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June 29, 2020

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1000 Corporate Boulevard
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U.S. Toll Free: 1-866-RING-AUA
(1-866-746-4282)

Phone: 410-689-3700

Fax: 410-689-3800

Email: AUA@AUAnet.org

Websites: AUAnet.org

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The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar and Administrator Verma:

The American Urological Association (AUA) writes to thank you for your leadership and continued efforts to ensure that patients have access to high quality patient care during the public health emergency (PHE). The flexibilities implemented by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) in response to the COVID-19 pandemic have quickly transformed the delivery of patient care. This letter outlines a number of policies that have not only benefited patients and providers, but could also support the nation's economic recovery, if they were to be made permanent.

We understand the PHE may end in late July. The AUA urges HHS to use its authority to extend the emergency for at least another 90 days to protect patients as states see surges in COVID-19 cases. As the country's economy re-opens, it is critical that patients and providers continue to have access to the flexibilities that have supported the continued delivery of health care services while minimizing exposure to COVID-19 since the beginning of the PHE. The AUA does not anticipate that in-person care will return to pre-pandemic levels before the end of the year because of both the social distancing limitations practices must maintain and patients' reticence to return to doctors' office. Therefore, the AUA recommends that the PHE be extended until there is a way to vaccinate and protect the most vulnerable Americans.

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The COVID-19 pandemic precipitated a rapid transition to virtual health care delivery. Under these challenging circumstances, virtual care has created a number of benefits for our members and the patients they treat that should become a permanent part of health care delivery. The AUA shares the administration's goal of expanding access to telehealth services as it provides many benefits for patients and providers. We ask that you please consider making the following telehealth provisions permanent, after the conclusion of the PHE.

- **Maintain both the expanded list of Medicare telehealth services and the subregulatory process by which new services are added to the list**

Since the beginning of the PHE, CMS has added 135 codes to the Medicare telehealth list. AUA believes that the services on this list should be retained, particularly the telephone E/M services (CPT codes 99441-99443), as they have been invaluable to urologists. AUA recognizes expanding access to broadband services in rural areas is an administration priority, but until access to reliable expands, access to care in rural and underserved areas will be hindered, as patients remain unable to achieve video connection with providers making the retention of the telephone E/M services critical. Further, we ask that you maintain the subregulatory process in which new services are added to the Medicare telehealth list. This is exceptionally important as it will allow services to be added outside of the annual Physician Fee Schedule rulemaking.

Since the start of the pandemic, our members are reporting that telehealth is allowing them to meet the needs of their patients including those with non-routine issues, such as kidney stones and prostate disorders. Telehealth is playing a critical role in reducing the barriers created by the shortage of urologists in certain geographical areas. Additionally, telehealth facilitates coordination of care for patients who require family members or caregivers to assist in the encounter due to an intellectual or language barrier. In many cases these facilitators are unable to physically be present at an in-person visit which may result in an insufficient encounter leading to the deferral of care until it is urgent, complex, and expensive. Telehealth also provides greater access to patients with limited mobility for whom navigating an in-person visit can be overwhelming, such as patients with spinal cord injuries or other significant impediments to mobilization.

- **Continue to provide coverage and enhanced payment for the telephone E/M services (CPT codes 99441-99443)**

Many Medicare beneficiaries, particularly those who are older, are not able to establish the simultaneous audio and visual connections required for telehealth services either because they do not have a device with this capability or access to a reliable broadband connection. This same population of beneficiaries, which is at high risk for COVID-19, may also not have reliable transportation to get to and from doctors' visits, a barrier to receiving regular care, particularly for urologic conditions that may be chronic. For these reasons, it is critical that



they have telehealth support to minimize the need for unnecessary visits to a higher risk clinical setting.

Our members note that the Medicaid beneficiaries they treat face similar barriers, including transportation, child care, and work challenges. For example, some patients are unable to attend health care visits in person due to poor access to child care or inability to get leave from their jobs. Providing coverage and enhanced payment for the telephone E/M services has an economic benefit for workers and their employees by reducing time spent traveling to and waiting for health care services and improving employee productivity. Moreover, even in a large city such as Atlanta, the Medicaid population may be limited to one hospital system, during normal times. During the COVID-19 PHE, access to care within that hospital system may be exceptionally difficult, even for patients with complex medical conditions including aggressive, life-threatening prostate and other cancers. Telehealth greatly enhances the patients' access to specialists who would otherwise be available if it weren't for the challenging circumstances of COVID-19.

