HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

September 8, 2023

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

Dear Administrator Brooks-LaSure,

The Healthcare Business Management Association (HBMA) is pleased to submit these comments to you on the 2024 Medicare Physician Fee Schedule (PFS) proposed rule (CMS–1784–P).

HBMA is a national non-profit professional trade association for the healthcare revenue cycle management industry. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

HBMA members have an essential role in the operational and financial aspects of the healthcare system. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care - where it should be directed - instead of on the many administrative burdens they currently face. The RCM process involves everything from the lifecycle of a claim to credentialing, compliance, coding and managing participation in value-based payment programs.

❖ Conversion Factor

The proposed CY2024 PFS Conversion Factor (CF) is 32.7476, a reduction from the 2023 PFS CF of 33.8872, which translates to a 3.4% reduction. The proposed Anesthesia CF is 20.4370, a reduction from the 2023 Anesthesia CF of 21.1249.

Much of the reduction is caused by the expiration of a one-time 2.5% increase to the CF (that was not subject to budget neutrality) that Congress passed for CY 2023. The CF includes a 1.25% increase that Congress passed for 2024. The proposed CF also includes a -2.17% budget neutrality adjustment, which, as described in the E/M section below, is partially caused by CMS proposing to begin paying for the G2211 add-on payment to E/M services.

We understand that CMS is statutorily bound by the budget neutrality requirement and that many of CMS' long-term policy goals, such as beginning payment for G2211, could result in CF reductions due to budget neutrality.

HBMA opposes any reduction to physician payments in 2024. As illustrated by MedPAC, medical inflation (as measured by MEI) has far outpaced updates to the PFS CF since 2010. The fact is, there is currently no regular statutory adjustment to the PFS CF. The Quality Payment Program (QPP) is the only way for physicians to earn a positive adjustment. However, Advanced Alternative Payment Models (Advanced APM) are not a viable option for many clinicians and most physicians do not earn a meaningful increase through the Merit-based Incentive Payment System (MIPS) despite achieving high scores.

The administrative costs practices incur to comply with programs like MIPS far outweigh the potential financial reward they can earn through the program. There are many other unfunded mandates beyond MIPS that have exacerbated the negative impact stagnating CF updates have imposed on practices.

We urge CMS to use what authority it has to prevent additional negative payment reductions to physicians.

❖ **Evaluation and Management (E/M) Visits**

HBMA supports the CMS collaboration with AMA and other interested parties to update coding and payment for E/M visits so that the policies better reflect the current practice of medicine, are less administratively complex, and are paid more accurately under the PFS. Although CMS stated, "This work is critical to improve payment accuracy and help reduce practitioner burnout", many of the CMS proposed rules create a higher burden by adding unnecessary and increasing complexity, coding guideline confusion, reduced efficiency, and increased cost.

In general, CMS' proposals do not adopt key principles of the AMA CPT coding guidelines, rather there are different code sets (HCPCS), different definitions, and conflicting time calculations, among other coding contradictions. Each and every one of these decision inconsistencies and contradictions will continue to increase provider burden and burnout. Each inconsistency requires separate education, special system programming and other unfunded physician costs. The 2024 proposed new E/M complexity add-on G code, the proposed social determinates of health (SDOH) new G code, the principal illness navigator (PIN) new G code, and the new G code for community health integration (CHI) all create multiple operational issues and probability of physician misunderstanding resulting in coding errors.

HBMA supports the focus on more comprehensively addressing SDOH risks and coordination with appropriate entities. However, we believe there is significant overlap with CPT E/M code descriptions in medical decision making, as well as work already included in a complete social history. CPT already has multiple codes that could address the proposed new G codes, in lieu of creating the proposed codes with the associated burden. Examples include; Care plan oversight, medical team conferences, preventive medicine individual counseling, behavior change intervention, etc. Because CMS recommends reporting ICD-10-CM codes Z55-Z65 with these services, the coding for professional claims could easily provide the information CMS is seeking through already established coding guidelines. In addition, there is a high likelihood of overlap with other services patients already are utilizing, i.e., home health, social programs, navigators, etc. Consideration must also be given to the fact that state laws and scope of practice can vary widely, resulting in disparities in care for the very patients the proposed rule is intended to help.

HBMA believes CMS is minimizing the additional confusion the "incident to" provisions in the proposed rule will create. Physicians are focused on patient care. Determining whether the "incident to" rules apply and in what circumstances to a routine office visit vs, all the new G codes, when and under what criteria also adds a significant burden to physicians and their representatives. Merely changing the supervision definition for some services, but not all CPT and HCPCS codes does not address all the issues inherent in the proposed changes.

