Envision HEALTHCARE

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Via online submission at www.regulations.gov

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

Dear Administrator Brooks-LaSure,

On behalf of our 17,000 clinicians who provide approximately 29 million patient encounters every year, we appreciate the opportunity to provide comments on the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule.

Envision Healthcare is a leading national medical group, delivering care when and where it is needed most. Our clinicians care for nearly 8% of the U.S. population each year across the spectrum of specialty care from operating rooms to emergency departments to birthing suites. Our teams provide access to highly complex, high-need care where there is the greatest opportunity to meaningfully improve outcomes at lower cost in both urban and non-urban communities, providing access to underserved populations. Our practice areas include anesthesiology, critical care medicine, emergency medicine, hospital medicine, radiology, surgical services, primary care, pain and addiction medicine, and women's and children's services.

Envision Healthcare has continued our focus on and commitment to addressing social determinants of health (SDOH) and improving health equity. Our responsibility to our patients includes addressing the root causes of their healthcare needs, and we continue to pursue innovative ways of fulfilling this responsibility. The health and well-being of our workforce is also essential. We have enhanced our wellness program by offering free online therapy, peer-to-peer support programs, and intensive professional coaching to care for the clinicians who care for our patients. We remain steadfast in protecting our clinicians by ensuring they have the resources they need and by empowering them to focus on patient care.

Below are critical issues in this year's proposed rule that will have a significant impact on our clinicians and, ultimately, on the patients and communities they serve. Our comments are focused on the following key topics:

Payment Provisions:

- Proposed Conversion Factors
- Proposal for O/O E/M Visit HCPCS Add-on Code G2211
- Proposed Valuation of Specific Codes
- Telehealth
- Split (or Shared) Evaluation and Management Visits
- Rebasing and Revising the Medicare Economic Index
- Electronic Prescribing of Controlled Substances

Quality Provisions:

- Merit-based Incentive Payment System (MIPS)
- MIPS Value Pathway Development and Reporting Requirements

PAYMENT PROVISIONS

We ask the Centers for Medicare & Medicaid Services (CMS) to consider each of our comments related to payment policy within the relevant context of the continued strain placed on clinicians by inflation, workforce shortages and burnout, and the slow recovery of our healthcare system. While the cost of goods and services has grown significantly, relative Medicare physician pay has not. In fact, according to the American Medical Association (AMA)'s analysis of Medicare Trustees' Reports and data from the U.S. Bureau of Labor Statistics, Medicare physician pay has declined by 26% from 2001 to 2023. This overall payment reduction places enormous strain on our clinicians and jeopardizes patient access to high-quality care.

In almost every other setting, CMS has proposed, and in some cases already finalized, payment increases for other providers for 2024. These updated payments seek to address inflation and recognize the challenging economic environment. In contrast, the Medicare PFS proposed rule fails to reflect the current healthcare world and workforce challenges. We ask that CMS use all of its authority to prevent unsustainable cuts to our clinicians as well as work with policymakers to identify future improvements to continue to support Medicare reimbursement for physicians.

CY 2024 Proposed Conversion Factors

We share the concerns of several medical societies regarding the potential impact of cuts to clinician Medicare reimbursement. The proposed conversion factor (CF) reduction of -3.36% (from $33.8872 to $32.7476) as well as the proposed 2024 Anesthesia CF of $20.4370 (in

comparison to the 2023 Anesthesia CF of $21.1249, a -3.26% reduction), represents a tangible threat to physician practices. While CMS is limited in its ability to mitigate statutory cuts due to the current budget neutrality requirement, it is critical that the agency understand the potential negative consequences of continued cuts to clinician reimbursement and patient care.

The current reimbursement environment threatens to impact the availability of the highest quality medical care for patients who need it most and may worsen healthcare disparities. While Envision Healthcare remains steadfast in its commitment to the communities we serve, threats to the availability of clinical labor cannot be ignored and may become difficult to mitigate. Clinical labor shortages can manifest quickly but may take years to correct. We will continue to advocate for improvements to the healthcare environment that prevent a degradation of access. We believe that preventing reduced access to services is preferable to correcting access degradations after patient harm has already been done.