Our members have reported that the work of an audio-only and simultaneous audio and visual visit are equivalent. Seeing the patient does not change the medical complexity or decision making of the visit. One AUA member reported that this flexibility has allowed him to see at least 30 patients who otherwise would not have been able to access care. All too often those without access to the internet also lack access to necessary health care services, and this policy addresses that disparity.

Data from Kaiser Permanente show that from February 2019 to February 2020, thirteen urology departments in southern California, saw a total of 8209 patients through telephone E/M services. The patient satisfaction scores (access to care, provider satisfaction, reception satisfaction, overall experience) were in the 85-90 median percentile. Additional data from 2015 to 2020 in northern California shows patient satisfaction scores for the telephone visits in the 89-90 median percentile compared to direct outpatient visits which were in the 91-93 median percentile. This demonstrates that telephone visits play an important role in patient care under appropriate circumstances, like those related to COVID-19 and when face-to-face visits are not feasible.

Should CMS determine that these codes must be revised in order to maintain coverage and payment, the AUA would welcome the opportunity to participate in the process to revise these service codes.

- **Continue to allow certain telehealth and virtual care services to be provided to both new and established patients**

CMS has also ensured access to patient care by allowing telehealth services to be furnished to both new and established patients, and that consent for these services can be documented on an annual basis, and is not required in advance of the visit. Specifically,



remote patient monitoring (RPM) services, virtual check-ins, and e-visits have been essential to urologists and their patients during this time. This policy has provided AUA members with more flexibility to deliver care for their patients virtually during the COVID-19 pandemic, and will be necessary as the economy begins to re-open.

AUA members have improved the care of some patients and reduced costs to the Medicare program using this flexibility. For example, a new patient without immediate access to transportation contacts an urologist because he is experiencing intermittent mild asymptomatic gross hematuria. Normally, he could take a costly ambulance ride to an emergency room for a condition that is not emergent. Using this telehealth flexibility, an urologist can initiate the treatment immediately at lower cost via telehealth.

Specifically, our member's report the use of RPM services can provide early warning signs for certain conditions and prevent hospitalizations. Patients and providers use technology which allows AUA members to record a patient's post void residual (PVR) volume to monitor urination remotely and alert them to impending urinary retention rather than the patient presenting in the emergency room. Technologies like these allow urologists to monitor patients without seeing them in person. As more virtual tools are being introduced, we must ensure the code structure is sufficient to capture all of the work being done by providers.

- **Continue to allow Medicare supervision of residents and in-office clinical staff to be performed by telehealth or other communications technologies**

Typically, residents deliver services in person under the direct supervision of a teaching physician. Prior to the implementation of the PHE flexibilities, residents were not able to furnish care via telehealth. Eliminating this flexibility for direct supervision will create a barrier to patient access to telehealth services. There may be circumstances where patients may need to be isolated due to risk of exposure or a resident or teaching physician is under quarantine and cannot provide face-to-face care. Retaining this direct supervision policy ensures that patients will continue to have access to health care services during future pandemics and PHEs.

Today's technology allows residents to communicate with attending urologists virtually to evaluate patients and CMS has expanding the ability to do this during the PHE. AUA members have supervised residents with urological examinations, endoscopies, and accomplishing difficult urinary catheterizations (DUC). Patients often present to the emergency room in excruciating pain with kidney stones. Telemedical supervision allows the resident to initiate treatment without the delay of waiting for the arrival of the attending Urologist, allowing better quality care and faster turn over in a crowded emergency room. Technology could prevent residents from having to wait for an urologist to travel to the ER and therefore, has the potential to reduce the turnaround time for patients in the ER. PercuVisions DirectVision System-III Telehealth Hub (DVS-III) has a



built-in telehealth platform enabling a resident to connect with an attending supervisory urologist in real-time to help aid in the difficult placement of a urinary catheter via a fiberoptic relay of the appearance of the urinary tract in real time, removing the barrier for securing an in-person Urologist at the patient's bedside. Currently, this technology is being used by Cleveland Clinic Foundation, OhioHealth, Bon Secours Mercy Health, Veterans Administration, Orland Health, and Yale New Haven Health.