HBMA understands CMS does not have authority to modify statutory restrictions. However, HBMA strongly encourages CMS to reconsider the issue of beneficiary advance notice (ABN). CMS noted that physicians have advised obtaining patient notices is a burden. However, the fact that the patients may or will have cost share responsibilities for the proposed new codes creates what is in fact a surprise bill. We are concerned that beneficiaries will not only dispute the cost share they did not expect but may refuse additional planned services as a result.

HBMA recommends CMS delay implementation of the proposed new G codes for complexity, SDOH, PIN and CHI to allow a far more detailed analysis of how best to achieve improved beneficiary care based on SDOH. HBMA also recommends CMS cease creating unique codes that are not consistent with CPT and that result in increased physician burden, cost and frustration. We also recommend thoughtful consideration of the increased beneficiary cost share that may have the unintended consequences of discouraging participation in the care needed.

- **Split/Shared Evaluation and Management Services**

HBMA understands CMS' concern over fee schedule differences and which practitioner provided the substantive portion of the beneficiary care. However, many of our physician practices continue to focus on medical decision-making and not time as the basis for assigning CPT E/M codes. In fact, the complexities and administrative burden of time-based documentation, tracking and reporting have caused some practices to completely avoid that

option because it does not work in the real care setting. Different patient populations and practice efficiencies require different approaches to provide care to beneficiaries.

We believe CMS is ignoring the many physicians and commenters who continue to point out the significant disruption to best practices and patient care the mandatory time-only option will create. Contending with this type of designating one subset in a category of E/M codes for different rules is unduly and unnecessarily burdensome. Perhaps more importantly, removing medical decision making as an option is a punitive approach to practices who efficiently and effectively provide quality care to beneficiaries as a team.

We agree with CMS' proposal to delay implementation of its methodology for determining which provider furnished the substantive portion of a split (or shared) service. We urge CMS to make important changes to its finalized policy to reduce burdens and align with current documentation and clinical practices. This becomes even more important as 2024 CPT changes specific to time and split/shared visits are unknown at this time. More closely aligning CMS and AMA CPT coding guidelines is an important and needed goal.

Substantive Portion

We believe that CMS' recognition of the emergence of team-based care and the integrated work between physicians and non-physician practitioners (NPP) should be the basis for additional burden reduction. **The provision of effective and efficient quality care to patients should not be subject to detailed documentation of qualifying time by each provider as proposed in the rule. We do not believe that efforts to quantify which provider may have contributed the "substantive portion" of the care is appropriate when both providers are working closely together as one in the patient's care. A physician's training, experience, and skill-set, when combined with the care provided by the NPP, should not be parsed, but taken as a whole and billed by the physician; the physician's involvement is the substantive portion.**

Our experience is that the level of care provided by a majority of physicians is reflected more accurately by medical decision-making (MDM) than the time related to the encounter. As previously mentioned by CMS, MDM is difficult to attribute when multiple providers are involved. While that may be true, it should not be the rationale to mandate a time-based documentation system that will not work in the real world and that will increase administrative burden. We also note that continuing to allow the past key components of history and physical examination as an interim substantive portion is problematic and in direct contradiction to the reasons those documentation requirements were eliminated from determining the correct E/M level of service. The HBMA believes the only appropriate focus is on quality care and outcomes, not who spent three minutes more during the encounter.

HBMA recommends CMS continue allowing both medical decision-making and time as options for billing split (or shared) services, consistent with all other E/M services. We also strongly recommend that CMS stop carving out specific visit types to impose rules that do not match other E/M changes and requirements. HBMA also wants to stress again to CMS

that the long history of issuing rules and implementation dates and then delaying said rules year after year is in and of itself a significant burden. Physicians and their representatives spend unfunded, valuable resources in time, education, training, practice analysis, and system programming in preparation. The CMS statement that the current additional proposed delay is through, "at least December 31, 2024" and "whether a further implementation delay beyond CY 2024…is warranted" demonstrates CMS' failure to recognize the additional burdens this places on practices that have no way to know if or when the rule will ever be implemented.

- **Appropriate Use Criteria for Advanced Imaging Services**

HBMA appreciates CMS' efforts since 2015, to establish the AUC program and fully implement the statutory requirements of the Protecting Access to Medicare Act (PAMA) to improve patient care and provide potential savings to the Medicare program.