Proposal for O/O E/M Visit HCPCS Add-on Code G2211

In the CY 2020 PFS final rule, CMS established HCPCS add-on code G2211[1] (formerly, GPC1X) for office/outpatient (O/O) Evaluation and Management (E/M) visit complexity. Following the publication of the CY 2020 Medicare PFS final rule, Congress took note of the significant payment cuts resulting from this new coding scheme for many medical specialties and, in Section 113 of the *Consolidated Appropriations Act, 2021*, delayed Medicare payment for G2211 until January 1, 2024.[2] In this year's proposed rule, CMS is moving forward with implementing G2211. While CMS is instituting some refinements that will result in less of a budget neutrality adjustment, we remain concerned about the need for this code and how it may distort overall physician payment. CMS estimates that implementing the code as proposed would result in over -2% of the overall CF cut.

CMS proposes two policy refinements with respect to G2211. First, CMS clarifies that G2211 would not be payable when the O/O E/M visit is reported with payment modifier -25, which denotes a separately billable E/M service provided by the same practitioner furnished on the same day of a procedure or other service. Second, CMS revises its previous utilization assumption to reflect that practitioners are not likely to report G2211 with every O/O E/M visit they report. CMS now estimates that G2211 will be billed with 38% of all O/O E/M visits initially and that, when fully adopted after several years, G2211 will be billed with 54% of all O/O E/M visits.

We appreciate the policy refinements with respect to G2211 that CMS is proposing for CY 2024. However, G2211 remains duplicative of work already accounted for by existing codes and, if implemented, will inappropriately distort the current structure for complex patients, which is

[1] G2211, Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
[2] Consolidated Appropriations Act, 1 U.S.C. § 113 (2021).

largely already part of the E/M coding structure. CMS itself has significantly changed its view on what specialties and how often the G2211 may be utilized, suggesting that its forecasting for the code may be inaccurate. If CMS chooses to move forward with the code, it should first better evaluate the actual utilization of G2211, taking a least a year to collect actual data on claims to see if the Agency's utilization estimates are correct. We continue to assert that the utilization of 38% is too high and simply results in cuts to the conversion factor that may not be offset by actional payment from the code.

G-codes can also create additional complexity across different payers. Private payers and other payers outside of traditional Medicare often will not cover and equally reimburse for these codes. This creates inconsistencies across payers and the coding system, which should not be the goal of CMS policy. Accordingly, Envision Healthcare urges CMS not to implement code G2211 for 2024. At a minimum, CMS should further revise its utilization assumptions to further mitigate the budget neutrality adjustment to the conversion factor based on the adoption of this code.

Valuation of Specific Codes – Emergency Medicine

We support CMS' ongoing activity to identify and diminish barriers to high-quality outcomes created by Social Determinants of Health (SDOH). The creation of new G codes for practitioner time and effort associated with the navigation of these barriers is an important step toward regularly integrating these efforts into the standard of care.

Valuation of Specific Codes – Anesthesiology

We support and echo the recommendations made by the American Society of Anesthesiologists (ASA) on the proposed values of codes related to Dorsal Sacroiliac Joint Arthrodesis (CPT code 2X000) and ask that CMS finalize its proposed valuation of 7.86 wRVUs, and the RUC-recommended direct PE inputs, without refinement, for CPT code 2X000. Similarly, we support, and CMS should finalize its proposed valuation for Spinal Neurostimulator Services (CPT codes 63685, 63688) of 5.19 and 4.35 wRVUs, respectively, and the RUC-recommended direct PE inputs, without refinement.

Telehealth

The COVID-19 pandemic created an urgent, large-scale transition from in-person to virtual care. In 2020 alone, we conducted more than 250,000 telehealth visits. The flexibilities that enabled this important expansion in care access should remain in place after the pandemic ends. We believe telehealth will continue to allow us to provide access to more patients in rural areas, help to alleviate physician burden, and ensure that patients are getting the care they need with the least interruption to their lives. To this end, we encourage CMS to continue offering flexibility to providers on telehealth services and requirements. We offer the following comments on specific telehealth proposals:

- We request that CMS permanently add emergency services and observation services to the Medicare Telehealth List.

