



# American Urological Association

## BOARD OF DIRECTORS

September 1, 2022

### Officers

Edward M. Messing, MD  
President

Randall B. Meacham, MD  
President-elect

Raju Thomas, MD  
Immediate Past President

John D. Denstedt, MD  
Secretary

David F. Penson, MD, MPH  
Secretary-elect

Thomas F. Stringer, MD  
Treasurer

Chiquita Brooks-LaSure  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1770-P  
P.O. Box 8016,  
Baltimore, MD 21244-8016

Submitted electronically via <http://www.regulations.gov>

RE: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-P)

### Section Representatives

Kurt A. McCammon, MD  
Mid-Atlantic

Arthur E. Tarantino, MD  
New England

Reza Ghavamian, MD  
New York

James C. Ulchaker, MD  
North Central

Hassan Razvi, MD  
Northeastern

Damara L. Kaplan, MD, PhD  
South Central

Martin K. Dineen, MD  
Southeastern

Eric J. Zeidman, MD  
Western

Dear Administrator Brooks-LaSure:

The American Urological Association (AUA) appreciates the opportunity to provide comments on the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) proposed rule (CMS-1770-P). The AUA is a globally-engaged organization with more than 22,000 physician, physician assistant, and advanced practice nursing members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 15,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research and the formulation of health policy.

The AUA respectfully submits comments to Centers for Medicare & Medicaid Services (CMS) on the following provisions of the proposed rule:

- Conversion Factor Update
- Proposed Valuation of Specific Codes for CY 2023
- Evaluation and Management (E/M) Services
- Payment for Medicare Telehealth Services
- Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts
- Strategies for Improving Global Surgical Package Valuation
- Rebasing and Revising the Medicare Economic Index (MEI)
- Strategies for Updates to Practice Expense Data Collection and Methodology
- Medicare Potentially Underutilized Services
- Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs)
- Request for Information: Health Equity Measures

### Headquarters

Michael T. Sheppard, CPA, CAE  
Chief Executive Officer

1000 Corporate Boulevard  
Linthicum, MD 21090

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

Phone: 410-689-3700

Fax: 410-689-3800

Email: [AUA@AUAnet.org](mailto:AUA@AUAnet.org)

Websites: [AUAnet.org](http://AUAnet.org)  
[UrologyHealth.org](http://UrologyHealth.org)  
[UrologicHistory.museum](http://UrologicHistory.museum)



### **Conversion Factor Update**

CMS has proposed to decrease the conversion factor from \$34.6026 to \$33.0775 as a result of the expiration of the 3 percent increase included in the Protecting Medicare & American Farmers from Sequester Cuts Act (P.L. 117-71) at the end of 2022 coupled with the mandated 0 percent conversion factor increase and the required budget neutrality adjustments. The AUA recognizes CMS' ability to mitigate this cut is limited because of the budget neutral nature of the MPFS and lack of statutory authority. However, this proposed reduction comes at the same time urologists and other physicians are facing the continued challenges associated with the continued spread of COVID-19, significant increased costs due to inflation, the second year of the phased-in changes to the clinical labor practice expense (PE) updates, and four percent across the board PAYGO cut to the Medicare program, all of which place significant pressure on physicians and their practices. The AUA will be working with Congress to mitigate this decrease to the conversion factor.

### **Proposed Valuation of Specific Codes**

#### ***Laparoscopic Simple Prostatectomy (CPT codes 55821, 55831, 55866, and 558XX)***

The AUA would like to thank the agency for accepting the Relative Value Scale Update Committee's (RUC) recommended work and PE relative value units (RVUs) for laparoscopic simple prostatectomy procedures as reported by CPT codes 55821, 55831, 55866, and 558XX. Our members participated in the RUC survey used to support these values, and the AUA is grateful to see them proposed as recommended.

