



American Urological Association

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September 11, 2023

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Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016,
Baltimore, MD 21244-8016

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

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RE: 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 La-Sure,

The American Urological Association (AUA) appreciates the opportunity to provide comments on the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) proposed rule (CMS-1784-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 the Centers for Medicare & Medicaid Services (CMS) on the following provisions of the proposed rule:

- Proposed Valuation of Specific Codes for CY 2023
- Conversion Factor Update
- Delaying the Implementation of the Rebased Medicare Economic Index
- Evaluation and Management (E/M) Services
- Split/Shared Services
- Telehealth Services and Remote Monitoring and Therapeutic Services
- Services Addressing Health-Related Social Needs
- Drugs and Biologics Paid Under Medicare Part B
- Quality Payment Program Proposed Provisions

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PROPOSED VALUATION OF SPECIFIC CODES

Cystourethroscopy (CPT Code 5X800)

The AUA would like to thank the agency for proposing the Relative Value Scale Update Committee's (RUC) recommended work and Practice Expense (PE) relative value units (RVUs) for CPT code 5X000, *cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed*. **We recommend that these values be finalized as proposed.**

Neurostimulator Services (CPT Codes 64590 and 64595)

The AUA would like to thank the agency for proposing the RUC's recommended work RVUs for CPT codes 64590, *Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver* and 64595, *revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array*.

Furthermore, the AUA agrees with CMS' proposal to update the PE inputs as following:

- 48 minutes of equipment time for EQ114 (electrosurgical generator), and,
- 84 minutes of equipment time for EQ209 (programmer, neurostimulator (with printer))

These amendments to the PE inputs align with the clinical labor time and equipment time used for a power table at the follow-up visit. **AUA members actively participated in the RUC survey processes used to support the values recommended for these codes, and the AUA is grateful to see them proposed as recommended and urges the agency to finalize these values.**

CONVERSION FACTOR UPDATE

CMS has proposed to decrease the conversion factor from \$33.887 to \$32.7476 as the result of a statutory 0% update scheduled for the MPFS in 2024, a negative 2.17% RVU budget neutrality adjustment, and the expiration of part of the funding Congress allocated to the MPFS at the end of 2022 through the Consolidated Appropriations Act (CAA) of 2023. The AUA acknowledges CMS' inability to mitigate these cuts, given the budget neutral nature of the MPFS and lack of statutory authority. However, urologists and other physicians continue to face budgetary challenges as operational and clinical labor expenses continue to increase and Medicare reimbursement has stagnated. Physician payments have already declined, especially when compared to inflation, all while payment rates to other Medicare providers continue to increase. **The proposed conversion factor cut exacerbates these challenges, undermining urologists' capacity to provide optimal patient care while sustaining viability of their practices.** While the AUA appreciates CMS' efforts in this proposed rule to develop new policies to support the delivery of patient centered care, every new service added erodes the value of



existing services. The AUA is committed to collaborating with Congress to address and ameliorate the impending decrease in the conversion factor and other cuts to physician payment.

REBASING THE MEDICARE ECONOMIC INDEX

In the CY 2023 MPFS, CMS finalized a policy to rebase and revise the Medicare Economic Index (MEI) to reflect current market conditions in providing physician services. In the proposed CY 2024 MPFS, CMS is proposing to delay implementation of this policy in consideration of the American Medical Association's (AMA) project of updating and collecting new data through the Physician Practice Information Survey (PPIS). The AUA supports this proposal, recognizing that AUA members' active participation in the PPIS survey will contribute to a more precise and comprehensive understanding of the evolving costs affiliated with healthcare. The AUA continues to encourage CMS to review and update this data at regular intervals to ensure that the MEI is current even beyond the PPIS survey. Regular review of the MEI and practice expense inputs is critical to prevent the significant redistributive effects that result when data is updated after not being kept current.

