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September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244 –8016

Re: Comments on CMS-1807-P: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure:

On behalf of the American Urogynecologic Society (AUGS), I am pleased to submit comments in response to the proposed rule for the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (CMS-1807-P). AUGS is a national medical society whose mission is to promote the highest quality of care in urogynecology and pelvic reconstructive surgery through excellence in education, research, and advocacy.

Our comments address the following CMS proposals:

CY 2025 Updates to the Physician Fee Schedule

1. Calendar Year 2025 Conversion Factor

Proposed Rule: Average payments under the Medicare Physician Fee Schedule (MPFS) are proposed to be reduced by 2.93% in CY 2025 compared to the average amount these services are being paid for most of CY 2024.The change to the MPFS conversion factor incorporates the 0.00 percent overall update required by statute, the expiration of the 2.93% increase in payment for CY 2024 required by statute, and a relatively small estimated 0.05% adjustment necessary to account for changes in work relative value units (RVUs) for some services. This amounts to a proposed estimated CY 2025 PFS conversion factor of $32.36, a decrease of $0.93 (or 2.80%) from the current CY 2024 conversion factor of $33.29.

AUGS Recommendation: CMS proposes a 2.8% cut to Medicare physician payments starting January 1, 2025, while estimating that the costs of practicing medicine, as measured by the Medicare Economic Index (MEI), will increase by 3.6%. In other words, while the costs of paying clinical and administrative staff, rent, and purchasing equipment and supplies are projected to rise by 3.6%, physicians' payments will decrease by nearly 3%. The CY 2025 conversion factor reduction of 2.8% percent continues to undermine the long-term financial viability of physician practices and seniors' access to critical treatments and procedures by implementing additional, significant cuts in physician reimbursement. Once again, physicians must rely on Congressional action to mitigate these scheduled reductions, and these year-over-year cuts are a clear indicator that the Medicare physician payment system is broken. Systemic issues such as the negative impact of the Medicare physician fee schedule's budget

neutrality requirements and the lack of an annual inflationary update will continue to generate significant instability for health care clinicians moving forward, threatening beneficiary access to essential health care services. National policy makers, both within the Administration and in Congress, have a duty to ensure a Medicare system that provides financial stability through an annual positive update for physician payments that reflects the impact of inflation on practice costs.

We urge CMS to work with Congress to enact a permanent, annual inflation-based update to Medicare physician payments tied to the MEI and address the physician fee schedule payment cuts before January 1, 2025. At a minimum, CMS should acknowledge the negative effects of the proposed payment cuts on Medicare beneficiaries in the final rule and encourage Congressional action to reverse it.

2. Telehealth Services

a) Audio-only Coverage, Additions to Telehealth List, Lifting of Frequency Limits

Proposed Rule: CMS proposes a new permanent policy allowing audio-only telehealth services for clinical care delivered to patients in their home if the physician can use audio-video, but the patient does not have or does not consent to video use. This is an expansion of the policy previously adopted that allowed audio-only services for patients receiving telehealth for mental health conditions. Through 2025, CMS also proposes to continue lifting frequency limits on telehealth for subsequent inpatient and nursing facility visits and critical care consultations, as well as to not require physicians providing telehealth to report their home address. Moreover, additions to the Medicare Telehealth Services List are proposed for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV), home International Normalized Ratio (INR) monitoring, and caregiver training services.

AUGS Recommendation: - We support the proposed new permanent policy allowing audio-only telehealth services for services delivered to patients in their home if the patient does not have or does not consent to video use. Access to broadband internet is a social determinant of health, and discontinuing audio-only coverage would exacerbate health inequities, including for historically marginalized, minoritized and underserved populations. Audio-only services can enhance quality and improve patient health outcomes. Some patients are more comfortable speaking with their physicians without video. Audio-only services can also be used to manage treatment for patients with chronic conditions. Although few patients would want to obtain all their health care services over the phone, in the nearly five years since CMS has been allowing payment for audio-only services, it has become clear that they play an important role in digitally enabled hybrid models of in-person and virtual care. The CMS proposal to make permanent coverage of audio-only telehealth services delivered to patients in their home is a critical step in addressing inequities and we urge CMS to finalize it.

b) Virtual Supervision

Proposed Rule: Since COVID-19, CMS has defined physicians' "immediate availability" for services that require direct supervision to include real-time audio and visual interactive telecommunications technology. The proposed rule would permit virtual direct supervision as a permanent policy for a subset of services requiring direct supervision. For others, however, virtual direct supervision would continue to be allowed through December 31, 2025. CMS also proposes continuing its current policy through 2025 allowing teaching physicians to virtually supervise residents, but only when the service is furnished virtually (e.g., when the patient, resident, and teaching physician are all in separate locations).

