



September 11, 2023

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-1784-P; Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (August 7, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Pediatrics (AAP), a non-profit, professional organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on the Medicare Program; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies.

Moreover, while very few children are covered under the Medicare program, CMS must acknowledge the impact that its national policy has outside the Medicare program, including policy uptake by commercial carriers and Medicaid agencies. CMS has a responsibility to address the impact of its payment policies introduced in Medicare, such as the promulgating of the Medicare Physician Fee Schedule (MPFS), quality measurement systems, and recently enacted telehealth flexibilities, on populations who are not Medicare beneficiaries, and particularly on Medicaid and CHIP enrollees for whom CMS has a direct responsibility. The impact of these policies on children cannot be an afterthought

Given that Medicaid and the Children's Health Insurance Program (CHIP) cover more than half of US children, CMS has an opportunity to meet its mandate to children as well as adults by considering the impact of every policy on children, their families, and their physicians. The AAP offers comments on the following sections in the proposed rule to ensure consideration of pediatric patients and their care teams:

- Decrease of Medicare Conversion Factor
- Efforts to Update Practice Expenses
- Extension of Telehealth Flexibilities
- Access to Behavioral Health
- Preventive Vaccine Administration Services
- Venography Services Work RVUs
- Medicare/Medicaid Provider Enrollment
- Caregiver Behavior Management/Modification Training
- CPT Codes for Health-Related Social Needs
- Expanded Diabetes Screening and Diabetes Definition

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- Electronic Prescribing of Controlled Substances
- Extension of Audio-Only Flexibilities for Periodic Assessments Furnished by Opioid Treatment Programs
- Quality Payment Program

Decrease of Medicare Conversion Factor Fails to Account for Impact of High Inflation [FR section VII.C.]

We request that CMS reconsider its proposal to decrease the Medicare Conversion Factor for 2024. CMS proposes a 2024 Medicare conversion factor (CF) of \$32.7476, which represents a 3.36% decrease from 2023 (\$33.8872) based on budget neutrality adjustments and a –1.25% reduction in the temporary update to the CF per the Consolidated Appropriations Act, 2023. The proposed CF does not account for the impact on their practices of having to absorb the substantial cost increases in an inflationary environment and continued recovery from the impact of the COVID-19 public health emergency. These cuts come at a time when the costs of practicing medicine are escalating, with CMS projecting a robust 4.5 percent MEI increase for the same year. As Medicare payment fails to keep up with inflation, patient access is threatened due to reduction in payment that may make physician practices financially unsustainable thus threatening the health care delivery infrastructure with a resultant reduction in access to care across the age spectrum. Many pediatricians work in institutions that rely on Medicare payments such as academic medical centers, multi-specialty practices, community health centers, general hospitals, etc. Therefore, reductions in payments can significantly impact the financial status of these health care facilities/practices. This financial stress extends to non-Medicare payers of pediatric services since the MPFS is typically utilized by Medicaid agencies and private payers to establish fee schedules. Any reduction in payment rates could disproportionately affect underserved communities, exacerbating health disparities and making it even more challenging for children in these areas to receive the care they need. For example, in 2022 CMS approved Medicaid §1115 waivers that required the states to demonstrate that Medicaid fee-for-service payment rates for primary care, behavioral health, and obstetric care were at least equal to 80 percent of Medicare rates for the same services; reductions in Medicare rates will have a direct impact on such benchmarks.

Efforts to Update Practice Expenses Needs to Consider Wide Variety of Practice Settings [FR section II.B.5]

CMS seeks input on how to best update practice expense (PE) data collection and methodology. The AAP believes that regional adjustments for PE must be updated in a manner that incorporates the wide variety of practice settings. Small and medium independent practices do not have the same access to large volume supplies and other cost-cutting practice expenses that are afforded to larger integrated health systems. The ability to negotiate prices is severely hindered in completely independent vs. private-equity or health system owned groups (especially those who are only primary care, and those who are smaller). As a result, they do not have the ability to offset Medicaid payments that are too low (which are lower than, and based on Medicare rates). Consideration must be given to support all types of practice settings and delivery models for patient care to be delivered equitably across a diversity of community nationally. AAP members are participating in the Physician Practice Information study being conducted by the AMA and Mathematica and the AAP anticipates that the results of this study may better inform CMS' work in this area.

