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Department of Health and Human Services
Attention: CMS-1784-P
Submitted Electronically via https://www.regulations.gov
Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, etc. (CMS-1784-P)

Dear Administrator Brooks-LaSure:

University of California Health (UC Health) appreciates the opportunity to submit the following comments regarding the Center for Medicare & Medicaid Services (CMS) Proposed Medicare Physician Fee Schedule (PFS) for calendar year (CY) 2024.

UC Health supports CMS's efforts to expand the use of digital and connected health technologies which are known to improve patient outcomes, reduce costs, support clinical decision-making, and improve health care workforce experiences. We are committed to working with CMS to ensure that Medicare payment policies support access to high quality telehealth for patients and write to highlight comments about CMS's proposals regarding telehealth payment policy:

- Support the extension of virtual supervision of residents to other important scenarios where it can improve patient experience and access to care.
- Urge CMS to extend and clarify the use of Remote Physiological Monitoring (RPM) codes.
- Oppose the use of the provider's home address on Medicare enrollment; and
- Request CMS to clarify that the non-facility rate applies to Hospital Outpatient Department (HOPD)-based telehealth visits.

Background

Guided by its tripartite mission of teaching, research, and public service, the University of California has a bold vision: to improve the health and well-being of all people living in California now and in the future by training an inclusive workforce; delivering exceptional care; and discovering life-changing treatments and cures. UC Health operates the nation's largest health sciences education program which includes six Academic Health Centers (AHCs) and twenty health professional schools (medical, nursing, pharmacy, optometry, dentistry, veterinary, and public health), enrolling approximately 16,000 health sciences students, trainees, and residents. More than 70 percent of our students build their careers in California after graduating from our health professional schools. We treat the most challenging and complex cases and provide tertiary and quaternary care to patients across the state including half of all organ transplants and one-fourth of extensive burn care in California.

UC Health has a mission guided commitment to improve access to care for all Californians by increasing physical locations to provide greater reach and services and expanding the use of virtual care. In a state as large and populated as California, not all patients can come in person to our six AHCs. The use of telehealth expanded dramatically during the pandemic out of necessity and the changes in policies on telehealth reimbursement under Medicare that were provided in temporary waivers authorized during the public health emergency has enabled UC Health to extend our clinical expertise to physicians in emergency rooms and intensive care units at smaller hospitals who were flooded with COVID-19 patients but did not have the needed specialists.

From February 2020 through March of 2021, direct-to-patient virtual care went from a systemwide average of 6,000 visits per month to an average of 137,000 per month.[1] This rapid growth exposed patients and clinicians to the matured capabilities of virtual care, overcoming one of the historic barriers to adoption. Even as in-person visits rebound, we believe the landscape is fundamentally more receptive to virtual care. Therefore, it is critical that CMS continues flexibilities that have facilitated telehealth.

Comments on Proposed Rule Making

Our experience demonstrates that the responsible use of telehealth produces better patient outcomes, reduces costs, augments population health management, and improves the health care workforce experience. Based on our shared commitment to the responsible use of telehealth, UC Health offers the following comments to assist CMS in finalizing the proposed Medicare PFS for calendar year (CY) 2024.

CMS should finalize the proposed extensions of telehealth services:

UC Health recognizes and appreciates the extension of existing telehealth benefits through December 31, 2024, the COVID-19 flexibilities provided for in the Consolidated Appropriations Act of 2023. In addition, we are supportive of the following telehealth flexibilities that can be permanently integrated into the health care system in ways that can improve access, care coordination, medication adherence, post-operative care, diagnostic testing review, patient engagement, and facilitate access for patients who have difficulty traveling to receive care. UC Health appreciates the following extensions and asks CMS to make them permanent:

1. Virtual supervision of physician residents: We appreciate the current enforcement discretion to allow teaching physicians in Metropolitan Statistical Areas (MSAs) to be present virtually, through audio/video real-time communications technology, for purposes of billing under the PFS for services they furnish involving resident physicians. Virtual supervision is recognized by the Accreditation Council for Graduate Medical Education (ACGME) as an acceptable and safe form of direct supervision, the highest level of supervision. The current extension of direct supervision of residents via telehealth to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications has proven to be effective.

[1] See: UC Health: Improving Access to Care

2. Originating Site: The temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any location where the beneficiary is located at the time of the telehealth service, including an individual's home.
3. Additional Providers: The expansion of the definition of telehealth practitioners to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists. This expansion allows more patients to access care in their home.

CMS should extend virtual supervision to other important scenarios where it can improve patient experience and access to care:

CMS's proposed extension of virtual direct supervision is commendable, and aligned with the position of The Accreditation Council for Graduate Medical Education (ACGME) that virtual supervision allows for adequate oversight and education and can be conducted safely. UC Health supports CMS's proposal to allow virtual supervision of residents for telehealth services in all residency training locations through the end of CY 2024. However, we urge CMS to allow virtual supervision of residents for both in-person and telehealth services in all residency training locations permanently when clinically appropriate.