The AUA reiterates that the MEI update cannot be completed in a budget neutral manner without destabilizing effects to the services provided under the MPFS. The AUA recognizes that CMS does not have the authority to implement this policy with new funds without Congressional action and remains committed to advocating for Congress to allocate additional funding to the MPFS. The proposed payment reductions within this fee schedule, coupled with escalating inflation, place an untenable burden on physicians. Today's conversion factor is approximately half of what it would have been had it been indexed for general inflation beginning in 1998. As such, the AUA is extremely concerned about the impact these cuts resulting from this update could have on patient access to care.

EVALUATION AND MANAGEMENT (E/M) SERVICES

Request for Comments about Evaluating E/M Services More Regularly and Comprehensively

The AUA appreciates the opportunity to speak to the potential evaluation of E/M services more regularly and comprehensively. The AUA believes that current E/M HCPCS codes accurately define the full range of E/M services and that the methods used by the RUC and CMS accurately value E/M and other HCPCS codes. The RUC process incorporates the input of physicians and specialty societies that are well-versed in the nuances, complexities, and value of procedures. This ensures appropriate service valuation. **The AUA encourages continued collaboration between CMS and the RUC.**

Split/Shared Services

CMS has previously introduced and subsequently delayed the change in the definition of "substantive portion" of a split/shared visit to be determined by which practitioner provides



more than half of the service by time. In the CY 2024 proposed rule, the agency proposes to maintain the current definition of “substantive portion” which allows for the use of either one of three components - history, exam, or medical-decision making (MDM) – or more than half of the total time spent to determine the provider that will bill for the visit.

The AUA firmly believes that billing for split/shared services should align with the billing criteria applied to other E/M services – based on MDM or time. This approach ensures consistency and equitable treatment across various types of services, reflecting the AUA’s commitment to streamlining practices, promoting fair billing standards and ultimately providing higher quality patient care. The retention of MDM-based billing for split/shared services would not only enhance clarity but also facilitate a more straightforward and transparent billing process.

TELEHEALTH SERVICES AND REMOTE MONITORING AND THERAPEUTIC SERVICES

Implementation of Provisions of the Consolidations Appropriations Act of 2023

The CAA of 2023 finalized an extension for certain telehealth policies through December 31, 2024. CMS is proposing to update its regulations to reflect this extension for many of these flexibilities, including the waiver of the originating site requirements and geographic restrictions and audio-only services. Previously, in CY 2023, CMS established POS 10 for telehealth provided in a patient’s home. At this time, CMS is proposing to pay claims billed with POS 10 at the non-facility rate for CY 2024 as practitioners will need to maintain an in-person practice setting in addition to providing telehealth services.

The AUA appreciates CMS’ commitment to support extending telehealth flexibilities through December 31, 2024. Additionally, the AUA supports payment parity for telehealth services and urges CMS to finalize the proposal to reimburse telehealth services billed with POS 10 at the physician office rate. The AUA believes that telehealth services require the same level of work and MDM as an in-person visit regardless of the site of service. Without payment parity, many physicians will not be able to afford to provide telehealth services, which ultimately may impact patient access to care. The AUA believes this policy supports health equity and will minimize health disparities by ensuring Medicare beneficiaries retain broad access to telehealth services and remains committed to working with CMS and Congress to ensure Medicare beneficiaries retain access to medically appropriate telehealth services.

Virtual Direct Supervision

The AUA continues to support the existing definition of virtual direct supervision and urges CMS to allow direct supervision via virtual presence to be a permanent policy. AUA members utilize this flexibility and have successfully provided direct supervision remotely since the start of the COVID-19 pandemic. Urologists have been able to provide virtual direct supervision for procedures such as placing a catheter and E/M services. This increases patient access, particularly in rural and underserved areas experiencing urologist shortages.



SERVICES ADDRESSING HEALTH-RELATED SOCIAL NEEDS

Establishment of a HCPCS G Code for Social Determinants of Health Assessments

CMS is proposing the development of a HCPCS G Code for a Social Determinants of Health (SDOH) risk assessment with a proposed total RVU of 0.57 when performed in the non-facility setting. CMS is also proposing to add this code as an optional, additional element of the annual wellness visit with an additional payment.