CMS Extension of Telehealth Flexibilities Commended [FR section II.D.]

The AAP strongly supports the CMS proposal to align Physician Fee Schedule (PFS) payment policies with the extension of Medicare telehealth flexibilities as provided through the Consolidated Appropriations Act (CAA), 2023. These flexibilities across various services, patient locations, and delivery modes improve access to care for

pediatric patients, including mental health services, supports the needs of their caregivers, and enables more equitable care delivery. While we recognize CMS does not have the statutory authority to make all these flexibilities permanent, we urge CMS to do so for as many of them as possible.

The AAP supports the proposals around virtual telehealth supervision as this flexibility improves access to care and extends the existing workforce. Similarly, continuing to allow virtual presence of physicians in teaching settings expands the expertise available to trainees/learners. Considering the shortage in many areas of the pediatric specialty workforce, making virtual supervision a permanent policy may open the door for expansion of pediatric specialty teaching.¹

The AAP also supports the proposed change to public reporting on the Compare tool to use the most recent coding policies at the time the data are refreshed that identify a clinician as furnishing services via telehealth. We believe this change will make the indicator more accurate and up-to-date.

CMS proposes a new process for adding, removing, or otherwise changing codes to the Medicare Telehealth Service list. The AAP supports the new process as it appears to take each code through a transparent, stepwise process that will result in a clear yes/no decision and an indication of whether the new code is permanent or provisional as informed by the strength of clinical evidence provided.

The AAP appreciates the clarifications around remote monitoring services in the proposed rule. With that said, it is imperative that policy changes with respect to Remote Physiologic Monitoring and Remote Therapeutic Monitoring keep pace with the technological advances in this digital health space. There is a substantial administrative burden to review and report the required data collection each month.

Finally, the AAP has concerns about the proposal that beginning in CY2024, claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) would continue to be paid at the lower facility rate. Claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the higher non-facility rate. The AAP supports payment parity for telehealth services regardless of patient location. Care delivery via telehealth requires similar resources and expenses, e.g., office, staff and telehealth infrastructure, which is not dependent on the location of the patient. Also, most physicians who provide services both in-person and via telehealth require maintaining the costs associated with their physical clinic. The facility costs are not reduced when providing a telehealth visit during the course of a usual day of providing services in person. Payment parity should be based on services provided as guided by complexity of medical decision-making or amount of time spent with the patient.

Efforts to Advance Access to Behavioral Health Commended [FR section II.J.]

The AAP applauds CMS for its continued efforts to advance access to behavioral health services. Child health professionals are witnessing soaring rates of depression, anxiety, trauma, loneliness, and suicidality in their young patients. For this reason, leading child health organizations have declared a National Emergency in Child and Adolescent Mental Health.² Young people were already facing challenges to their mental health, and the

¹ Alison Curfman, Jesse M. Hackell, Neil E. Herendeen, Joshua Alexander, James P. Marcin, William B. Moskowitz, Chelsea E. F. Bodnar, Harold K. Simon, S. David McSwain, SECTION ON TELEHEALTH CARE, COMMITTEE ON PRACTICE AND AMBULATORY MEDICINE, COMMITTEE ON PEDIATRIC WORKFORCE; Telehealth: Opportunities to Improve Access, Quality, and Cost in Pediatric Care. Pediatrics March 2022; 149 (3): e2021056035. 10.1542/peds.2021-056035

² <https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/>

COVID-19 pandemic only made them worse. The declaration has served as an urgent call for policymakers to recognize the state of children's mental health as a national emergency and to take bold, comprehensive action to address it.

Bolstering the workforce of highly trained child mental health professionals, currently in short supply in every state, is one important piece of a comprehensive approach to addressing this national emergency.³ While more providers are needed to address the mental health needs of the pediatric population, payment rates for these services are a key barrier to both building the workforce and building practices.