CMS has proposed to pause the AUC program for reevaluation, including the operational testing and educational period. Further, CMS has proposed to rescind the current AUC program regulations. While CMS carefully deployed a stepwise approach to implement the statutory provisions by establishing the first two components – AUC and the mechanism for consultation. CMS also began building parameters for the third and fourth components. During this phase, CMS cited they "…have exhausted all reasonable options for fully operationalizing the AUC program consistent with the statutory provisions…" (p. 1352).

HBMA supports the proposed pause of the AUC program implementation for reevaluation and supports rescinding the current AUC program regulations at § 414.94. We agree with CMS there is no reasonable option to fully operationalize this program consistent with the statutory provisions.

HBMA urges CMS and Congress to work with the radiology and revenue cycle community during the reevaluation process. Appropriate ordering of advanced imaging is vital to patient care and safety. While significant progress has been made to educate ordering providers on appropriate use during the educational and operational testing period, there is no initial penalty for the ordering provider if an incorrect advanced imaging test is ordered.

Financially penalizing the advanced imaging providers for the lack of knowledge from the ordering provider is unreasonable.

There have been significant investments not only in dollars but in time, education, and adopting new processes and protocols for providers and support staff across healthcare organizations to prepare for this program from a clinical perspective. Further, changes and investments have been made to prepare, test, and implement the revenue cycle process for appropriate application of modifiers required for accurate reporting to comply with the requirements of AUC. This

program, which is not even operational, has been an extreme administrative burden for all involved in radiology. The administrative burden must be considered before attempting to implement a process that cannot be fully operationalized by statutory provisions.

HBMA is available and would welcome the opportunity to be a resource for the reevaluation of the AUC program for both CMS and Congress. The potential savings to the Medicare program, reduction of administrative burden for physicians and staff along with providing patient safety and care, demonstrates how important a program for ordering appropriate advanced imaging studies is to the healthcare community.

❖ Medicare and Provider and Supplier Enrollment

HBMA members often provide a variety of Medicare provider enrollment services for our physician clients. CMS is proposing several regulatory provisions regarding Medicare and Medicaid provider and supplier enrollment. **HBMA supports most of CMS' proposal on this subject.** For example, the proposal to require all Medicare provider and supplier types to report additions, deletions, or changes in their practice locations within 30 days should not be an issue for practices or RCM companies.

However, we do not support CMS' proposal to reduce its timeline for effectuating the revocation after notifying the provider or supplier from 30 days to 15 days. We feel that 15 days is not enough time, especially when factoring in unreliable and slow US Postal Service (USPS) delivery schedules.

In addition to maintaining the 30-day effectuation, we recommend that CMS uses multiple notification methods for revocations. Specifically, we believe CMS should use an electronic notification and that CMS should always copy a provider's third party RCM company if one is listed as a surrogate in PECOS. Notifying the RCM company can help ensure the provider receives the notice and can address the issues or appeal the revocation.

❖ Updates to the Definitions of Certified Electronic Health Record Technology (CEHRT)

CMS is proposing to revise the definitions of CEHRT for MIPS so these definitions would be consistent with the "edition-less" approach to health IT certification as proposed in ONC HTI-1.

We support CMS' approach as it establishes uniformity and predictability for EHR developers. It also makes this portion of evaluating an EHR easier for a provider by only requiring the provider to ask if the EHR is certified to the current ONC standard without having to know which standard(s) are acceptable.

❖ Medicare Ground Ambulance Data Collecting System (GADCS)

CMS proposes several changes to the GADCS such as providing a field in GADCS for suppliers to report if they provide ambulatory services for only a part of the 12-month collection period. CMS also proposes editing the programming logic to exclude hospital-based providers from receiving questions meant for organizations where ambulance staff share other public safety responsibilities (fire, policing). Additionally, CMS proposes four corrections for typos and other technical corrections within the GADCS printable reporting instrument.

HBMA agrees these changes will be helpful and reiterates our appreciation to CMS for listening to comments from past PFS proposed rules which have improved the GADCS.

❖ Telehealth

HBMA recognizes and appreciates the flexibilities in the provision of telehealth/telemedicine services during the Public Health Emergency (PHE). The ability for physicians and other types of providers to continue to provide beneficiary access to care via multiple telecommunication modalities was extremely important. HBMA also recognizes and appreciates the flexibility for beneficiaries' homes to be an originating site was one effective way to help protect beneficiaries.