While the AUA is supportive of the broader integration of SDOH health assessments to comprehensively gauge patient treatment and recovery risks, we seek further clarification on the precise utilization of this proposed code. In instances where a patient seeks services from both a primary care provider and a specialist within a six-month period, would both providers be able to conduct and bill for the assessment independently? Many urologists conduct informal SDOH assessments for their patients to better understand and develop a possible treatment or recovery plan. As part of this proposal, urologists should be able to bill for this code. Given the impact SDOH have on patients' ability to adhere to a care plan and their health outcomes, the AUA believes both a urologist and primary care provider should be able to bill this service during the same six-month period if they both provide care to the patient during that time. **The AUA recommends CMS provide additional clarification on billing specifications for this service including which providers can bill for this code and how frequently.**

Principal Illness Navigation Services

Additionally, CMS is also proposing to create HCPCS codes for Principal Illness Navigation (PIN) services to expand care for different types of populations. The current proposed code describes services associated with the care of patients with a "serious, high-risk disease expected to last at least three months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decomposition, functional decline, or death."

The AUA requests additional clarification on the definition of serious, high risk disease as many urologists use navigators for illnesses that may not necessarily fit into the existing definition but could potentially count as navigation services. For example, a urologist may see a patient with a urethral stricture who has significant lower urinary tract symptoms, elevated post-void residual, and is at high risk of acute exacerbation over the next three or more months, especially if the patient chooses observation or surgical interventions are delayed. A medical assistant would fill out short-term disability paperwork for surgery on behalf of the physician. In these instances, a urologist's care team would benefit from being able to utilize the HCPCS code for PIN services. **In addition to requesting clarification, the AUA also recommends broadening the definition to include "at high risk for complications after an intervention," which could include wound healing.**

The AUA fully supports the broader implementation of services targeting health-related social needs, a step that enhances patient care and cultivates better health outcomes. **We seek**



clarity not only on the utilization of these new codes but also on the allocation of payment for them, emphasizing the importance of a clear understanding of the financial framework underpinning these proposed changes especially given the budget-neutral nature of Medicare.

DRUGS AND BIOLOGICS PAID UNDER MEDICARE PART B

CMS is requesting comments on complex drug administration coding, particularly as stakeholders have raised concerns that non-chemotherapeutic complex drug administration payments are inadequate and do not reflect the resources used to furnish infusion services. The current payment methodologies also influence MAC payments. **The AUA recommends the codes utilized for these services be submitted to the CPT Editorial Panel to be redefined and then revalued.** This will allow for the development of accurate practice expense inputs as well as ensure that the work RVUs reflect the skill and time affiliated with each procedure. This will ensure proper valuation and payment for complex drug administration.

QUALITY PAYMENT PROGRAM PROPOSED PROVISIONS

MIPS Value Pathways (MVPs)

CMS proposes revisions that would require Qualified Clinical Data Registries (QCDRs) to support only those measures within applicable MVPs that are pertinent to their specialty without requiring that QCDRs support other QCDR measures. **The AUA strongly favors this flexibility for QCDRs; the proposed changes will reduce the costs required to operationalize data collection, the administrative burden associated with licensing QCDR measures that are not relevant, and the time and resources needed for complex consumer education.** This proposed change may also help to increase the uptake of MVPs.

Data Completeness Threshold

CMS is proposing to modify the quality performance category for MIPS in two ways: to maintain the data completeness criteria threshold to at least 75% for the 2026 Performance Year (PY)/2028 MIPS payment year, and to increase the threshold to at least 80% for the 2027 PY/2029 MIPS payment year. **The AUA supports maintaining the data completeness threshold at 75% through the 2026 PY.** However, we oppose increasing the threshold to 80% for the 2027 PY. The AUA understands and agrees with CMS' intent to minimize selection bias; however, we believe it is both premature and unfair to increase the data completeness threshold while clinicians are unable to access data seamlessly across locations and care settings.