Allowing marriage and family therapists and mental health counselors to furnish and bill for health behavior assessment and intervention services expands the available workforce to support patients and their families. As noted in a 2022 *Morbidity and Mortality Weekly Report (MMWR)* from the Centers for Disease Control and Prevention,⁴ twenty percent of all children have an identified mental condition while 40% of all children will meet criteria by age 18. While the Medicare program covers a very small number of children, Medicare protocols are frequently adopted and applied to pediatric services covered by the Medicaid program and by private payers. The CMS proposals, if finalized and adopted by other payers, will decrease barriers to integrating mental health within the medical home, a necessary piece of value-based payment reforms.

Medicare Part B Payment for Preventive Vaccine Administration Services – Expansion of In-Home Additional Payment Commended [FR section III.H.]

The AAP supports the CMS proposal to continue the in-home additional payment for COVID-19 vaccines and extend it to all designated Medicare preventive vaccines. As noted in the proposed rule, such action will improve vaccine access to often-underserved Medicare populations, thus positively impacting health equity and healthcare access. The AAP believes vaccine policy decisions must include adequate compensation for vaccine administration to ensure a robust pool of clinicians trained not only to administer vaccines, but to provide vaccine counseling and address vaccine hesitancy. Therefore, the AAP urges CMS to continue its current rate of \$40 for COVID-19 vaccine administration beyond the end of CY 2023 and extend it to all Medicare preventive vaccines.

The importance of immunization administration (IA) cannot be underestimated. The COVID-19 PHE highlighted the need for a robust and effective vaccine delivery infrastructure to protect individuals and communities from vaccine-preventable diseases. As CMS identifies in its May 2021 preliminary Medicaid & CHIP data snapshot, the number of routine childhood immunizations delivered to children under age 19 dropped by approximately 2% (1.6 million) between March 2020 and May 2021 as compared to the same period two years prior.⁵ These declines leave children and their communities susceptible to outbreaks of preventable diseases like measles while their communities continue to grapple with COVID-19.⁶

The declines in service use have also harmed pediatric practices and other primary care clinicians, who have

³ Turner A, et al. "Comparison of Number and Geographic Distribution of Pediatric Subspecialists and Patient Proximity to Specialized Care in the US Between 2003 and 2019." *JAMA Pediatrics*. doi:10.1001/jamapediatrics.2020.1124. Published online May 18, 2020.

⁴ Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children — United States, 2013–2019. *MMWR Suppl* 2022;71(Suppl-2):1–42. DOI: <http://dx.doi.org/10.15585/mmwr.su7102a1>

⁵ <https://www.medicaid.gov/sites/default/files/2021-11/covid19-data-snapshot-11122021.pdf>

⁶ Zucker JR, Rosen JB, Iwamoto M, et. Al. Consequences of Undervaccination – Measles Outbreak, New York City, 2018–2019. *N Engl J Med* 2020; 382:1009–1017 DOI: 10.1056/NEJMoa1912514.

confronted serious financial challenges and limited financial relief leading to furloughs, layoffs, forgone salaries, schedule reductions, and even temporary or permanent closure. One-third of pediatric visits include immunization administration and counseling, with the typical child receiving a total of 76 vaccines from birth to age 18.⁷ Inadequate payment for this essential service threatens the ongoing viability of pediatric practices. The AAP is deeply concerned that inadequate payment will force pediatric practices to consider permanent closure of resulting in decreased access to care, widening health disparities, reduced investment in vaccine counseling and confronting vaccine hesitancy, limited participation in Medicaid and CHIP, or restricted service hours or days. These outcomes would have long-lasting impacts on children's timely access to care and on the nation's vulnerability to outbreaks of vaccine-preventable diseases.

In promulgating the PFS, CMS must acknowledge the impact that its national policy has outside the traditional Medicare fee-for-service program, including uptake by commercial carriers and Medicaid agencies. CMS has an obligation to address the impact of its PFS on populations who are not Medicare beneficiaries, and particularly on Medicaid and CHIP enrollees for whom CMS has a direct responsibility.

Request for Reconsideration of Venography Services Work RVUs (9X004 and 9X005) [FR section II.E]

The new venography service codes represent add-on services that are performed during cardiac catheterization for congenital heart defects in the superior vena cava, the inferior vena cava, and in other congenital veins to be reported in conjunction with the main cardiac catheterization injection procedure codes (CPT codes 93593 – 93597). While we applaud CMS for accepting the RUC recommended work RVUs for CPT codes 9X000, 9X002, and 9X003, we are disappointed by CMS' failure to accept the RUC work RVU recommendations for CPT codes 9X004 and 9X005 and respectfully request reconsideration. We support the rationale provided by the American Medical Association in their comment letter on this proposed rule and reiterate the following key points.