- We appreciate CMS' efforts to simplify the process of adding new services to the Medicare Telehealth List, but we believe that it will be difficult to provide enough clinical evidence to permanently add new codes to the List under the rule's proposals.
- We support telehealth proposals enabling more flexible supervision.

CMS added all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes to the approved telehealth list through December 31, 2021. The codes were added to the Telehealth Services List on a special "Category 3" basis that CMS added for the public health emergency (PHE). In this rule, CMS proposes to maintain ED E/M levels 1-3 and some observation codes on the list of approved telehealth services through the end of CY 2024 but determined that none of the other codes met the Category 1 or Category 2 criteria and, therefore, will not be extended permanently at this time. We continue to encourage CMS to keep these codes permanently on the Medicare Telehealth Services List, as we believe they provide critical access to patients. Yearly updates create further uncertainty for providers and add administrative burden to our practices. At this stage, we believe there is sufficient evidence to support permanent addition of these codes.

As stated in previous comments, we remain concerned about the process for adding new telehealth services on a permanent basis. While we appreciate that CMS is seeking to address this issue, we do not think it is reasonable that a service provided via telehealth must demonstrate specific clinical value. As many of the services currently available on a provisional basis are relatively new to telehealth at scale, we question whether the fifth criterion may present an undue burden to getting new services authorized for telehealth provision. In some cases, especially for services that are not provided frequently via telehealth, it may be difficult to develop extensive clinical evidence specifically demonstrating the benefit of the service as provided virtually, rather than demonstrating that the service has a clinical benefit generally and can be appropriately provided via telehealth.

Overall, we support CMS' alignment of policies with passed legislation to continue to allow flexibility in providing, supervising, and offering telehealth services.

Split (or Shared) Evaluation and Management (E/M) Visits in the Emergency Department

Envision Healthcare strongly supports CMS' continued delay of policies related to split (or shared) services. We have long held serious concerns about the proposed use of time-only methods to determine how split or shared services are billed, as outlined in depth in our comments on the CY 2023 proposed rule. By proposing to only use time as the standard for identifying the billing clinician, CMS treats the time spent by a Nurse Practitioner (NP) as interchangeable with a Physician's time.

We strongly support CMS' proposal to further delay the transition to time-only billing, and we urge the agency to discard this proposed transition entirely. Instead, we urge CMS to finalize a permanent policy to allow billing based on history, exam, medical decision-making, *or* time,

which would focus on the qualitative contributions of the clinicians involved in a given visit and would encourage the highest-quality and most efficient outcomes for patients.

Rebasing and Revising the Medicare Economic Index

Envision Healthcare generally supports a rebasing of the Medicare Economic Index (MEI) to use more up-to-date data. However, we do not believe that using an already outdated rebasing year (2017) or rebasing during a significant period of uncertainty is the right approach. The purpose of the MEI is to approximate inflationary impacts on Practice Expense (PE) and wages. Rebasing the MEI using data that fails to capture the unique impact of the PHE on these cost inputs is unlikely to significantly improve the accuracy of the MEI.

The proposed rebasing would drastically favor specialties with higher PE costs over those with higher physician work RVUs. CMS also estimates significant reductions for many specialties, especially within the facility setting, as a result of the proposed rebasing and revision. These reductions would further compound the problems associated with the conversion factor cuts. Accordingly, we agree that CMS should delay rebasing the MEI until more recent and relevant data is available. Further, CMS should allow for a multi-year transition period once the MEI is updated in order to prevent significant negative impacts to specific specialties or sites of service.

Electronic Prescribing of Controlled Substances

We appreciate CMS' continued acknowledgment of the difficulties in implementing the Electronic Prescribing of Controlled Substances (EPCS) system, and we support CMS' proposal to not impose financial penalties when enforcing the EPCS requirement. We encourage CMS to continue to engage with stakeholders before moving forward with the enforcement of the EPCS provisions.

QUALITY PROVISIONS

Envision Healthcare is committed to reliably providing high-quality, high-value care. We share the agency's desire to fulfill the vision of the CMS National Quality Strategy to shape a resilient American healthcare system that achieves timely, high-quality, safe, equitable, and accessible care for all. We are encouraged by CMS' stated commitment to continually improving the Quality Payment Program (QPP), especially the emphasis on meaningful patient outcomes and responsiveness to input from interested parties.