Performance Threshold

CMS is also proposing changes to a provider's requirements to be eligible for a positive payment adjustment. Under the proposed rule, the performance threshold for PY 2024 would be 82 points, a 7% increase from the PY 2023 threshold. The AUA recognizes that this updated threshold incorporates data from several preceding years while omitting information from PY



2020 and PY 2021 due to the influence of the COVID public health crisis. We are aware that opting for alternative years would yield an even greater suggested threshold. However, the AUA does not believe that incremental increases in the threshold will improve attention to quality and subsequent improvements in care. In fact, we believe such increases may have the opposite effect. Additionally, a shift to an 82-point threshold likely would result in more than half of eligible clinicians receiving a negative payment adjustment, making it even more difficult for many providers – including small, rural, or those serving a high proportion of underserved patients – to provide high-quality care. **Therefore, we strongly oppose the proposed increase in the performance threshold and urge CMS to continue to use a threshold of 75 points for PY 2024 and beyond.**

Request for Feedback on Promoting Continuous Improvement in MIPS

In the proposed rule, CMS is requesting feedback on how to modify policies under the QPP to foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries. The AUA appreciates this opportunity to provide input, as we agree that participating clinicians may select and report on measures and activities on which they are already performing well as part of their reporting measures.

The AUA welcomes changes to the MIPS program that would more effectively foster efforts to improve care and positively impact patient outcomes. We encourage CMS to consider the following suggestions for changes to the MIPS program:

- Limit the number of years for reporting measures if performance is consistently high, barring significant changes to measures.
- Revise Improvement Activities (IA) by narrowing flexibility, adjusting the number of required activities, adjusting the scoring methodology, and/or better integrating activities with reported measures for traditional MIPS.
- Discontinue mandatory increases in the overall performance threshold.
- Increase credit for improvement (e.g., up to 10 points per measure) in the scoring system.
- Reward clinicians for reporting more than the minimal number of measures, particularly when such measures closely align with the care they provide or when performance is suboptimal.

The AUA recognizes that implementing changes in one area may impact other areas and that changes that increase provider burden may disproportionately impact providers in smaller or rural practices or those with a greater percentage of underserved patients. **Importantly, the AUA opposes mandating the utilization and reporting of specific measures by participating providers. This type of mandate would erode clinician autonomy and lead to additional opportunity costs, potentially diverting focus from other vital quality-of-care considerations. Furthermore, obligatory quality measures would inherently be cross-cutting, potentially**



posing challenges for subspecialists who prefer more tailored measures that better align with their practice.

Request for Information on Publicly Reporting Cost Measures

CMS intends to begin publicly reporting cost measure results beginning with the CY 2024 performance period/2026 MIPS payment year. The AUA agrees that assessing costs is an essential step toward reducing overall healthcare expenses and fostering understanding of and accountability for provider cost variations. Nevertheless, cost measurement is complex, and we are unsure if results can be effectively communicated to empower consumer decisions, even when paired with limited available quality measures. Therefore, **the AUA objects to publicizing cost measure results at this time. Instead, we encourage CMS to continue to refine cost measurement methods and collaborate with providers to help them understand how they can contribute to broader cost reduction efforts. We also recommend that CMS provide alternative methods for patients to access and understand care costs specific to their needs. Lastly, we encourage CMS to invest in further research on how to best link cost, quality, and access measures to reflect value and how to best present such information to consumers.**

Additions, Deletions, and Modifications of Measures, IAs, and MVPs

Finally, the AUA has no concerns regarding potential additions and deletions to the list of quality measures and improvement activities, nor to the potential modifications to the Urology measure set. We also have no concerns regarding the potential additions and modifications to available MVPs, particularly as the majority are not relevant to urology.

We are grateful to CMS for the opportunity to provide these comments on the CY 2024 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 with any questions.

Sincerely,

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

Eugene Rhee, MD, MBA
Chair, Public Policy Council