- The work RVU for CPT code 9X004 is properly valued at 2.11 as recommended by the RUC.
- The methodology used by CMS to calculate the proposed work RVU does not take into account the complexity and risk of this specific add-on procedure.
- The proposed value of 1.92 appears to be obtained using an equation to calculate 60% of the 9X000 code based on a belief by CMS that that the work RVU needs to account for the increased intra-service time compared to CPT code 9X000.
- There is no crosswalk code or further justification provided for the proposed value.
- CMS is basing its proposed work RVUs for CPT codes 9X004 and 9X005 by using a percentage of 9X000 to reach its proposed values. CPT code 9X000 is not a base code, introducing another flaw in the methodology.
- AAP believes the RUC recommended value is justified given the intensity of the physician work as these collateral procedures are not done in normal vessels and the work becomes even more intense and complex when the patients are infants.
- Comparable procedures common in adult practice hold an RVU closer to 2.22, further supporting the value of 2.11 for 9X004 as the more appropriate value.
- For similar reasons, we disagree with the proposal to lower the work RVU for CPT code 9X005 to 2.04. We strongly believe that this code is properly valued at 2.13 as recommended by the RUC.

⁷ American Academy of Pediatrics. Child and Adolescent Immunization Schedule by Age - Recommendations for Ages 18 Years or Younger, United States, 2023. <https://publications.aap.org/redbook/pages/Immunization-Schedules?autologincheck=redirected>. Accessed August 31, 2023.

Several Medicare and Medicaid Provider Enrollment Proposals Supported [FR section III.K.]

The AAP believes CMS' proposal to create a new enrollment status labeled a "stay of enrollment" that CMS can use to delay for 60-days revocation or deactivation of billing privileges for simple paperwork mistakes or missed delays is critical. If CMS chooses not to allow a provider to receive payments for services furnished to patients during the stay of enrollment, then a mechanism should exist to allow for expedient retroactive payments once the issue has been resolved.

The AAP supports CMS' proposals to address termination database-related matters. The divergent rules surrounding provider terminations between Medicare and state Medicaid/CHIP programs create a significant ripple effect that profoundly impacts both patients' access to care and the overall adequacy of healthcare networks. The lack of uniformity in termination timelines generates confusion and uncertainty for patients, jeopardizing their ability to receive consistent and reliable medical attention. The list of network providers often contains inaccurate information. This inconsistency also weakens the assurance patients have in their care providers, potentially leading to hesitancy in seeking necessary treatment. Moreover, the disparities contribute to an uneven distribution of providers, particularly in areas with limited options, resulting in longer wait times and reduced availability of crucial services. This, in turn, undermines the overall network adequacy, straining an already challenged healthcare system. Establishing harmonized and transparent regulations for provider terminations is paramount to mitigating these negative consequences, ensuring seamless access to care, and enhancing the robustness of healthcare networks for all beneficiaries.

Coverage of Caregiver Behavior Management/Modification Training Commended [FR section II.E.]

The AAP commends CMS for proposing to establish an active payment status for CPT codes 96202 and 96203 (caregiver behavior management/modification training services). As noted by CMS, such services can play an important role in fulfilling the practitioner's treatment plan and therefore should be considered reasonable and necessary under the Medicare program. From a pediatric perspective, patients with autism spectrum disorder, oppositional defiance disorder or other intellectual or cognitive disabilities have challenging behaviors that often require caregiver assistance to carry out a treatment plan. Another potential benefit of coverage of these codes not noted by CMS is the potential to prevent unnecessary emergency department visits, thus saving money for the Medicare program. The AAP applauds CMS for accepting the RUC-recommended work RVUs of 0.43 for CPT code 96202 and the RUC-recommended work RVU of 0.12 for CPT code 96203, as well as the RUC-recommended direct PE inputs for these codes.

Request to Simplify and Expand CPT Codes for Services Addressing Health-Related Social Needs [FR section II.E]

CMS proposes to establish separate coding and payment for community health integration (CHI) services through the creation of two (2) new G codes (GXXX1, GXXX2) describing CHI services performed by certified or trained auxiliary personnel, which may include a community health worker (CHW), incident to the professional services and under the general supervision of the billing practitioner. Further, CMS states in the proposal that "CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit."

It is extremely important that CMS payment policy also recognizes the role clinical psychologists play in supervising and supporting CHWs services and allow reimbursement of CHWs services provided under the supervision of a clinical psychologist or "incident to" the services of a psychologist. CMS has stipulated that the

initiating visit must be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff), which clinical psychologists cannot report under Medicare. Therefore, AAP believes that to allow for equitable access to this meaningful service, CPT codes 90791 (*Psychiatric diagnostic evaluation*) and 96156 (*Health behavior assessment, or re-assessment*) should be included in the definition of a CHI initiating visit. Limiting payment policy for CHWs to clinicians who only report E/M services will severely limit access to CHI services for beneficiaries with behavioral health problems.

The AAP commends CMS for recognizing the need for a stand-alone code to report the assessment of Social Determinants of Health (SDOH). The research on SDOH, resiliency, adverse childhood experiences (ACEs), and toxic stress makes clear that healthy child development is dependent upon safety, stability, security, and nurturing in the child's home environment.⁸ Routine assessment of SDOH is currently performed by physicians and other qualified healthcare professionals and the establishment of new coding and payment policies should allow all eligible clinicians equal opportunity to participate fully in initiatives aimed at providing effective, whole-person care, better tracking patient needs, and improving the health of patients and the communities in which they reside. Therefore, we recommend that CMS include additional codes as eligible to be reported with the proposed SDOH Risk Assessment code GXXX5 as follows: CPT code 90791 (*Psychiatric diagnostic evaluation*), 96156 (*Health behavior assessment, or re-assessment*), 96116 (*Neurobehavioral status exam physician/QHP first hour*) and 96121 (*Neurobehavioral status exam physician /QHP each additional hour*).

While the AAP applauds CMS for addressing this cost-reducing clinically impactful work, we note that all the care management services requiring independent tracking over the course of a month are likely under-reported due to the complexity of tracking/reporting and poor support for this function by current EHRs. Even large health systems that have additional resources to deliver, track and submit this care for payment have difficulty reporting. Small to medium-sized practices may not be able to report at all due to the administrative burden. Until such time as there are accurate ways to risk adjust the population of pediatric patients in all types of practice modalities, then this reporting and payment model must be moved away from a model of independent tracking services over the course of a calendar period and continue to be simplified. Also, it is critical for services addressing health-related social needs to consider both the needs of the patient and their family/caregivers. The ability of the patient to achieve their health goals is inextricably tied to the social and financial stability and security of their caregivers.

Expanded Diabetes Screening and Diabetes Definitions Commended [FR section III.L.]

CMS proposes to add the HBA1c test to the types of diabetes screening tests covered by Medicare and expand frequency limitations to such tests to twice in a 12-month period. It also proposes to simplify the definition of "diabetes" to remove the codified clinical test requirements. The AAP supports these changes as they align with current United States Preventive Services Task Force, American Diabetes Association, and American Association of Clinical Endocrinologist recommendations and reduce unnecessary regulatory complexity. We concur with CMS that these changes will expand access to quality care and improve health outcomes for patients through prevention, early detection, and effective treatment.

Changes to Electronic Prescribing for Controlled Substances (EPCS) Supported [FR section III.M.]

CMS proposes several changes to the Electronic Prescribing for Controlled Substances program designed to

⁸ COUNCIL ON COMMUNITY PEDIATRICS, Poverty and Child Health in the United States. *Pediatrics* April 2016; 137 (4): e20160339. 10.1542/peds.2016-0339

advance e-prescribing standardization and reduce clinician administrative burden. Specifically CMS proposes to “identify electronic prescriptions for Schedule II-V controlled substances that are Part D drugs using the Prescription Origin Code data element in the PDE record, where a value of three indicates electronic transmission” and to “expand the available standards for prescribers that are within the same legal entities as the dispensing pharmacy under the CMS EPCS Program, as defined by the Medicare Program; E-Prescribing and Prescription Drug Program final rule (70 FR 67581), by cross-referencing the standards at § 423.160(a)(3)(iii), which broadens the requirements of the e-prescribing standard that can be used to meet CMS EPCS Program requirements.” CMS also proposes to specify how the compliance threshold is affected by multiple fills within the same year. AAP supports both proposals as they seem reasonable and appropriate to achieve the desired outcomes.