In response to CMS's request for additional scenarios where virtual direct supervision has been shown to improve efficiencies in medical workforce and patient safety, we offer the following for your consideration:

- *Resident and Patient are Together in a Hospital; Attending Physician is Remote*: Virtual supervision is useful when the resident and patient are together in person, but the attending is at another site. For example, a psychiatric resident is on call overnight seeing a patient in the hospital emergency department, and the attending psychiatrist is at another clinical site or at home. The resident can provide a clinically valuable in-person examination while the attending supervises via real-time audio-video connection. We urge CMS to consider allowing the flexibility for the supervising physician to participate in key portions of the service without being physically co-located with the resident.

- *Attending Physician Supervises Residents at Multiple Physically Distant Sites:* Most AHCs in the UC Health system operate hospitals and ambulatory clinics on multiple campuses that cover many city blocks and sometimes different cities. For example, UC San Diego Health has the La Jolla campus, Hillcrest campus and many ambulatory clinics throughout the region; UC Davis Health has 17 clinic locations throughout the Sacramento region. UCLA Health has four hospitals on two campuses and more than 260 clinics throughout Southern California. A single attending physician can provide supervision to residents at different clinical sites within the system, or on the same large campus, where virtual direct supervision can improve efficiencies and patient safety.

- *Attending Physician Supervises Residents Working Beyond Clinic Walls:* UC Health's mission of public service often requires bringing health care to patients, rather than requiring patients to come to us. Virtual supervision allows residents to see patients in-person in their home, in mobile clinic vans, and in other non-traditional settings such as street medicine programs where the additional physical presence of an attending physician would be impractical. It is not necessary to staff all outreach with an onsite clinician and the requirement to do so will dramatically limit patient access.

CMS should extend and clarify the use of Remote Physiological Monitoring (RPM) codes:
We appreciate CMS's efforts to support and expand RPM services, which will only increase as technological innovations advance and become more affordable. We recognize that there are additional issues that need to be addressed and urge the final rule to consider the input below to ensure the full potential of RPM is realized:

- CMS should extend the definition of CPT code 99454 (automated data transmission from the patient's device) to specify that it is billable when the number of days of data collected is clinically suitable for the condition being managed via RPM. Without this clarification, the requirement defaults to the "50% plus one" metric applied to time-based services, which is 16 days in a 30-day period. Many conditions suitable for RPM do not require receipt of data at this frequency.
- CMS should clarify that RPM Professional Work CPT codes 99457 (20-minute physician time for evaluating and responding to the data) and 99458 (additional 20-minutes for evaluating and responding to data) are billable even when the minimum number of days of data collected is not sufficient to bill code 99454. This requested clarification is consistent with CMS' established approach and the CPT code set.
- CMS should remove the limitation that restricts use of either RPM or remote therapeutic monitoring (RTM) by one provider to one patient per 30-day period even when there is more than one device provided to the patient. This restriction withholds the benefits of RPM and RTM from vulnerable patients with co-morbidities. For example, when a single patient has multiple co-morbidities, like chronic obstructive pulmonary disease (COPD) and hypertension, monitoring of both conditions through RPM should be billable.
- We support CMS's proposal to clarify that beneficiaries getting surgery and related services covered by a global payment can also get RPM and RTM services if the latter is separate from the diagnosis for the procedure/services covered by a global payment. However, CMS is strongly encouraged to make clear that that RPM and RTM used in scenarios technically related to a diagnosis under a global period, but not provided for in the global payment, are supported in Part B. For example, providers should be able to use RTM to determine how frequently patients are compliant with the use of respiratory inhalers, oxygen, or other prescribed treatment both prior to and following pulmonary surgery.

CMS should not require a provider's home address:
We continue to oppose the implementation of a broad requirement that providers rendering telehealth services from their homes report their home address on their Medicare enrollment despite billing from a separately enrolled office location. In addition to our significant concerns regarding inadvertent public exposure of this information, the operational burden of modifying enrollment for tens of thousands of telehealth providers in the UC system is enormous. At a minimum, CMS should narrow this requirement to providers who offer a significant percentage of their services from their home, and/or who live in and bill from different Medicare Administration Center (MAC) jurisdictions.

CMS should clarify that the non-facility rate applies to Hospital Outpatient Department (HOPD) -based telehealth visits:

UC Health is seeking recognition of practice expense associated with virtual visits. Currently, telehealth visits with patients located in their homes are reimbursed at the non-facility provider rate. Prior to the public health emergency, these visits were paid at the lower facility rate. While telehealth programs do reduce some of the costs of traditional in-person visits, these savings are often more than offset by other necessary expenses, including hardware, software, and technical support services. We are seeking clarification from CMS regarding which rate applies to HOPDs through the end of 2024 and urge continuation of the non-facility rate.

UC Health appreciates the opportunity to submit these comments on the 2024 Medicare PFS for CY 2024. If you have any questions, please contact Kent Springfield (202) 993-8810 or kent.springfield@ucdc.edu.

Sincerely,

Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs