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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
Mail Stop C4-26-05,
7500 Security Boulevard
Baltimore, MD 21244-1850.

September 9, 2024

Re: RIN 0938-AV33

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

By Electronic Mail: (*MedicarePhysicianFeeSchedule@cms.hhs.gov*)

Dear Administrator Brooks-LaSure,

On behalf of our physician and medical student members, the American Association of Clinical Urologists (AACU) respectfully submits these comments to the Centers for Medicare & Medicaid Services (CMS) on the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) published in the *Federal Register* on July 31, 2024.

Founded in 1968 by urologists concerned by the government's increasing role in the practice of medicine, the AACU is a professional organization representing the interests of more than 3,700+ member urologists, and urologic societies engaged as advocacy affiliates across the United States. We are dedicated to developing and advancing health policy education as it affects urologic practice in order to preserve and promote the professional autonomy of our members and support the highest quality of care for patients.

We appreciate the opportunity to respectfully provide comments on the following provisions of the proposed rule.

General Observations Regarding the Proposed Conversion Factor
In examining this year's proposal from CMS, most of our comments and observations from last year remain intact.

Last year, we emphasized our recommendation that CMS join the AACU in urging Congress to continue increasing the conversion factor along with advocating to Congress that any further reimbursement changes be made in conjunction with the urology community.

Protecting the political and professional interests of Urology since 1968

American Association of Clinical Urologists, Inc.

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We still feel strongly that CMS should include an index to the conversion factor so that the income of providers is not eroded over time due to the effects of inflation.

Additionally, AACU is concerned that any continued downward trajectory in revenue will likely result in a further exodus from the field of medicine, which will have a chilling effect on timely access and effective care for Medicare beneficiaries.

We understand that a majority of the points outlined under this section are beyond CMS' assistance, since the decrease in the conversion factor is mainly due to the expiration of the one-time 2.9% temporary increase for 2024 as well as the relevant budget neutrality issues.

With that, the situation that we find ourselves with regarding the conversion factor is disappointing. When the conversion factor was instituted in 1992, it was valued at $31.001 and if that was adjusted for inflation it would be $70.53 as of June 2024. Instead, it is valued at $33.2875, a 52.8% decrease. The proposed $32.36 conversion factor for 2025 represents an additional 2.8% decrease from the current conversion factor.

Sadly, the U.S. Federal Government has a spending problem and urologists are suffering negatively due to it. The current US Federal debt exceeds 35 trillion dollars. Interest payments on the federal debt are expected to reach nearly $900 billion in 2024, representing 13% of federal spending, exceeding annual federal spending for defense.

Congress needs to realize this and change course so that our industry can stop hemorrhaging urologists. The correlation being that Congress overspends so to make up for it, Congress continues to push for decreased reimbursement. This bad fiscal policy has caused the increased corporatization of medicine and its undesired secondary effects are due to the erosion of the Medicare Physician Fee Schedule. The only way to preserve access to healthcare for seniors in the future is to restore appropriate compensation for physicians.

To that end, the AACU will continue to actively work on novel legislative solutions to restore fair pay for physicians so that they can continue the good work to which they were called to perform.

<u>Telehealth</u>
AACU wants to continue to voice our support for CMS's activity in telehealth recently where CMS has proposed several rules that implement much needed telehealth.

Telehealth is something that AACU feels would help improve outcomes and lower costs since telehealth in general would allow urologists to provide consultations, preoperative and postoperative evaluations and routine care for pediatric, adult and nursing home patients.

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Currently, telehealth is a patchwork of federal and state policies that reside in the emergency of COVID-19. However; as our response to COVID-19 continues to evolve, questions lie around whether protocols around state and federal telehealth expansion will be permanent.

AACU strongly urges CMS to permanently or indefinitely extend any and all waivers put in place for telehealth and to do so by instructing all interested parties, including commercial payers, that there should be payment parity when it comes to telehealth.

Whether via telehealth or an in office visit, simply put reimbursement should not matter whether a patient chooses to utilize access to a urologist in one point of care setting versus another since the services are the exact same.