CMS also proposes several updates to EPCS program exceptions for cases of recognized emergencies and extraordinary circumstances. The AAP commends CMS for continuing to refine their policies to address unintended consequences of the current regulations and to provide appropriate flexibilities to prescribers to support safe and appropriate care. We support the proposed modification of the definition of “extraordinary circumstance” as we agree that it would allow prescribers the ability to request a waiver regardless of whether CMS triggered the recognized emergency exception. The AAP also supports CMS’ extension of sending non-compliance notices to prescribers who are violating the CMS EPCS Program requirement.

Extension of Audio-Only Flexibilities for Periodic Assessments Furnished by Opioid Treatment Programs (OTPs) Commended [FR section III.F.]

The AAP supports the proposal to allow periodic assessments to be furnished via audio-only communication when two-way audio-video communications technology is not available to the beneficiary through the end of CY 2024, to the extent that it is authorized by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA) at the time the service is furnished, and all other applicable requirements are met. This flexibility meets the needs of the beneficiaries, is bounded by SAMHSA and DEA requirements, and is safe for recipients of the opioid treated individual when under an OTP.

Medicare Shared Savings Program Proposals Moving in a Good Direction but Need to Better Meet the Needs of Pediatricians [FR section III.G.]

CMS's proposed benchmarking refinements signify a crucial step towards fostering sustainable participation and safeguarding Accountable Care Organizations (ACOs) dedicated to serving medically and/or socially complex populations. By considering the inclusion of a potential higher-risk track, CMS acknowledges the unique challenges faced by ACOs catering to vulnerable populations. This would involve adjusting benchmarks based on the complexity of medical and social needs of the patients, ensuring that clinicians caring for high-risk and socially vulnerable individuals are not unfairly disadvantaged by benchmark calculations. This track could align benchmarks more closely with the elevated risks and costs associated with complex patient demographics, thereby ensuring equitable opportunities for shared savings, and preventing undue financial strain. In addition, developing a tiered system of quality targets that align with the complexity of patient populations will be more equitable. Medicaid providers serving medically and/or socially complex populations could have customized quality goals that reflect the challenges they face, thereby preventing disincentives due to unrealistic benchmarks, particularly when a pediatric practice has more premature infants or foster care children assigned each year.

Furthermore, the refinements to the three-way blended benchmark methodology promise to offer a more balanced approach that accounts for the individual characteristics of ACOs while still promoting the efficient

delivery of high-quality care. This equitable approach recognizes that not all ACOs are alike and ensures that shared savings are attainable for ACOs that serve diverse populations and navigate intricate healthcare landscapes.

Additionally, the proposed strategies to collaborate with community-based organizations represent a groundbreaking approach to addressing health-related social needs. This partnership-centric approach acknowledges the interconnectedness of healthcare and social determinants of health, paving the way for more comprehensive and effective interventions. The introduction of innovative payment models that incorporate outcomes related to health-related social needs and partner with community-based organizations will incentivize clinicians and these organizations to collaborate in addressing social determinants of health, ultimately improving patient outcomes, and reducing healthcare costs. There is also a need to create collaborative performance metrics that assess the impact of clinicians' collaborations with community-based organizations. Metrics could evaluate the effectiveness of interventions targeting health-related social needs, fostering a stronger relationship between medical and community resources, and reinforcing the value of collaboration in achieving shared savings. By leveraging community resources, CMS can harness the collective power of medical and social initiatives, effectively improving patient outcomes, reducing healthcare utilization, and subsequently enhancing the potential for shared savings among clinicians.

