists, occupational therapists, and speech language pathologists, largely do not bill E/M services. This means that for these providers, they will not see a simple shifting of reimbursement from one code to another but an absolute reduction in total reimbursement, as reflected in CMS' own projections (Table 104 in the proposed rule).

We also recognize that the vast majority of this year's conversion factor cut, over two percent, is attributable to the implementation of the previously finalized add-on code for complex patient E/M services, G2211. AMRPA has previously supported the intent of this code and the desire to update payments for certain types of E/M services, but we maintain our concerns about the unintended impact of these changes on the bottom line for the majority of providers paid under the fee schedule. In prior years, these concerns were shared by Congress, which acted to delay the implementation of the add-on code for three years to mitigate its impact on the conversion factor in the early years of the COVID-19 pandemic. We appreciate the efforts CMS has taken in the intervening years to reevaluate the projected utilization for the code and thus the magnitude of its impact on budget neutrality; however, it still appears that a wide swath of providers will see their reimbursement decreased significantly due to its implementation without being able to take advantage of this code in their practice. For rehabilitation providers especially, the add-on code will have limited, if any, applicability.

Even as the COVID-19 public health emergency (PHE) has ended, health care providers continue to face unprecedented economic headwinds and enduring ripple effects from the pandemic. Staffing challenges remain formidable, with serious shortages of physicians, therapists, nurses, and other critical roles nationwide,[1] along with significant inflationary pressures impacting salaries as well as other rising costs for practice expenses and auxiliary staff. If the proposed cuts go into effect in this year's fee schedule, compounding prior years'

[1] See, e.g., Definitive Healthcare, *Addressing the Healthcare Staffing Shortage* (Oct 2022), finding that nearly 334,000 healthcare providers dropped out of the workforce in 2021, including more than 22,000 physical therapists, as well as 117,000 physicians and 76,000 non-physician practitioners.

decreases and current fiscal pressures, we fear that providers will be left with no choice but to reduce access for Medicare beneficiaries, close service locations and/or cancel expansion plans, provide less resource-intensive services, and take other measures that will have a direct impact on patient care.

Further, while the Fee Schedule reductions only directly apply to Medicare providers and beneficiaries, we remind CMS that the agency's payment policies set precedent for many commercial payers and other federal health care programs. Payment policy changes in Medicare Fee-for-Service will have an even wider-ranging impact beyond the nearly 30 million beneficiaries served by traditional Medicare.

We recognize that CMS has limited authority to modify the statutorily mandated budget neutrality requirement when calculating updates to the annual conversion factor, and that Congress and other stakeholders are actively engaged in discussions to help ensure that providers are not inordinately burdened by payment cuts in 2024. We urge the agency to coordinate with policymakers as much and as often as possible, both regarding a short-term solution for the CY 2024 Fee Schedule, as well as more permanent policies to better reflect sustainable payment rates for the long-term. At the same time, we urge CMS to use all existing authorities and seek to preserve payment updates to the maximum extent possible in CY 2024.

Recommendation:

- **CMS should exercise all available authorities to avoid harmful reimbursement cuts to critical rehabilitation services.**

II. Proposed Policy for Billing Split or Shared Services Undercuts Physician Expertise and Training.

In the CY 2022 proposed rule, CMS put forward new policies to determine which clinician may bill for a E/M service in a facility setting, including hospitals, when a visit is performed in part by both a physician and a non-physician practitioner (NPP). Under this proposal, CMS would only allow the clinician who performed the "substantive" portion of the visit to bill for the service. In the initial proposal, the substantive portion would be determined solely by the clinician who spent the most time on the visit. In the final rule for CY 2022, CMS instead implemented a transitional policy, in which the substantive portion could be identified by the "time-only" determination or by who conducted one of the three key E/M components: history, exam, or medical decision-making. This transitional policy was originally set to last for only a year but after stakeholders expressed serious concerns, CMS extended the policy by an additional year in the CY 2023 final rule. Now, CMS proposes to once again delay the transition to the time-only determination for another year, and to continue allowing clinicians to choose between time or the key E/M components for CY 2024.

AMRPA has long held serious concerns about the proposed use of time-only to determine how split or shared services are billed, outlined in depth in our comments on the CY 2022 proposed

rule. By proposing to only use time as the standard for identifying the billing clinician, CMS treats the time spent by an NPP as interchangeable with that of a physician, contrary to CMS' own longstanding policy of recognizing physicians as the highest-trained and qualified clinicians to oversee care in a hospital. NPPs do play a crucial role in the hospital setting, particularly in geographic areas or specialties where there is a shortage of physicians. In fact, patients frequently benefit most from a collaborative approach to care, utilizing physicians, NPPs, and other clinicians. Such an interdisciplinary model is a core feature of the intensive rehabilitation care provided in IRFs, and AMRPA supports the use of a diverse range of clinicians to provide the care needed by patients in different settings.