Changes to the Merit-Based Incentive Payment System (MIPS)

In general, CMS should recognize that year-on-year increases in quality performance requirements are not necessary and can create problems by constantly ratcheting up requirements rather than driving actual improvement in care quality. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) never required that the program become harder each year or that, at some point, CMS should transition MIPS into a penalty program. Envision Healthcare therefore opposes the proposal to raise the MIPS penalty threshold to 82 points. CMS itself recognizes the agency's flexibility in selecting the MIPS threshold, and we urge the agency to use its authority to maintain the threshold at 75 points for the CY 2024 performance year.

Without changing the proposal, CMS estimates that increasing the penalty threshold would result in 54% -- that is, over half of all MIPS participants -- incurring a penalty for the next payment year, with the majority of participants facing a 2% (or more) reduction. Given the significant proposed cuts to the conversion factor in this year's rule, combined with the cuts finalized in recent years and the ongoing fiscal pressures faced by the healthcare field, levying an additional penalty on the majority of providers through MIPS would seriously threaten providers' viability and, thus, patient access to care.

In addition, CMS fails to consider the numerous ways in which the agency proposes to make the MIPS program more challenging beyond the proposal to raise the penalty threshold. On top of the higher penalty threshold, CMS proposes to raise the MIPS data completeness criteria from 70% to 75% for the CY 2024 and CY 2025 performance periods and then again to 80%. We believe this increase provides little additional benefit while adding significant administrative burden for our physicians. Given staffing challenges, this increase will further strain resources simply to produce more data without providing real benefits to patients or more actionable information. In addition, for more complex measures, an 80% data completeness benchmark may not be feasible. Overall, we believe that an accurate and comprehensive picture of performance is obtainable with the current data threshold and that increasing the threshold will add little value at a high cost.

CMS also proposes additional requirements for third party intermediaries submitting MIPS data on behalf of eligible clinicians. Specifically, requiring individual signatories for virtual group reporting creates unnecessary administrative burden without creating value beyond less cumbersome approaches. CMS should alternatively allow the option for documentation of submission authority for virtual groups to occur at either the TIN *or* clinician level.

MVP Development and Reporting Requirements

As CMS tests the MIPS Value Pathways (MVPs), we support CMS' proposals that encourage transparency and engagement with specialties and practicing physicians when developing new (and maintaining current) MVPs. Specifically, while we are encouraged that new MVPs will be posted online for a 30-day comment period, we would also urge CMS to provide additional time for significant changes or significant new additions.

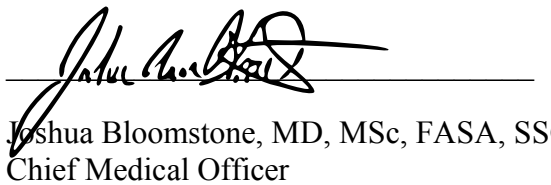
Like quality measures, MVPs must be reviewed on an annual basis to assess participation rates, scores, and relevance to clinical outcomes and costs. Scrutiny of MVPs will be needed to ensure continued buy-in and relevance and to prevent any increases to reporting burden. Overall, CMS should not require MVPs reporting until clinicians have shown successful uptake and use of MVPs, especially as there is no statutory requirement for their use. Only by examining clinicians' use of MVPs can CMS make an informed proposal on the eventual sunsetting of traditional MIPS. Given that certain practices and specialties may not feel MVPs align with their practice and workflows, we continue to support providing options for physician quality reporting.

As stated in previous comments, we continue to recommend incentives designed to encourage participation in MVPs. We support the American College of Emergency Physicians' recommendation to provide at least a five-point bonus for participating in an MVP initially and to hold these clinicians harmless from downside risk for at least the first two years of participation.

CONCLUSION

On behalf of our clinicians and the patients they serve, we appreciate the opportunity to provide comments on the CY 2024 Medicare PFS proposed rule. We encourage CMS to continue to work with physicians and their specialty societies through the rulemaking process to create a stable and equitable payment system. We look forward to continued dialogue with CMS about these and other issues affecting our critical practice areas, as we work together to build a high-quality, accessible, and equitable healthcare system.

Sincerely,



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