#### ***Percutaneous Nephrolithotomy (CPT codes 50080, 50081)***

The AUA disagrees with CMS's decision to not accept the RUC valuation of CPT codes 50080 (*Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (e.g., stone[s] up to 2 cm in a single location of kidney or renal pelvis, nonbranching stones)* and 50081 ... *complex (e.g., stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)*). We believe that CMS used incorrect and flawed logic to obtain their valuation and that CMS should accept the original RUC-recommended values. The reasons this logic was faulty and incorrect is that despite a similar general descriptor of these codes, CPT codes 50080 and 50081 are now markedly different than before as the procedure now encompasses several other procedures that previously could have been separately billable, thereby increasing the intensity and complexity of the procedure. In addition, per CPT's request to try to encompass a percutaneous nephrolithotomy procedure in one code rather than possibly multiple codes, the descriptor was changed to include other procedures that were previously separately coded, thereby increasing the intensity and complexity of the procedure. These additions include imaging supervision and interpretation, antegrade stent placement, nephrostomy tube placement and antegrade ureteroscopy. The logic used by CMS was to reduce the work RVU level from the old 50080 to the new 50080 equal to the reduction in intra-operative time; in this case there was a reduction of about 23% of intra-operative time for 50080 but only a reduction in 14% of the work RVU to 13.5wRVU. Using this logic, CMS calculated the wRVU to be 12.11, which is about a 23% reduction. This is faulty logic because CPT codes 50080 and 50081 were Harvard-valued codes and therefore the intra-operative times were never truly calculated and had never gone through a RUC review based upon surveys. Therefore, the original times were not proved to be accurate so should not be used for comparison in valuation; rather these "new" code(s) should be valued de-novo, which they were at the RUC. The RUC recommended valuations were based on an extremely robust survey of AUA members and as stated before is truly the first time these codes have



ever been accurately valued. CMS had justified choosing a wRVU value of 12.11 by comparing 50080 to CPT code 36830 (*Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)*), and CPT code 36818 (*Arteriovenous anastomosis, open; by upper arm cephalic vein transposition*). These are not valid comparisons as CMS did not accept the RUC recommended work values for these codes, and the RUC process does not allow codes to be used as crosswalks that were not accepted by CMS. We suggest that the agency consider the following codes for relative comparison (see table below) when proposing values for CPT codes 50080 and 50081. The codes listed in the table are more comparable in intra-operative time, global, mental effort and skill associated with CPT codes 50080 and 50081.

The RUC maintains the original recommended work RVU of 22.00 for CPT 50081 which reflects the 25th percentile survey results from 277 urologists. For additional support, the RUC reviewed 090 global codes with approximately 140 minutes of intra-service time, similar total times, and relative intensity with the surveyed code and found that the RUC recommended RVU maintains relativity within the payment schedule. The RUC offered two additional comparison codes 35302 Thromboendarterectomy, including patch graft, if performed; superficial femoral artery (work RVU = 21.35, 150 minutes intra-service time, and 392 minutes total time) and 35616 Bypass graft, with other than vein; subclavian-axillary (work RVU = 21.82, 140 minutes intra-service time, and 367 minutes total time). The AUA urges CMS to accept a work RVU of 22.00 for CPT code 50081. We also disagree with CMS simply adding 8.5 wRVU to 50080 to reach that of 50081 based upon the same discussion above; we do understand that was the original difference between the 2 codes based upon the current RUC valuation. However, we would support this if CMS accepted the RUC-recommended valuation of 13.50 wRVU for CPT code 50080 and therefore 22.0 wRVU for CPT 50081.

CPT Code	Description	Intra-Service Time (min.)	Global	Work RVU
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)	88	90 days	14.16
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	88	90 days	13.50
57260	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;	90	90 days	13.46
58542	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	90	90 days	13.25

## Evaluation and Management Services

### *Inpatient and Observation Codes*

In this proposed rule, CMS continued its work to revise the evaluation and management (E/M) code set that began with changes to the documentation requirements and values for the outpatient E/M services. The AUA is pleased that the agency is proposing to accept the changes to the inpatient E/M services, specifically the merger of the inpatient and hospital observation unit E/M services as adopted



by the CPT® Editorial Panel. Hospital providers may have difficulty distinguishing between patients who have been admitted rather than those just being observed, and this change eliminates that distinction, which is not meaningful to deliver the necessary care. Additionally, the AUA appreciates that the documentation guidelines have been revised to be consistent with the outpatient E/M services allowing physicians to bill by time or medical decision making (MDM); this needed change simplifies the documentation requirements, reduces the administrative burden on physicians, and creates consistency in documentation across E/M code families. The AUA urges CMS to finalize the changes to the code set, including the new prolonged service code HCPCS GXXX1 and proposed values.

### ***Split/Shared Services***

CMS first considered changes to the split/shared E/M visit services in the CY 2022 MPFS proposed rule. Now the agency is proposing to delay the implementation of this policy for another year until 2024. The AUA supports this delay, but believes that CMS should continue to work with physicians and other providers to improve this policy in the interim. Our concerns with the policy as finalized in the CY 2022 MPFS final rule are greater than just the necessary changes to physician workflow to comply; the reporting requirements for split/shared services are inconsistent with other E/M services as the agency is requiring reporting by time rather than time or MDM as other E/M code families are documented. The AUA believes that without change this policy will undermine the agency's efforts to move towards team-based care as physicians will be less likely to perform these visits.

### **Payment for Medicare Telehealth Services**

CMS proposed multiple policies and provided information on how the 151-extension of certain telehealth flexibilities authorized by the Consolidated Appropriations Act, 2022 (P.L. 117-103) will be implemented and how telehealth modifiers should be billed after the conclusion of that extended period. The AUA remains committed to working with CMS to ensure Medicare beneficiaries retain access to medically appropriate telehealth services consistent with the agency's statutory authority.

### ***Changes to the Medicare Telehealth Services List***

The AUA applauds CMS for proposing policies to expand access to telehealth services, including adding services to the telehealth list both on a permanent Category 1 or 2 basis and a temporary Category 3 basis. The AUA supports the agency's proposal to add the new HCPCS codes for prolonged services associated with certain types of E/M services—GXXX1, GXXX2 and GXXX3—to the telehealth list on a Category 1 basis to replace the existing prolonged service codes, which are currently on this list. Additionally, we urge CMS to finalize the proposal to allow all services that were added to the telehealth list on a temporary basis during the public health emergency (PHE), including those that have not been converted to Category 1, 2 or 3, to remain available through the 151-day period following the conclusion of the PHE during which certain Medicare telehealth flexibilities will remain in place. This policy will allow the agency to continue to collect data on telehealth utilization to inform permanent policies. The AUA welcomes the opportunity to provide input on future policy changes based upon the data collected since the start of the PHE.

CMS received requests to add the telephone E/M codes to the telehealth list on a Category 3 basis to allow the continued delivery of audio-only services, and in response, reiterated its position that these services are not analogous to in-person care or a substitute for a face-to-face encounter outside of the PHE. The AUA respectfully disagrees with this position and believes that telephone E/M services serve a significant role in delivering care to Medicare beneficiaries in areas without strong broadband access



and for those beneficiaries who are not technologically digitally literate or do not have the devices required to establish a simultaneous audio-visual connection. Congress has extended the agency's authority to cover audio-only services for 151-days after the PHE. Given this extension of the agency's authority, the AUA urges CMS to continue to collect data on when and how these services are being utilized as we believe eliminating coverage of these services will exacerbate existing health inequities. Data from our membership shows that most non-face-to-face visits occur using a simultaneous audio-visual connect and audio-only visits are only performed in limited circumstances. However, the small number of patients who utilize audio-only visits would be disadvantaged without that option. The AUA recognizes that CMS does not have authority to extend coverage of audio-visits beyond the 151-day extension authorized by Congress and will continue to work with Congress to expand the agency's permanent authority to preserve patient access to this service modality and promote health equity.

### ***Virtual Direct Supervision***

CMS' current policy is that virtual direct supervision will be permissible through December 31 of the year the COVID-19 PHE concludes. In preparation, the agency has requested stakeholder feedback on whether virtual direct supervision should be permitted permanently and if it should only apply to a subset of services. AUA members have been utilizing this flexibility and providing direct supervision remotely successfully throughout the COVID-19 pandemic. Specifically, they have provided virtual direct supervision for both procedures, like placing a catheter or passing a cystoscope, and E/M services, allowing those qualified health professionals being supervised to practice to the top of their licenses. According to our members, they have virtually supervised their physician assistants who are performing hospital rounds and provided direct supervision from a different office location, allowing them to expand the number of patients treated. This flexibility is a valuable tool to improve patient access, particularly in rural and underserved areas experiencing urologist shortages. While the AUA does not have any efficacy or safety data to share, our members have provided anecdotal information on instances when they have provided supervision virtually and directed patients to go from the office to the emergency room. The AUA welcomes the opportunity to work closely with CMS as a final policy is being developed.