Incorporating these multifaceted benchmarking refinements and fostering collaboration with community-based organizations would undeniably amplify the shared savings potential for clinicians. Not only would this facilitate the sustainability of ACOs serving complex populations, but it also aligns with the broader shift towards value-based care, where financial incentives are linked to superior patient outcomes and holistic wellbeing. The AAP believes ongoing input is critical from an expert on child health financing to ensure that children's care teams can develop or join high functioning ACOs. As a result, care teams would be further incentivized to deliver comprehensive, patient-centered care that addresses not only medical needs but also the underlying social factors that influence health. This multi-pronged approach bolsters the effectiveness and reach of shared savings initiatives, driving improvements in healthcare quality, accessibility, and cost efficiency.

The AAP agrees with removal of the exception to the shared governance policy. If this money is to get to the participating practice, there must be governance by the involved participants.

While the AAP commends CMS for the above program refinements, we strongly encourage CMS to make further refinements to better support pediatrician participation in shared saving initiatives and high-quality care. Specifically, the AAP is concerned that these risk adjustment models lack any pediatric relevance yet will impact organizations that care for children leading to the potential to harm pediatricians who care for complex children and leaving them without sufficient resources to provide high quality care. One way CMS can rectify this problem is to develop a pediatric risk algorithm to identify the level of risk for pediatric patients. CMS provision that an ACO TIN participated in a performance-based risk Medicare ACO initiative excludes the vast majority of pediatricians. Only those who participate in a multi-specialty adult-based health system will be eligible. CMS must ensure Medicaid is not the "forgotten M" in CMS by finding ways to support pediatric innovation and participation in programs that reward engagement, improved outcomes and health equity.

The AAP stands ready to collaborate with CMS to intentionally address pediatric issues in further policy changes to MSSP and other value-based payment programs, including policies that support prevention and early intervention. CMS must take concerted action to proactively design policies that work for pediatrics from inception, rather than as an afterthought.

Quality Payment Program [FR section IV.]

A small minority of pediatricians participate directly in the Quality Payment Program (QPP). Nonetheless, the QPP affects children's health and the practice of pediatricians because CMS' Medicare payment programs set the direction for value-based payment by a multitude of payers, integrated health systems, and other stakeholders. It is essential that CMS consider the impact of the QPP and other Medicare-centric payment programs on pediatrics. The inherent differences between children and adults require special consideration when implementing value-based payment models in pediatric populations. Bundling the care of adults and children into one health care delivery and financing system risks encouraging system transformation that ignores the unique characteristics of children. Innovations toward value-based payment and other alternative payment models, including accountable care organizations, inclusion of health-related social needs, population health, appropriate quality measurement for the pediatric population, and other initiatives and reforms are not only critically important for pediatrics but must be developed with a pediatric focus, as pediatrics differs in many ways from adult-oriented medical care. The AAP asks CMS to include this consideration in further development of Medicaid-led system transformation as well as in the future directions of the QPP.

Merit-based Incentive Payment Systems (MIPS) Performance Threshold

The AAP urges CMS not to increase the performance threshold for avoiding a MIPS penalty from 75 points to 82 points. Such action would result in greater than 50% of eligible clinicians receiving a penalty of up to -9%. Physicians have repeatedly told CMS that the MIPS program is extremely burdensome. While CMS has taken steps over the years to try to simplify the program, including special considerations for small practices, it remains burdensome. The AAP is concerned that such a large increase in the number of physicians being penalized will disproportionately affect smaller and rural practices, further exacerbating health inequities.

Finalized Quality Measures Proposed for Removal in the CY 2024 Performance Period/2026 MIPS Payment

CMS proposes removal of Q093 Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use, stating the measure has "topped out" and there isn't room to improve clinical outcomes. The AAP respectfully disagrees with this analysis as pediatricians still see too many clinicians giving systemic antibiotics every time a parent asks for an antibiotic for ear pain. Thus, we argue there is still an important opportunity to improve clinical outcomes by offering clinicians continued access to this quality measure.

The AAP appreciates the opportunity to provide comments on the August 7th proposed rule and looks forward to working with CMS to ensure that the PFS accurately reflects the work value of pediatric physician practice and creates an environment that supports access to quality patient care for pediatric patients.

If you have any questions, please contact Stephanie Glier, AAP Director of Federal Advocacy, sglier@aap.org.

Sincerely,



Sandy L. Chung, MD, FAAP
President

SLC/ms