AUA members are also using these flexibilities to provide supervision of their office staff remotely. This grants significant flexibility not only during public health emergencies, but also to expand access to care in rural and underserved areas where patients access to certain services is limited. Retaining this flexibility has the potential to significantly expand access to urologists and other specialists in certain areas of the country or in the event of a physician requiring quarantine. Currently, our members are providing direct supervision for staff delivering intramuscular injections remotely. This is the type of work that could be expanded should this policy be made permanent.

- **Relax the telehealth originating site requirements to allow patients to receive telehealth services in their homes**

The PHE has demonstrated that telehealth services can successfully be delivered to patients in their homes or other locations without requiring them to travel to an originating site. The originating site and geographic eligibility requirements that limit the delivery of telehealth services to areas outside of metropolitan statistical areas and health professional shortage areas should be permanently relaxed. This flexibility reduces the burden on patients that have to travel significant distances to see an urologist and may be forced to choose between attending their jobs and receiving necessary medicine care. This flexibility allows patients to receive care that does not require a face-to-face visit or exam in the locations that are most convenient to them, which we anticipate will result in increased patient compliance to medical recommendations.

Relaxing the requirement that physicians update their Medicare Provider Enrollment, Chain and Ownership System (PECOS) with their home or other address to allow them to deliver care from locations outside of their offices reduces burden on physicians and their practice administrators while potentially expanding patient access to care, as providers may be able to expand the hours in which they can see patients. AUA members, for example, have extended their hours in the mornings and afternoons and some often hold virtual clinics on the weekends.

- **Eliminate the site of service differential between reimbursement for telehealth and in-person services**

AUA recommends the elimination of the site of service differential between reimbursement for telehealth and in-person services to promote expansion of telehealth among providers.



Physician practice costs may increase by acquiring and maintaining the required equipment and software necessary for virtual care, and this would eliminate financial penalty for practices that choose to expand telehealth. By creating a payment system that encourages the use of telehealth, the AUA anticipates that expanded patient access to care will reduce delays in evaluation and management and therefore reduce the complexity and cost of managing these conditions.

- **Adopt the Interstate Medical Licensure Compact (IMLC) to facilitate broader expansion of telehealth and improve access to care across state lines**

AUA appreciates that CMS has waived the requirement for providers to be licensed in the state where the patient resides when delivering Medicare telehealth services during the PHE and recommend that this policy remain in place until effective vaccines and treatments are widely available. While the AUA recognizes that licensure is a state issue, we hope this will provide an opportunity for states to adopt the IMLC.

- **Allow face-to-face visits required by national coverage determinations (NCDs) and local coverage determinations (LCDs) to be delivered via telehealth unless there is a medical reason the patient must be seen face-to-face**

This policy will allow patients to remain in their homes rather than requiring them to travel to a doctor's office for a face-to-face visit at a time when they may be at higher risk for COVID-19 or under other circumstances when a face-to-face visit is not feasible. AUA believes this decision should be left to the discretion of the physician. CMS should allow these visits to be delivered by telehealth if it is consistent with the best clinical practices.

- **Adjustments to the Quality Payment Program**

The AUA also requests that you consider the following changes to the Quality Payment Program and appropriate use criteria as we anticipate that our members will continue to address the effects of COVID-19 for the rest of this year.

- Delay the implementation of the MIPS Values Pathway (MVP) Program until at least the 2022 performance year to reduce the burden on physicians whose practices are focused on COVID-19 and do not have the resources to implement the workflow and reporting changes that will be required.
- Delay the implementation of qualified clinical data registry (QCDR) measure testing and data collection until September of the year following the completion of the COVID-19 public health emergency. This will relieve medical societies and physicians of the burden associated with the QCDR measure approval criteria during the COVID-19 pandemic and provide adequate time to complete the QCDR requirements after the PHE.



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- Delay the implementation of appropriate use criteria (AUC) from January 1, 2021 to at least January 1, 2022.

Thank you again for protecting patient access to care during the PHE. We appreciate your consideration of these comments and welcome the opportunity to continue this discussion and answer any questions you may have. Should you require any further information, please contact Keith Hawman, Payment Policy Manager at khawman@auanet.org or at 443-689-4045.

Sincerely,

A handwritten signature in cursive script that reads "Eugene Rhee, MD MBA".

Eugene Rhee, MD MBA
Chair,
Public Policy Council