AUGS Recommendation: With respect to direct supervision by interactive telecommunications technology, we believe the current policy during the COVID-19 PHE allowing "direct supervision'' to include immediate availability through the virtual presence of the supervising physician using real-time, interactive audio/video communications technology should be made permanent. The fact that remote supervision may be inappropriate in some cases does not justify refusing to pay for it under any circumstance. In many rural and underserved areas patients may be unable to access important services if the only physician available must supervise or deliver services at multiple locations and may not be available to supervise services when all patients need them.

Several factors, including inadequate payments and burdensome administrative requirements in Medicare and other health insurance programs, have resulted in increasingly severe shortages of physicians in many specialties and geographic areas. These shortages are forcing physician practices, hospitals, and other providers in many communities to organize and staff services in different ways than in the past, including through remote physician supervision. In addition, some innovative approaches to care, such as hospital-at-home, are only feasible if they can be delivered using remote supervision. It will be more difficult to recruit and retain non-physician staff with the necessary training and experience to safely deliver services under remote physician supervision, and it will be more difficult for innovative programs to recruit and retain physicians who can effectively provide remote supervision, if those staff and physicians are concerned that the policy enabling remote supervision could be revoked within a year. This uncertainty could force the services to be delivered using less capable staff or prevent the services from being delivered at all. As a result, rather than protecting patients, the temporary status of the supervision policy could worsen patient care. Both patients and CMS rely on physicians' professional judgment to determine the most appropriate services to deliver, and the same principle should apply to how supervision is provided.

While we appreciate CMS proposing to continue the current policy through 2025, the policy has been in place long enough that any serious problems should already have been identified, so we believe it is time to end the uncertainty and make the policy permanent.

3. Updates to Prices for Existing Direct PE Inputs – Supply Pack Updates

Proposed Rule: For CY 2025, CMS is proposing to implement the supply pack pricing update and associated revisions as recommended by the RVS Update Committee's (RUC) workgroup. They are proposing to update the pricing of the "pack, urology cystoscopy visit" (SA058) supply from $113.70 to $37.63, a reduction of 67% that will negatively impact the practice expense RVUs for thirty-eight procedures in the physician-owned office-setting. This update was based on only two submitted invoices to CMS from the RUC workgroup.

AUGS Recommendations: AUGS is very concerned that this proposed reduction will negatively impact the availability of procedures for diagnosis and treatment in the community, office-based setting for women with urinary incontinence. We do not believe it is appropriate for CMS to change the pricing of "pack, urology cystoscopy visit," (SA058) based on only two submitted invoices for pricing of the items on the pack. A reduction of greater than 50% in this practice expense direct cost input at a time when physician practices are being hit hard by inflation and other economic pressures is not appropriate. AUGS urges CMS to delay the implementation of this proposed re-pricing until the RUC or independent sources can provide CMS with at least five invoices for the items in this urology, cystoscopy visit pack.

4. Office/Outpatient (O/O) E/M Visit Complexity Add-on Code

Proposed Rule: CMS proposes to amend its previously finalized policy not to allow payment of the add-on code G2211 when reported with Modifier -25 and to pay for the add-on code when the E/M visit is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. CMS does not assume any additional spending beyond its original utilization projections for G2211 associated with this new proposal for CY2025.