<u>Telehealth and Telemedicine Issues</u>
The PHE provided numerous opportunities to evaluate care appropriateness and the safety and effectiveness of medically necessary services delivered via telecommunications. **Because statutory flexibilities permit coverage for most Medicare telehealth services to continue through 2024, HBMA recommends this additional time be used to more closely align CMS policies permitted by statute with healthcare commercial payer policies.** Commercial payers are not bound by the same statutory restrictions as Medicare and therefore more accurately reflect appropriate, safe and desirable telehealth coverage policies.

CMS should also work with Congress to make appropriate additions to the currently approved list and types of codes that could be covered under Medicare to better align Medicare's list of covered telehealth services with other payers.

In addition, Medicaid telehealth/telemedicine policies have significant differences between states that do not match CMS or commercial policies. State laws often determine what types of providers and what types of services can be delivered via telecommunications. The fact that coverage policies, CPT codes, modifiers and place of service are all affected by the above can make generating correct telehealth claims challenging, confusing and burdensome for providers of all types.

Covered Telehealth and Telemedicine Code Sets

HBMA recognizes and appreciates the simplification and clarification of the steps used in determining if and under what criteria codes can be added to the list of covered telehealth/telemedicine services.

However, we recommend updating the list of telehealth CPT codes that qualify for Medicare coverage. Specifically, numerous CPT codes listed in the proposed rule have been deleted from the AMA CPT code sets and are no longer valid codes. In addition, although consultation codes are included, Medicare has not recognized consultation codes as covered services since 2010. Although the initial categories of covered services are still valid, HBMA believes the listing of these CPT codes is misleading. We recommend citing the types of services that qualify, i.e., the clarified steps, but only list current CPT codes that match the CMS listing of telehealth services. We believe this would also eliminate confusion and questions in the provision of qualified services.

"Incident To" Direct Supervision

CMS' stated concern about an abrupt transition from the PHE policy that defines direct supervision for "incident to" services is important. Delaying the definition of direct supervision for telehealth/telemedicine services until 2025 will not minimize this concern. Rather, it will serve to reinforce practice patterns that may not be permitted in the future.

HBMA believes CMS is minimizing the additional confusion the "incident to" provisions in the proposed rule will create both now and in the future. Physicians are focused on patient care. Determining whether the "incident to" rules apply and in what circumstances to a routine office visit vs various direct supervision via telehealth/telemedicine modalities, when and under what criteria also adds a significant burden to physicians and their representatives. Merely changing the supervision definition for some services, but not all CPT and HCPCS codes, does not address all the issues inherent in the proposed changes.

Equally important, CMS requested comments on "incident to" related improper billing concerns. Department of Justice settlements and past HHS Office of Inspector General reports detail various improper "incident to" billing practices. These vulnerabilities should be a priority in any CMS supervision policies.

Telehealth/Telemedicine Frequency Limitations

HBMA has grave concerns and is not supportive of the removal of frequency requirements for virtual visits for hospitalized inpatients, critical care visits and SNF visits. CMS' own 2023 publications and 2023 publications by OIG HHS both address the finding that 1 out of 4 Medicare beneficiaries suffer preventable harm while they are hospitalized. Presumably, this is when face to face visits are occurring vs. relying on virtual visits.

Telehealth and telemedicine patient assessments and evaluations are never the same as in person, hands on visits and should not be considered a viable replacement with no limitations for in

person care. Clearly, there are completely valid reasons for virtual visits and some patient care is provided very effectively and beneficially using the various visit options, as we have discussed in other comments. **However, HBMA does not support unlimited virtual visits for the sickest and at most risk patients.**

We recommend CMS thoughtfully consider the current, extremely high risk of preventable beneficiary inpatient harm before implementing policies that may pose even greater risk to the sickest patients.

❖ Merit-based Incentive Payment System

- Performance Threshold

  As overall participation in the program grows more difficult and burdensome, CMS proposes to increase the MIPS performance threshold from 75 points to 82 points for all three MIPS reporting options. This increase to the performance threshold will make it more difficult for many providers to avoid negative payment adjustments.

  Moving towards using a "prior year" defined based on a 3-year average could create more stability for the program. However, this is incredibly problematic when considering the years affected by the COVID-19 PHE as well as any years before that being irrelevant considering all the program changes that come along with transitional year policies. Additionally, although the PHE has ended, this "prior period" does not account for residual effects practices are experiencing that will make it very difficult to invest more time and resources into MIPS compliance (i.e., staffing shortages, staff training, capacity challenges).