### ***Reimbursing Telehealth Services at the Facility Rate***

CMS noted that once the PHE concludes telehealth services will be reimbursed at the facility payment rate in accordance with established policy as the agency believes the facility payment amount best reflects the direct and indirect practice expenses of telehealth services. The AUA respectfully disagrees and requests that CMS reconsider this policy and continue to reimburse telehealth services at the physician office rate. After more than two and half years delivering telehealth services regularly, our members report that the costs and resources required do not differ significantly from those required to deliver face-to-face services. Besides the hardware and software costs, clinical and office staff must commit considerable time preparing patients to successfully participate in these virtual visits, which is a significant practice expense. The AUA cautions CMS that without change to this policy, practices that are already under significant financial strain will be forced to discontinue telehealth services when reimbursement decreases, disadvantaging beneficiaries. The AUA urges CMS to reimburse telehealth services at the physician office rate to accurately reflect the physician work and practice expense of these services after the conclusion of the PHE.



### **Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts**

In this proposed rule, CMS articulated how §90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117-58) requiring manufacturers to refund the agency for certain discarded drug amounts from certain single-dose containers or single-use package drugs paid under Part B will be implemented. The already-reported JW modifier will indicate discarded amounts of an applicable drug, and the proposed JZ modifier will indicate those instances when there are no discarded amounts. The AUA notes the agency's proposal closely follows the statutory language.

CMS outlined certain drug exclusions and considered whether to use the authority granted by Congress to raise the applicable percentage of waste that triggers a refund for drugs with unique circumstances. Specifically, the agency considered drugs that must be reconstituted with hydrogel and a substantial amount adheres to the vial wall during preparation and speculated that 35 percent may be appropriate to account for the portion of the drug that adheres to the vial. CMS requested comments on, but did not propose, whether specifying a higher applicable percentage, like 35 percent for drugs that are diluted in hydrogel and administered via pyelocaliceal route would be appropriate. AUA members deliver the drug in question, and the AUA urges CMS to use its authority and finalize policy that raises the applicable percentage to 35 percent in this circumstance. As the agency recognized, there is no way to reduce the amount of drug waste in this specific circumstance and finalizing a higher applicable percentage will appropriately recognize the uniqueness of this situation.

### **Strategies for Improving Global Surgical Package Valuation**

The AUA appreciates the thoughtfulness with which CMS is approaching the effort to improve the valuation of global surgical packages. AUA membership includes those who are primarily proceduralists who regularly bill 10- and 90-day global services, and as such, CMS' ultimate approach to the global periods will affect our members. At this time, the AUA does not have data to respond meaningfully to the agency's request for comment on this topic; however, we welcome the opportunity to engage with the agency on this issue, particularly as proposed changes are being formulated and considered.

### **Rebasing and Revising the Medicare Economic Index (MEI)**

CMS outlined plans to rebase and revise the MEI, which measures practice cost inflation and serves as a mechanism to determine the portion of payments attributed to physician earnings and practice costs. The current MEI weights utilize data obtained from the American Medical Association's (AMA) Physician Practice Information (PPI) Survey, which includes 2006 data. The agency proposed to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey but did not propose to implement this change in CY 2023 because of the significant redistributive effect of the policy, and instead, is seeking comment.

The AUA supports CMS' efforts to base physician payment on the most current data available. In the CY 2022 MPFS proposed rule, the agency proposed to update the clinical labor inputs used to calculate direct PE, which also resulted in significant redistribution of RVUs, particularly for device intensive procedures; the AUA recommended that the agency more regularly review these inputs to ensure predictability in changes and to lessen the degree of difference between review periods in our comments. Again, we make the recommendation to regularly review these MEI inputs to avoid significant, disruptive redistributive effects.