AUGS Recommendations: AUGS appreciates CMS proposing to allow for the use of the G2211, the E/M Visit Complexity Add-on Code, with the Medicare Part B preventative services visits. For patients that have to travel long distances or do not have easy access to specialty care, the ability for their physician to continue the care of chronic, complex conditions, such as urinary incontinence during an annual preventative visit and have that work be recognized via the billing of G2211 is helpful to support Medicare beneficiary access. It is important that physicians have the flexibility, where it is also clinically appropriate, to discuss and review the care plans and pathways for chronic women's health related conditions during preventative care visits. AUGS supports this proposal by CMS regarding expanding the codes that G2211 can be billed with.

5. Strategies for Improving Global Surgery Payment Accuracy

Proposed Rule: For CY 2025, CMS is proposing to broaden the applicability of the transfer of care modifiers for global packages and require the use of the existing modifiers (-54, -55, and -56) for all 90-day global surgical packages in any case when a practitioner (or another practitioner from the same group practice) expects to furnish only the pre-operative(-56), procedure (-54), or post operative portions of a global package (including but not limited to when there is a formal, documented transfer of care as under current policy or an informal, non-documented but expected, transfer of care). For CY2025, CMS is also proposing a new add-on code, GPOC1, for post-operative care services to reflect the time and resources involved more appropriately in these post-operative visits to compensate the additional resources involved by practitioners who were not involved in furnishing the surgical procedure.

AUGS Recommendation: AUGS does not believe that CMS will gather actionable data based on the proposed policies and CMS should not revalue global codes based on flawed or inaccurate data on post-operative visits. If CMS finalizes the proposal to expand use of existing modifiers for all 90-day global surgical packages, it should ensure patient choice is preserved by requiring informed consent for transfers of care and only apply this policy to those formal transfers of care for which CMS has a definition in sub-regulatory guidance.

Under CMS' current transfer of care policy, the surgeon and one or more practitioners (who are not in the same group practice as the surgeon) formally document their agreement to provide distinct portions of the global package. Transfer of care modifiers must be appended to the global code(s) by both the operating surgeon and the provider taking over some or all the postoperative work within the scope of the global package. Postoperative work that is unrelated to the surgery does not apply to the transfer of care policy. The proposed expansion of the use of the transfer of care modifiers to report informal, non-documented but expected transfers of care is poorly defined, making its value uncertain and, to the extent it drives changes in claims data if finalized, will not result in accurate, complete, and actionable data.

Until CMS is ready to commitment to the provision of detailed guidance and education to ensure operating and non-operating physicians and fully qualified health professionals understand the appropriate use and documentation of the -54 and -55 modifiers, AUGS believes this policy proposal should not be implemented in FY 2025.

With payments for evaluation and management (E/M) visits increasing substantially in 2021, CMS should finally apply those payment increases to the post-operative visits bundled into global surgical codes. Failure to do so is a violation of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), which prohibits Medicare from paying physicians differently for the same work. The absence of equitable adjustments is negatively impacting the relativity and the integrity of the physician fee schedule, and we urge CMS to apply the increased values to the E/M portion of global surgical codes.

Regarding CMS' proposal to create a new add-on code, GPOC1, AUGS is concerned that this proposal does not address the critical issue of liability as it relates to reporting of GPOC1. We understand that CMS' overarching goal is to gain a better understanding of which practitioners are providing postoperative care. But by billing GPOC1, a practitioner who did not provide the surgery and who is, by definition, unfamiliar with the surgery and requires additional resources to learn about the procedure and all the possible postoperative complications to monitor and address, is also then taking on the liability for the postoperative care and post-surgical outcomes. A provider who performs a surgical procedure would also be providing postoperative care for their patients. In cases where an uninformed practitioner in a different group was to claim to take over this care, at times without the knowledge of the surgeon, that provider must be held accountable for the risk as well.

Therefore, given the ambiguity of code GPOC1, the potential for misuse of the code, the unaccounted for issues related to liability, and the failure of the code to provide **any** meaningful information to CMS about the care that surgeons are providing to their patients in the postoperative portion of the global period at all (let alone for potentially valuing global periods), AUGS opposes the CMS implementation of GPOCI.

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Thank you for the opportunity to provide comments for your consideration. If AUGS can provide CMS with additional information regarding these matters, please contact me at 301-273-0570, ext. 116 or email Stacey@augs.org.

Sincerely,

Stacey Barnes
Chief Executive Officer