  Over the last few years, many practices took the COVID-19 hardship exemption and will be entering a program that looks drastically different from what they remember. This inevitably creates a learning curve that they will have to achieve under the heightened pressure of increased performance thresholds and scoring limitations.

  Additionally, many specialties face measure sets that are topped out or have no established benchmark, making it nearly impossible to achieve a final score of 82 points as proposed by CMS, even if the practice has historically performed well in the program.

  Raising the threshold in 2024 could disincentivize clinicians moving to MVPs since practices will be hesitant to test a new participation pathway when faced with a higher threshold. This is especially true for specialties that have measures with scoring limitations since each quality measure contributes more weight towards the quality category under MVPs compared to traditional MIPS reporting.

  CMS estimates 54% of clinicians are expected to receive a penalty in 2026 if CMS raises the threshold to 82 points (with an average 2.4% penalty) and the impact on smaller practices is

even greater. This does not incentivize participation in the program the way CMS intends. Rather, it defines "success" in MIPS as weighing the cost of a penalty vs. a small reward.

CMS also estimated that among clinicians serving more dual eligible beneficiaries, slightly fewer would receive a negative adjustment compared to the overall population (i.e., 52% vs 54%), which does not seem to be in alignment with CMS meeting its goals related to health equity. As the performance threshold goes up, there is a small group that will benefit through larger bonuses, but there is a much larger group who will be penalized in order to accommodate that adjustment.

For this program to truly meet its purpose and encourage quality improvement and equity in healthcare, CMS must acknowledge the administrative burden involved with the current program and how it is impacting patient care. An effort must be made to give every specialty an equal and less burdensome opportunity to participate fully. This could be done by not increasing the performance and data completeness thresholds as well as correct the scoring limitations by expanding measure options for all specialties and creating quicker benchmarking processes for new measures.

- Data Completeness Threshold
  CMS is proposing to not make changes to the 75% data completeness threshold finalized for 2024 and 2025 in the 2023 PFS final rule. For the 2026 performance period, CMS is proposing to retain the 75% data completeness threshold for eCQMs, MIPS CQMs, Medicare Part B claims measures, QCDR measures, and Medicare CQMs while increasing the threshold to 80% for the 2027 performance period.

  It is important to consider the termination of the COVID-19 PHE and the residual effects that physicians and practices are facing when reviewing Data Completeness threshold. Physicians are experiencing a higher level of burnout than ever before and staffing shortages, capacity issues, and added administrative burden of difficult measures and data collection for MIPS is not helping the problem. The data completeness threshold should reflect these factors and be set as a feasible level for practices to achieve.

- MIPS Value Pathways (MVP)
  CMS is proposing to add five new MIPS Value Pathways (MVPs) for 2024. Although MVPs are great in theory, MVPS are not widely offered to all specialties reporting for MIPS. As a result, they do not work for everyone and the urge to move towards the MVPs might decline with the proposed increase to the performance threshold.

- Updates to MIPS Quality Measures
  For traditional MIPS reporting, CMS proposed to implement 14 quality measures, including one composite measure, and seven high-priority measures, of which four are patient-reported outcomes. In addition, CMS is proposing to remove 12 quality measures, and the partial removal of 3 quality measures from the MIPS quality measure inventory.

Outcome measures are complicated to utilize as most do not have benchmarks and are automatically selected by CMS as a reporting measure even if it is not one of the top six scoring measures for that TIN just because it is an outcome measure. This causes a fear of tracking these measures by providers across all specialties as no one wants to get stuck with a low scoring measure that could negatively impact their Quality score and overall performance score. This is unfortunate because these could be valuable measures if ever benchmarked. But because of the risk, they will continue to struggle to get enough reporting data to be benchmarked.

- Public Reporting
  CMS is proposed to include Medicare Advantage (MA) data on publicly available utilization data available on clinician profiles. Specifically, CMS plans to align the release of the data with existing disclosure timelines on the Care Compare website.

  Also, CMS is proposing to publicly report cost measures beginning in CY 2024 Reporting Year/CY 2026 Payment Year. CMS is seeking feedback on how to move forward with this proposal through an RFI.

  Many providers are nervous about this as the data may not accurately reflect their practice and care of patients. Especially when some specialties (e.g., radiology) have no control over the cost measures they flag.

- APM Proposals
  CMS proposes to make QP determinations at the individual level rather than at the APM Entity-level and to change the definition of "attribution-eligible beneficiary" for purposes of QP determinations to include beneficiaries who have received a covered professional service furnished by an eligible clinician, rather than require an E/M service specifically. Both seem to be aimed at ensuring that more specialists can qualify as QPs (or at least contribute to the threshold).