AACU will continue to strongly advocate that telehealth needs to be extended by Congress and we at AACU applaud both Congress and CMS for proactively coming up with CPT codes and paying at Non-Facility rates to help our industry thrive.

Delaying the Implementation of the Rebase Medicare Economic Index

Last year we were happy to report that the AACU supported the continued delay in implementing the Rebased Medicare Economic Index (MEI) until the completion and review of the AMA PPIS survey.

Today we feel that the MEI still needs to be adjusted by Congress. We agree with the delay of the implementation of the 2017 -based MEI cost weights as they await the AMA Physician Practice Information survey. However, the AACU would like to respectfully request that CMS continue to discuss this issue with Congress as the failure of any Congressional action on this vital issue of importance will make future access of urologists to Medicare beneficiaries much more difficult.

Other Relevant Issues of Concern

- Global Surgery Payment Accuracy:

With regards to the Strategies for Improving Global Surgery Payment Accuracy described below:

We are proposing new coding in other sections of this CY 2025 proposed rule that might be used to bill for managing fractures under a treatment plan, including the global post-operative add-on code, HCPCS code GPOC1, in section II.G.5 of this proposed rule and the advanced primary care management codes in section II.G.2 of this proposed rule. Interested parties have indicated that orthopedic surgeons, skilled nursing facilities (SNFs), and other practitioners and providers may not be providing comprehensive patient centered fracture management care for quality, payment, or administrative

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reasons, and that there is inadequate "hand-off" when post- discharge fracture care is transferred to practitioners in the community. They indicate a systemic disconnect on which provider and/or specialty is responsible for osteoporosis diagnosis and treatment, and that global surgical periods focus on acute fracture recovery rather than addressing osteoporosis. We are interested in hearing if the proposed global postop add-on code could help resolve these issues."

The AACU has serious concerns about Strategies for Improving Global Surgery Payment Accuracy. The aforementioned described metric in this proposed rule is vague and has the unintentional consequence of potentially making appropriate medical care post surgery hard to find and in a medical world of burnout make it impossible to find call coverage. This may require physicians who perform surgery to be on call 24/7365. Although the projected 2% cut may be small to those in CMS it is devastating for the MDs already facing a 3% cut. The proposed one-time add on code (GPO1C) seems insufficient.

MIPS Payment Adjustments

After examining the proposal last year, AACU respectfully requested that the threshold for a MIPS penalty not be increased from 74 to 82 points for the year 2024. Many physicians have filed and received an exception to MIPS for the last three to four years and subjecting physicians to a penalty for a program that is burdensome and exacerbates inequalities creates unintended negative policy implications.

Additionally, AACU also recommended a delay in the implementation of the cost category to MIPS CY 2024. The AACU feels that the cost category for urology (episodic treatment for nephrolithiasis) will unfairly punish urologists. Many of the members of the AACU do not have access to free standing outpatient ambulatory surgical centers (an example of this would be hospital based rural providers). These providers will be penalized for an increased cost that is out of their control. However, even those providers who do have access to outpatient ambulatory surgical centers will be penalized if they perform Extracorporeal Shock Wave Lithotripsy (ESWL) as it is currently reimbursed at APC 5384 (a reimbursement level that does not cover the cost of providing the service). The AACU is recommending that the cost category for urology either be suspended for CY 2024 or modified to achieve a more equitable formula.

The AACU saw that CMS addressed this issue again in this year's proposal:

"As discussed in section II.E. of this proposed rule, under Valuation of Specific Codes, each year we develop appropriate adjustments to the RVUs taking into account recommendations provided by the American Medical Association (AMA) Resource-Based Relative Value Scale (RBRVS) Update Committee (RUC), MedPAC, and other interested parties. For many years, the RUC has provided us with recommendations on the appropriate relative values for new, revised, and potentially misvalued PFS services. We

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review these recommendations on a code- by-code basis and consider these recommendations in conjunction with analyses of other data, such as claims data, to inform the decision-making process as authorized by statute. We may also consider analyses of work time, work RVUs, or direct PE inputs using other data sources, such as the Veterans Health Administration (VHA), National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS), and the Merit-based Incentive Payment System (MIPS) data. In addition to considering the most recently available data, we assess the results of physician surveys and specialty recommendations submitted to us by the RUC for our review. We also consider information provided by other interested parties such as from the general medical-related community and the public. We conduct a review to assess the appropriate RVUs in the context of contemporary medical practice. We note that section 1848(c)(2)(A)(ii) of the Act authorizes the use of extrapolation and other techniques to determine the RVUs for physicians' services for which specific data are not available and requires us to take into account the results of consultations with organizations representing physicians who provide the services. In accordance with section 1848(c) of the Act, we determine and make appropriate adjustments to the RVUs."

