The Hospital + Healthsystem
Association of Pennsylvania

Leading for Better Health

September 11, 2023

The Honorable 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

RE: 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; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program; Proposed Rule, August 7, 2023

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 230 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Physician Fee Schedule proposed rule for calendar year (CY) 2024.

HAP is deeply concerned that CMS' proposed payment rate will substantially reduce payments from their current level posing significant risk to patients' access to care and health systems' financial stability, particularly for safety-net providers.

However, HAP is pleased to see the agency's continued efforts to retain important telehealth flexibilities permitted during the COVID-19 pandemic as well as the delay in implementing the proposal to change how a split visit is defined.

In addition, we incorporate, by reference, all of the comments provided in the American Hospital Association's response to the proposed rule.

Thank you for your consideration of HAP's comments regarding this proposed rule. If you have any questions, contact Kate Slatt, vice president, innovative payment and care delivery, at (717) 561-5317.

Sincerely,

Jeffrey Bechtel
Senior Vice President, Health Economics and Policy

Attachment

HAP Comments—Physician Fee Schedule
Proposed Rule for Calendar Year 2024

CONVERSION FACTOR UPDATE

CMS' proposed policies would reduce the Physician Fee Schedule (PFS) conversion factor by 3.34 percent to $32.75, as compared to $33.89 in CY 2023.

HAP echoes the AHA concerns about CMS' proposed payment update, which would substantially reduce CY 2024 payments from their CY 2023 levels. This update would pose significant risks to patients' access to care and health systems' financial stability, particularly for safety-net providers. Our concern is heightened by the fact that this cut is coming in the wake of more than three years of unrelenting financial pressures on Pennsylvania hospitals and health care systems due to COVID-19, along with rising inflation, increasing input costs, and persisting staffing shortages and supply chain disruptions.

PAYMENT FOR EVALUATION AND MANAGEMENT VISITS

In this rule, CMS proposes delaying the implementation of its policy related to "split" visits for one year, until July 1, 2024.

"Split" Evaluation and Management Visits: Split visits occur when both a physician and a non-physician provider (NPP) provide services during and Evaluation and Management (E/M) visit. Last year, CMS proposed to define "substantive portion" as more than half of the total time spent by the physician or the NPP. CMS further proposed that the distinct time of services spent by each physician or NPP furnishing a split visit would be summed to determine total time of the visit. This would establish who provided the substantive portion of the visit and would, therefore, bill for the service.

If a physician performs a substantive portion of the visit, they can bill for the E/M and receive Medicare payment equal to 80 percent of the otherwise applicable payment of the PFS, which is the lesser of the actual charge or the fee schedule amount for the service. If the NPP performs a substantive portion of the visit and, therefore, bills for the service, payment is 80 percent of the lesser of the actual charge or 85 percent of the fee schedule rate.

With the proposed delay, the substantive portion would continue to be defined as either one of the three key components of a visit, or more than half the total time through 2023.

While HAP appreciates the proposal to delay this change for one year, CMS' intent to continue to implement this change is troublesome. It does not take into account how clinical workflows are structured. This change also directly contradicts former efforts to reduce administrative burden and will cause significant patient flow inefficiencies at a time when the strain on the health care workforce has never been greater, and the need for patient care has never been more urgent in the wake of COVID-19.

While HAP appreciates the delay in implementing the split visit proposal, HAP strongly urges CMS to resist implementing this proposal in which "substantive portion" is based on time in its entirety. As has been the practice, medical decision-making should determine the appropriate level of E/M visit.

TELEHEALTH

Prior to CY 2021, Medicare had two criteria categories for assessing requests for adding or deleting services from the Medicare telehealth list of services under Section 1834(m) of the Social Security Act:

- Category 1 are services similar to other services already on the Medicare telehealth list
- Category 2 are services that are not similar and, therefore, require additional supporting evidence of clinical benefit

In the CY 2021 final rule, CMS created a new category. Category 3 describes services added during the public health emergency (PHE) for which there is clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence to consider the service as permanent additions under Category 1 or 2 criteria. Category 3 services were to remain on the telehealth list until the end of the PHE.

Undoubtedly, the COVID-19 pandemic has created a world of uncertainty for patients and their health care providers. CMS recognized this uncertainty and the impact the end of the PHE might have on Category 3 services and proposed to retain services that are temporarily included on the telehealth list during the PHE but are not on a Category 1, 2, or 3 basis for 151 days following the end of the PHE, as required by the Consolidated Appropriations Act (CCA), 2022.

In the CY 2024 proposed rule, CMS proposes to include 42 codes on a temporary basis through CY 2024. These codes include:

- Cardiovascular and pulmonary rehabilitation
- Deep brain simulation
- Therapy services
- Hospital care and emergency department care
- Health and well-being coaching

Additionally, CMS proposes to again revise the process for which it will consider changes to the Medicare Telehealth Services List. It proposes that current Categories 1 and 2 be identified as "permanent", Category 3 or temporary codes will be identified as "provisional".

CMS also proposes to implement the telehealth provisions of the CCA 2023 which extend several favorable waiver policies until December 31, 2024. These include delaying in-person visit requirements for mental health services, waiving geographic and originating site rules, allowing physical, occupational, and speech therapists as well as audiologists to use telehealth

to deliver services, permitting audio-only for certain services, and allowing continued payment for telehealth services furnished by federally qualified health centers and rural health clinics.

HAP is encouraged by CMS' continued efforts related to making telehealth services accessible to its beneficiaries. HAP urges CMS to continue to make broad, permanent adoption of any services that were acceptable during the pandemic, given that only services that did not pose significant patient safety concerns were added to the list during this time. As such, we strongly urge CMS to make Category 3 "permanent" codes.

Direct Supervision: In the CY 2021 PFS Rule, CMS finalized its proposal to extend the allowance for providers to provide direct supervision via audio/video technology through the end of the calendar year in which the emergency ends or December 31, 2021, whichever is later. This rule extends this provision through CY 2024. CMS is again seeking comment on whether this provision should be made permanent.

HAP strongly urges CMS to permanently allow direct supervision via audio/video technology.

OPIOID USE DISORDER TREATMENT SERVICES

As a result of the PHE, CMS allowed Opioid Treatment Programs to furnish counseling and therapy services using audio-only telephone calls through CY 2023. In this rule, CMS is proposing to allow for continued audio-only telephone services in cases where audio/visual technology is not available to the beneficiary—defined as circumstances where beneficiaries are not capable or have not consented to the use of devices that permit a two-way, audio/visual interaction through CY 2024.

HAP strongly supports CMS' proposal to permit audio only telephone services permanently as it has become such a critical way to provide access and deliver these important services to beneficiaries.

APPROPRIATE USE CRITERIA PROGRAM

CMS has been in the process of implementing the appropriate use criteria (AUC) program for advanced diagnostic imaging during the past several years. During 2020, CMS began the educational and operations testing period. While testing, CMS continued to pay claims whether or not they correctly included AUC information. Testing was extended through 2023 as a result of the PHE.

Several issues have been identified during the testing period including the risk of inappropriate denials of valid claims and significant administrative burden on providers. Because of these

issues, CMS proposes withdrawing all previous rulemaking and regulations on the AUC program. The program will pause while efforts are made to find a workable path forward.

HAP fully supports the pause of the AUC program and appreciates CMS' acknowledgement of the ongoing challenges the program has created.