However, treating the time spent by a physician as equivalent to the time spent by an NPP discounts how the training and expertise of physicians allows them to quickly, effectively, and efficiently make complex medical decisions, and would essentially reward the quantity of time spent over the quality of time spent treating patients. Consistent with CMS' recognition of physicians as uniquely qualified to oversee care in a hospital setting, it should be expected that a physician could perform their aspect of a given service in a more time-efficient manner than an NPP, without sacrificing quality of care. In addition, we are concerned that switching to a time-only model will add significant administrative burden, as providers may be required to track and document each minute spent with and away from patients in order to appropriately allocate billing. This takes more time away from patient care for mere documentation tasks. In sum, physician judgment is critical to determining and developing the plan of care, overseeing the medical decision-making process, and addressing any complexities that arise with the patient's condition.

We strongly support CMS' proposal to further delay the transition to time-only billing, and urge the agency to discard this proposed transition entirely. Instead, we recommend that CMS finalize a permanent policy to allow billing based on history, exam, medical decision-making, *or* time, which would focus on the qualitative contributions of the clinicians involved in a given visit and encourage the highest-quality and most efficient outcomes for patients.

Recommendation:

- **CMS should permanently withdraw its delayed policy for billing split or shared E/M services and advance a policy to adequately account for the unique role of physicians.**

III. CMS Should Maintain Robust Access to Telehealth Rehabilitation Post-PHE.

AMRPA greatly appreciates the steps CMS has taken and continues to take to allow the provision of rehabilitation services, including physical therapy, occupational therapy, and speech language pathology services, to Medicare beneficiaries via telehealth both during and following the COVID-19 PHE. During the temporary expansion of telehealth over the past several years, rehabilitation providers have consistently reported that the experience of utilizing telehealth to provide rehabilitation services, especially therapy services, has been a lifeline for patient access and beneficial for both patients and providers. We continue to believe that such services should

become a permanent, safe, and appropriate option for Medicare beneficiaries and the providers who serve them.

Extension of Telehealth Authorities Through CY 2024

CMS proposes to align its telehealth policies in CY 2024 with the statutory changes enacted by Congress in the *Consolidated Appropriations Act, 2023*, essentially extending the current status quo for Medicare telehealth through December 31, 2024. We support these actions as they will allow Medicare beneficiaries to continue to receive a range of telehealth services in a variety of settings, including their homes, provided not only by physicians but physical and occupational therapists, speech language pathologists, audiologists, and other clinicians. Telehealth can be especially useful for patients with disabilities and chronic conditions who have an ongoing need for rehabilitation therapy following their IRF stay, such as patients with mobility impairments or who otherwise have difficulty traveling back and forth from in-person appointments. Telehealth can also be a lifeline for rural patients or those in medically underserved areas seeking improved access to rehabilitation. Individuals with brain injury or other cognitive impairments have also found telehealth and telerehabilitation to be an effective method of accessing therapy while cutting down on distractions or other difficulties associated with receiving care in an unfamiliar environment.

We particularly appreciate CMS' additional clarification regarding the ability of therapists employed in institutional settings to provide Medicare telehealth services after the end of the PHE. We support the proposal to extend billing flexibilities for these providers through the end of CY 2024, along with the other telehealth flexibilities advanced during the PHE, and encourage CMS to include these providers in any longer-term or permanent changes to the Medicare telehealth regulations.

AMRPA also recognizes, however, that permanent changes to Medicare telehealth will necessarily involve legislative change and engagement from Congress. As CMS, Congress, and other stakeholders prepare for discussions around longer-term extensions or permanent policy changes for pandemic-era flexibilities, we urge the agency to prioritize ensuring that beneficiaries maintain access to telehealth when it is clinically appropriate and beneficial for their care. We especially caution CMS not to jettison flexibilities around the provision of audio-only telehealth services, as older adult populations (who may have less facility with technology) and beneficiaries with limited broadband access continue to see significant benefits from these services even without a visual component. AMRPA stands ready to provide additional feedback and assistance to the agency and other policymakers to help inform the long-term telehealth paradigm through CY 2024 and beyond.