  At the same time, CMS is required by statute to increase the overall QP patient and payment thresholds starting next year, which will make it more challenging for all clinicians to achieve QP status.

❖ Conclusion

Thank you for considering our comments. Below is a summary of our key recommendations for the PFS proposed rule.

- HBMA opposes any reduction to physician payments in 2024. We urge CMS to use what authority it has to prevent additional negative payment reductions to physicians.

- CMS should better align its E/M coverage policies with AMA CPT coding guidelines. Each and every contradiction will continue to increase provider burden and burnout. The 2024 proposed new E/M complexity add-on G code, the proposed social determinates of health (SDOH) new G code, the principal illness navigator (PIN) new G code, and the new G code for community health integration (CHI) all create multiple operational issues and probability of physician misunderstanding resulting in coding errors.
- Delay implementation of the proposed new G codes for complexity, SDOH, PIN and CHI to allow a far more detailed analysis of how best to achieve improved beneficiary care based on SDOH. We also recommend thoughtful consideration of the increased beneficiary cost share that may have the unintended consequences of discouraging participation in the care needed. Cease creating unique codes that are not consistent with CPT and that result in increased physician burden, cost and frustration.
- We reluctantly agree with CMS' proposal to delay implementation of its methodology for determining which provider furnished the substantive portion of a split (or shared) service. We urge CMS to make important changes to its finalized policy to reduce burdens and align with current documentation and clinical practices.
    - A physician's training, experience, and skill-set, when combined with the care provided by the NPP, should not be parsed, but taken as a whole and billed by the physician; the physician's involvement is the substantive portion.
    - HBMA recommends CMS continue allowing both medical decision-making and time as options for billing split (or shared) services, consistent with all other E/M services. We also strongly recommend that CMS stop carving out specific visit types to impose rules that do not match other E/M changes and requirements.
- HBMA supports the proposed pause of the AUC program implementation for reevaluation and supports rescinding the current AUC program regulations at § 414.94. We agree with CMS there is no reasonable option to fully operationalize this program consistent with the statutory provisions.
- HBMA supports most of CMS' proposal on provider and supplier enrollment changes. However, we do not support CMS' proposal to reduce its timeline for effectuating the revocation after notifying the provider or supplier from 30 days to 15 days. In addition to maintaining the 30-day effectuation, we recommend that CMS uses multiple notification methods for revocations.
- We support CMS' proposal for updating CEHRT requirements. The proposed approach would establish uniformity and predictability for EHR developers. It also makes this portion of evaluating an EHR easier for a provider by only requiring the provider to ask if the EHR is certified to the current ONC standard without having to know which standard(s) are acceptable.
- HBMA agrees the proposed GADCS changes will be helpful and reiterates our appreciation to CMS for listening to comments from past PFS proposed rules which have improved the GADCS.
- Because statutory flexibilities permit coverage for most Medicare telehealth services to continue through 2024, HBMA recommends this additional time be used to more closely align CMS policies permitted by statute with healthcare commercial payer policies.

Commercial payers are not bound by the same statutory restrictions as Medicare and therefore more accurately reflect appropriate, safe and desirable telehealth coverage policies.
    - CMS should also work with Congress to make appropriate additions to the currently approved list and types of codes that could be covered under Medicare to better align Medicare's list of covered telehealth services with other payers.
- HBMA recognizes and appreciates the simplification and clarification of the steps used in determining if and under what criteria codes can be added to the list of covered telehealth/telemedicine services. However, we recommend updating the list of telehealth CPT codes that qualify for Medicare coverage to better align with AMA CPT code sets.
- By maintaining the status quo for virtual supervision, HBMA believes CMS is reinforcing practice patterns that may not be permitted in the future.
- HBMA has grave concerns and is not supportive of the removal of frequency requirements for virtual visits for hospitalized inpatients, critical care visits and SNF visits. We recommend CMS thoughtfully consider the current, extremely high risk of preventable beneficiary inpatient harm before implementing policies that may pose even greater risk to the sickest patients.
- For the MIPS program to truly meet its purpose and encourage quality improvement and equity in healthcare, CMS must acknowledge the administrative burden involved with the current program and how it is impacting patient care.

Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com or Brad Lund (brad@hbma.org) if you wish to discuss our recommendations in more detail.

Sincerely,

Landon Tooke

Landon Tooke, CHC, CPCO
President
Healthcare Business Management Association