As the agency predicts, this change will be extremely disruptive to physician payments. While the AUA strongly supports regular review and update of MPFS inputs, we cannot support completing this update in a budget neutral manner while recognizing that CMS does not have the authority to implement this policy with new money without an act of Congress. The AUA will continue to advocate for Congress to add more money to the MPFS and encourages CMS to make clear the limitations of the current system in its interactions with Congress as well. However, physicians cannot withstand additional destabilizing reductions in payment at this time. Without Congressional intervention, CMS will finalize the reduction in the conversion factor as proposed and an additional 4 percent cut to the entire Medicare program will be applied due to the PAYGO rules triggered by the American Rescue Plan Act (P.L. 117-2), totaling almost 10 percent in reimbursement cuts beginning on January 1, 2023. These cuts are in addition to the erosion of the investment in physician's services over the last two decades. Not only has the conversion factor not kept pace with inflation, today's conversion factor is approximately half of what it would have been had it been indexed for general inflation beginning in 1998. In addition, the cost of running a medical practice increased by 37 percent between 2001 and 2020, which does not account for the increased costs associated with the recent inflationary increases in goods and services. Accordingly, the AUA is extremely concerned about the impact on beneficiary access to care should these downward pressures on payment continue.

### **Strategies for Updates to Practice Expense Data Collection and Methodology**

CMS currently uses information from the AMA PPI Survey to set the indirect practice expense inputs, which as acknowledged in our discussion of the MEI changes is data from 2006. The AUA has been actively engaged in CMS' efforts to date to update the indirect practice expense methodology, participating in the 2021 virtual town hall on the topic. Again, the AUA supports CMS basing MPFS payments on regularly updated data to mitigate significant redistributive effects. As CMS develops a proposal on this topic, the AUA urges the agency to work with the AUA and other physician specialty societies, including the AMA, to develop a methodology that treats all physician specialties equitably when developing these inputs.

### **Request for Information: Medicare Potentially Underutilized Services**

The AUA appreciates CMS' interest in increasing the adoption of high-value services, which are underutilized, like preventive, cancer screening, and complex/chronic care management services. Many of our members treat Medicare beneficiaries with bladder, kidney, and prostate cancer, and these services would provide value to them. The AUA believes some physicians and coders lack an understanding of how and when these services should be billed, and any future educational efforts should target both groups. However, the practices that understand how to use these services choose not to utilize them after making the calculation that the additional RVUs are not worth the additional documentation burden and effort to seek a co-pay from the beneficiary. While CMS cannot address the co-pay requirements for many of these non-face-to-face services without Congressional action, the agency can revisit the documentation requirements to reduce the burden on practices.

### **Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs)**

The AUA recognizes the effort across stakeholder groups in designing and implementing MVPs, and we support the goal of linking performance measurement with relevant cost and improvement activities to accelerate improvement in care quality for patients and their families. Moreover, given the scope of this



new effort and the inherent challenges associated with its development and implementation, we thank CMS for recognizing that it is premature to finalize the sunset of traditional MIPS at this time. Going forward, we urge CMS to provide timely, detailed information from the field regarding uptake, challenges and solutions, and impact to patients and clinicians as MVPs are implemented, so that others can learn and better direct their own resources to ensure successful implementation.

The AUA agrees with CMS's proposal to solicit feedback on newly submitted MVPs from interested parties and the public via a 30-day comment period. However, we do not agree that CMS should revise MVPs based on comments received without first sharing those comments, proposed changes, and rationale for such changes to the original submitter of the MVP and other interested parties (e.g., developer of measures included in the MVP) and inviting further input from same. Such a dialogue could help validate and bolster confidence in the MVP if such entities agree with the proposed changes, but also limit changes that might ultimately prove infeasible, unhelpful, or undesirable. Moreover, we believe such a dialogue with the original submitter and other interested parties should be implemented as part of the maintenance of MVPs. However, we support receiving recommendations for revisions of established MVPs on a rolling basis.