Changes to Medicare Telehealth Services List

In preparation for more long-term revisions to the telehealth regulations, CMS proposes to revise the process by which the agency authorizes specific services for telehealth in Medicare. Under this proposal, the current three-tiered Medicare Telehealth Services List would be consolidated into a single list of "permanent" and "provisional" approved service codes. As the agency

recognizes, the current list has become confusing and unwieldy given the significant changes made during the PHE, and we support and appreciate this administrative simplification.

CMS also proposes to set five new steps (or criteria) for adding, removing, or changing the status of services on the Medicare Telehealth Services List, as follows:

1. Determine whether the service is separately payable under the PFS;
2. Determine whether the service is subject to the provisions of section 1834(m) of the [Social Security] Act;
3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system;
4. Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in final rulemakings; and
5. Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system.

Services that meet the first three criteria could be assigned a provisional status, while services would have to meet either criterion 4 or 5 to be assigned a permanent status. We support the proposed process and appreciate the clarity as to how CMS will evaluate requests for new services to be added to the list. However, as many of the services currently available on a provisional basis are relatively new to being provided via telehealth at scale, we question whether the fifth criterion may present an undue burden to getting new services authorized for telehealth provision. In some cases, especially for services that are not provided frequently via telehealth, it may be difficult to develop extensive clinical evidence specifically demonstrating the benefit of the service as provided virtually, rather than demonstrating that the service has a clinical benefit generally and can be appropriately provided via telehealth. Furthermore, having to produce specific data and evidence to show that providing a service virtually adds clinical value could be a time-consuming and costly endeavor that limits innovation. As discussions progress towards the long-term policies governing Medicare telehealth, we encourage CMS to carefully consider any potential barriers to authorization that the agency's evaluation process may present that could limit patient access to remote care.

As CMS is not proposing any major changes to the codes that are currently approved under the existing Telehealth Services List for CY 2024, we refrain from providing feedback on specific services that should be approved for Medicare telehealth on either a permanent or provisional basis. However, as the agency prepares its telehealth policies for CY 2025 and beyond, we continue to urge CMS to consider the importance of allowing beneficiaries to access telerehabilitation services (including physical therapy, occupational therapy, *and* speech-language pathology services) on a permanent basis. Our members consistently report that these services have a significant benefit for the patient populations we serve, and we believe these should remain a core component of the Medicare telehealth benefit.

Recommendations:

- **CMS should finalize its proposed alignment of Medicare telehealth regulations with the *Consolidated Appropriations Act, 2023* and allow beneficiaries to continue accessing telehealth services under expanded authorities through CY 2024.**
- **CMS should finalize its proposed consolidation of the Medicare Telehealth Services List but consider modifying the criteria for services to be considered eligible for permanent authorization.**

IV. Provider Enrollment and Revocation Processes Should Remain Reasonable Exercises of CMS Authority.

CMS proposes fairly significant changes to its existing Medicare provider enrollment authorities in this year's rule, including the agency's ability to stay or revoke a provider's or supplier's enrollment in the Medicare program. While AMRPA recognizes the importance of CMS' authority and governance over the Medicare program, including appropriate efforts to eliminate waste, fraud, abuse, malfeasance, and criminal misconduct from the Medicare program, we have concerns that several of the proposals would add uncertainty and potentially expand the agency's role beyond what is reasonable and necessary to protect Medicare beneficiaries and the fiscal integrity of the program.

Expansion of Revocation Authorities

As discussed in the proposed rule, CMS has specific authority to govern the Medicare enrollment process for providers and suppliers, as well as general authority to prescribe regulations for "efficient administration" of the Medicare program. This includes the ability to revoke a Medicare provider's or supplier's enrollment in the Medicare program for a specific set of reasons, including failure to adhere to enrollment requirements, exclusion by the HHS Office of Inspector General (OIG), a felony conviction within the previous 10 years, a pattern of improper or abusive billing, prescribing, or ordering, and/or termination by another Federal health care program.

Now, CMS proposes to expand the agency's authority to revoke enrollment. In particular, the agency proposes to allow revocation if any "provider, supplier, or any owner, managing employee, officer, or director thereof" was convicted of a misdemeanor under Federal or State law within the previous 10 years "that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries." CMS provides several examples of potential conduct that could be deemed detrimental, including fraud or criminal misconduct related to participation in a federal or state health care program or delivery of health care services; assault, battery, neglect, or abuse of a patient; or "any other misdemeanor that places the Medicare program or its beneficiaries at immediate risk."