After internal discussion, the AACU agrees with holding the MIPS threshold at 75% and agrees with the option for reweighting one of the categories for circumstances out of the provider's control. We strongly recommend adjustments for small, solo, rural, and safety net providers who have the burden of the negative adjustments.

- MIPS Value Pathway

At this time, the AACU is going to reserve comment on the MVP. While we have commented previously on MVPs, we believe that if CMS is planning on converting all MIPS to MVPs in 2027 urologists need to have access to the benchmarking data so that urologists can have a strong sense of the difficulty/ease of reporting.

- Cystoscopy Code Set Reduction

With regards to the proposed Cystoscopy Code Set Reduction, the AACU wants to ensure that our comments are on record.

"For CY 2025, we are proposing to implement the supply pack pricing update and associated revisions as recommended by the RUC's workgroup. We are proposing to update the pricing of the "pack, cleaning and disinfecting, endoscope" (SA042) supply from $19.43 to $31.29, to update the pricing of the "pack, drapes, cystoscopy" (SA045) supply from $17.33 to $14.99, to update the pricing of the "pack, ocular photodynamic therapy" (SA049) supply from $16.35 to $26.35, to update the pricing of the "pack, urology cystoscopy visit" (SA058) supply from $113.70 to $37.63, and to update the pricing of the "pack, ophthalmology visit (w-dilation)" (SA082) supply from $3.91 to $2.33. As recommended by the RUC workgroup, we are also proposing to delete the

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"pack, drapes, laparotomy (chest-abdomen)" (SA046) supply entirely. The proposed updated prices for these supply packs are listed in the valuation of specific codes section of the preamble under Table 16, CY 2025 Invoices Received for Existing Direct PE Inputs."

"We are also proposing the RUC-recommended direct PE inputs for CPT codes 5XX05 and 5XX06 without refinement. However, we note possible duplications in two of the supply items within CPT code 5XX05. Specifically, supply item SB027 (gown, staff, impervious) is already included in supply item SA042 (pack, cleaning and disinfecting, endoscope), and supply item SB024 (gloves, sterile) is included in supply items SA058 (pack, urology cystoscopy visit). We are seeking comments on whether a total of three SB027 impervious staff gowns and two SB024 pairs of sterile gloves would be typical and necessary when providing this procedure."

We at the AACU want to ensure that CMS reconsider the reimbursement proposed for this procedure. We strongly would like to voice our concerns on behalf of our members that the reimbursement for cystoscopy is less than our costs for providing the service when you consider the following important issues: acquisition cost of the cystoscope; maintenance; sterilization costs; supplies such as cystoscopy tubing/sterile water; staffing costs; and insurance, etc.

This ultimately leads urologists to perform the service in the hospital or the Ambulatory Surgical Center (ASC) and be reimbursed for the professional component only.

However, the cost to Medicare and other private payors increases due to the site of service differential.

To conclude, decreasing reimbursement for cystoscopy (and other in office services) hurts the physician, the insurer and patient (since the office is more convenient for their treatment). We strongly urge both CMS and Congress to increase the reimbursement for the Cystoscopy Code Set Reduction.

Conclusion

The AACU is grateful to CMS for allowing us the opportunity to provide these comments on the CY 2024 Medicare Physician Fee Schedule proposed rule. We look forward to future opportunities to provide comments to provide our viewpoints in order to work with CMS to make urology policy stronger. We stand by to readily serve as a resource to you.

Please reach out to Ron Lanton, AACU Director of Government Affairs at rlanton@aacuweb.org with any questions or concerns.

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