Regarding CMS's request for information on third party intermediary support of MVPs, the AUA strongly favors flexibility in the choice of measures supported in an MVP. Specifically, third party intermediaries should be required to support only those MVP measures they believe are relevant to their customers but have the option not to support measures that are not applicable or that would be applicable to relatively few of their customers. Barriers to supporting all measures in an MVP include, among others, costs to operationalize data collection, the administrative burden associated with licensing QCDR measures, and time and resources needed for customer education. While such outlays may be manageable and reasonable when relatively few MVPs are available, these may easily become unmanageable and unreasonable as MVPs begin to proliferate. Relatedly, we encourage CMS to provide additional clarity on what it means for an MVP and MVP-specific measures to be "relevant" or "applicable" for specific types of providers.

We are grateful for CMS's recognition of the impact of the COVID-19 PHE on QCDRs' ability to meet previously mandated measure testing requirements and agree with the proposal to delay requirements for full testing of QCDR measures at the clinician level until the 2024 performance year. We urge CMS to provide additional clarification on what it means for a QCDR measure to be "fully tested at the clinician level..." including what constitutes acceptable testing methods. Furthermore, we ask that CMS develop a transparent and consistent process for evaluating testing approaches and results, providing feedback, and allowing appeals, and to publicize this process to all relevant stakeholders in a timely manner.

#### ***Advancing Cancer Care MVP***

Regarding the newly proposed MVPs, the AUA supports the concept of MVPs that focus on various aspects of cancer care. However, we believe that the Advancing Cancer Care MVP, as currently proposed, would be of limited value to the majority of urologists who participate in the MIPS program. Several of the quality measures included in this MVP, including the two QCDR measures, are not applicable for urologists and two are focused on end-of-life care only. Thus, this MVP would be burdensome to implement in the AUA's QCDR and would provide insufficient choice for selection of measures for those urologists who provide care for those with cancer but whose patients are not near



the end of life. The AUA looks forward to working with CMS to develop a urology-specific MVP that reflects the scope of practice in the specialty.

Regarding potential quality measure additional and deletions, the AUA does not support removal of QPP #265 (Biopsy Follow-up), as this measure is relevant for urologists and data from our AQUA Registry suggests there is still room for improvement among providers who have selected to track this measure. While we support inclusion of the new Immunization Status Measure. However, we do not support removal of the two individual immunization measures (QPP #110 and QPP #111). We support removal of QPP119 (Diabetes Medical Attention for Nephropathy) if the new Kidney Health Evaluation measure is approved. We also support the addition of the Screening for Social Drivers of Health measure and favor its classification as a high-priority measure.

**Request for Information: Health Equity Measures**

The AUA applauds CMS's continued efforts to promote equity in health and health care, and supports its efforts to promote the systematic collection of social risk and demographic data, the use of such data to stratify quality measure results, and the development of measures that focus on equity. We support the inclusion of the "Screening for Social Drivers of Health" measure for the Alternative Payment Model Performance Pathways, traditional MIPS, and MVPs, assuming it receives NQF endorsement, as we believe information collected via this measure can be to inform the management and treatment of individual patients and allow stratification of measure results to promote system improvement. However, we strongly oppose inclusion of the "Screen Positive Rate for Social Drivers of Health" in any of these tracks, in part because it could drive unintended negative consequences such as reduced access to care, it is unclear how such information could be useful to healthcare consumers, and it may unfairly penalize clinicians who otherwise provide excellent care to their vulnerable patients. Moreover, although we believe that individual clinicians and the health care system can play a part in addressing social drivers of health for their patients, much is outside their control, making it unfair to hold them accountable for such a measure, particularly in a payment program such as the Quality Payment Program. Regarding future health equity measurement, we encourage CMS to concentrate on efforts to enable standardized and consistent data collection and stratification of current measures, and to develop additional measures that focus on access to care, patient-clinician communication, and patient experience.

We are grateful to CMS for the opportunity to provide these comments on the CY 2023 Medicare Physician Fee Schedule proposed rule and welcome the opportunity to continue to work together on these important policy issues. Please contact Raymond Wezik, AUA Director of Policy and Advocacy, at [rwezik@auanet.org](mailto:rwezik@auanet.org) with any questions.

Sincerely,

A handwritten signature in black ink that reads "Eugene Rhee, MD, MBA".

Eugene Rhee, MD, MBA  
Chair, Public Policy Council