AMRPA is concerned that the specific proposed regulatory language may capture misdemeanors of a broader range than those included in the corresponding examples. We are particularly

concerned that misdemeanors by individuals associated with provider entities that may be completely unrelated to the provider's operations could threaten a provider's enrollment entirely. We therefore urge CMS to more clearly specify in the final rule that revocations of enrollment for misdemeanors should only be tied to specific fraud, financial mismanagement, or threats to patient health or safety.

Proposed Stay of Enrollment

Additionally, CMS proposes a new "stay of enrollment" process to temporarily pause a Medicare provider's or supplier's billing privileges. Currently, the agency is able to fully revoke enrollment, or "deactivate" a provider or supplier from the program, which allows for an administrative reactivation process. CMS intends the stay of enrollment to be a more modest sanction than either, allowing the provider or supplier to remain enrolled in Medicare. Under this proposal, CMS would require both that a provider or supplier be actually non-compliant with at least one enrollment requirement, *and* that the agency determine the non-compliance can be remedied simply by submitting an enrollment or revalidation form (either Forms CMS-855, CMS-20134, or CMS-588). CMS suggests as an example that such a situation justifying a stay of enrollment could be when a provider fails to disclose a change of address, but then resubmits their enrollment form to reflect the new change.

A stay of enrollment would last no longer than 60 days, and CMS suggests that remediation could be processed more quickly than a full reactivation request. However, this process appears too punitive on providers in comparison to the types of non-compliance that appear to be targeted. This proposal seems overly broad and could be applied to simple clerical or administrative errors that may occur in the enrollment process. CMS makes clear that any and all items or services provided during a stay of enrollment period would not be payable by CMS, even retroactively after the requisite forms have been submitted and approved. Minor mistakes on a provider's enrollment application should not expose it to the possibility of a penalty involving the withhold of all Medicare payments during the stay of enrollment, the application of which would be egregious and punitive. According to the limitations CMS proposes on its own process, a stay of enrollment would only be appropriate when a concern of administrative non-compliance could be easily remedied by submission of a form. CMS does not appear to suggest this stay would be used or even considered in cases where actual misconduct is alleged, whether a felony or misdemeanor conviction, fraud, or any other adverse actions that might more appropriately trigger a revocation or a deactivation.

Given this wide gulf between misconduct and potentially innocuous technical non-compliance, we question whether providers should be prohibited from receiving payment for Medicare items and services provided during a stay period, if all other coverage conditions are met. If an issue as simple as an unreported change of address is timely resolved through the submission of one of the specified forms, we do not believe that claims submitted prior to the form submission should automatically be considered non-covered. If CMS is truly seeking a "more modest," and less punitive pathway, we urge the agency to consider a temporary stay of enrollment that allows claims to be retroactively paid if and when any technical non-compliance is appropriately resolved in a timely fashion.

Recommendations:

- **CMS should institute guardrails to ensure its revocation authority is limited to instances of fraud, financial misconduct, or threats to patient safety.**
- **CMS should only finalize its proposed "stay of enrollment" process if claims can be paid retroactively once technical issues are resolved.**
- **CMS should limit stays of enrollment to only significant and material deficiencies related to provider misconduct.**

V. Proposed Changes to MIPS Thresholds Further Threatens Provider Payment without Advancing Quality of Care.

CMS proposes various refinements and updates to the Merit-based Incentive Payment System (MIPS), which allows providers who are not participating in an Alternative Payment Model (APM) to participate in the Medicare Quality Payment Program (QPP). While we do not address every proposed change to the MIPS program, we find it important to draw CMS' attention to several proposals that we believe could negatively impact the quality of care and create more harm than benefit to providers and the Medicare program.

MIPS Penalty Threshold

For the CY 2024 performance period, CMS proposes to increase the MIPS performance threshold from 75 to 82 points. During the COVID-19 PHE, the agency had maintained the threshold at 75 points for two consecutive years. CMS previously calculated the MIPS threshold by evaluating the mean score for participating providers from a single performance period. Now, CMS proposes to review a "prior period" to establish the performance threshold, defined as three consecutive performance periods. Accordingly, for the CY 2024 performance period/2026 MIPS payment year, CMS proposes to review performance spanning the CY 2017 performance period/2019 payment year through the CY 2019 performance period/2021 payment year. As shown in Table 51 in the proposed rule, CMS could have considered alternative performance thresholds ranging from 75 to 89 points.

AMRPA opposes the proposal to raise the MIPS penalty threshold to 82 points. CMS recognizes the agency's flexibility in selecting the MIPS threshold, and we urge the agency to use its authority to maintain the threshold at 75 points for the CY 2024 performance year. CMS itself estimates that this change in the penalty threshold would result in 54% - over half of all MIPS participants – incurring a penalty for the next payment year, with the majority of participants facing a 2% or more reduction. Given the significant proposed cuts to the conversion factor in this year's rule, combined with the cuts finalized in recent years and the ongoing fiscal pressures faced by the health care field, levying an additional penalty on a majority of providers through MIPS would seriously threaten providers' viability and patient access to care.

In addition, CMS fails to take into account the numerous ways in which it is proposing to make the MIPS program more challenging beyond its proposal to raise the penalty threshold. As

detailed below, CMS is proposing to remove the ability to re-weight certain categories for participants, expand the data completeness threshold, double the reporting period for the Promoting Interoperability program, and refine various MIPS measures. Together, these actions create a significantly more challenging MIPS program, making it more difficult for providers to achieve success. Unfortunately, these proposals come at a time when some providers are simply choosing to "opt-out" of MIPS entirely, finding that the efforts required to comply with an ever-changing set of requirements outweighs the potential benefit, even factoring in the penalty for non-participation. Instead of arbitrarily making the program more difficult by simply raising the penalty threshold, we urge CMS to work with stakeholders to develop MIPS policies that truly incentivize quality of care improvements.

Data Completeness Criteria

In prior years, CMS finalized increases to the MIPS data completeness criteria from 70% to 75% for the CY 2024 and CY 2025 performance periods. Now, the agency again proposes to increase the threshold to at least 80% for the CY 2027 performance period/2029 payment year. Higher data completeness requirements can be disproportionately burdensome for smaller practices, especially those in rural and medically underserved areas. MIPS participants often spend the first few months of the year focusing on submitting and validating data from the previous reporting year. At the same time, groups need adequate staff resources to implement new and updated measure specifications for the current reporting year. These challenges can be significant for smaller practices with fewer resources and less staff support. We urge CMS not to add undue burden for clinicians and groups collecting and reporting MIPS data and not to finalize the proposal to increase the data completeness criteria to 80% in future years. At a minimum, CMS should first evaluate and report on the impact of the current 75% data threshold and weigh future changes against reporting burdens on providers.

Promoting Interoperability Performance Category

In the past, CMS has allowed certain clinicians deemed to have little control over the use of electronic health records (EHRs), including physical therapists, occupational therapists, and speech-language pathologists, to have the Promoting Interoperability (PI) category reweighted to zero if they report no relevant measures. In this rule, the agency proposes to no longer automatically reweight this category for therapists, and to lengthen the performance period for this category from 90 days to 180 days.

We urge the agency not to finalize this proposal and to continue offering the option to automatically reweight the PI category if they report no EHR-related measures. Therapists often do not have the same control over their practices' or facilities' use of EHRs as other MIPS-eligible clinicians and have historically been exempt from this category of MIPS. While we continue to support improved electronic access to patient information, we are concerned that CMS has done little to make the PI measures more meaningful to clinicians like therapists. Without changes to the structure of the PI program, we believe that offering the automatic reweighting option for this category is still appropriate. We encourage CMS to continue to allow

these clinicians to opt-in to reporting the PI category and then specifically assess performance from therapists before making participation mandatory.

Additionally, both rehabilitation therapists, physicians, and other eligible clinicians will be impacted by CMS' proposal to double the reporting period for the PI category to 180 days. We are concerned that this significant expansion will add undue administrative burden on participants and be especially challenging for therapist participants who may have limited or no prior experience with the program (particularly if CMS does not withdraw the proposal to mandate participation from these clinicians). At a minimum, for any clinicians who are newly mandated to participate in the PI category, we urge CMS to limit their reporting period to 90 days to provide an appropriate "on-ramp" to PI measures.

Recommendations:

- **CMS should maintain the MIPS penalty threshold at 75 points for performance year 2024, instead of raising the threshold to 82 points.**
- **CMS should not finalize its proposal to increase the MIPS data completeness criteria.**
- **CMS should maintain the reporting period for Promoting Interoperability at 90 days.**

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AMRPA appreciates CMS' attention to our comments and the agency's efforts to engage stakeholders as it continues to modernize the Physician Fee Schedule. AMRPA and our members remain committed to working with CMS to create a more patient-centered Medicare program. If you have any questions regarding our comments, please contact Joe Nahra, AMRPA Director of Government Relations and Regulatory Policy at (202) 207-1123 or by email at jnahra@amrpa.org.

Sincerely,

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