September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS–1770-P
Mail Stop C4-26-05
7500 Social Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of our membership, the American Thoracic Society (ATS) and the American College of Chest Physicians (CHEST) appreciate the opportunity to submit our shared comments on the proposed Medicare Physician Fee Schedule for 2023. Our societies represent over 25,000 pulmonary, critical care and sleep specialists dedicated to prevention, treatment, research and cure of respiratory disease, critical care illness and sleep disordered breathing. Our members provide care to Medicare beneficiaries for a wide range of conditions including critical care illness, asthma, COPD, lung cancer, alpha-1 antitrypsin deficiency, pulmonary fibrosis, pulmonary hypertension, and other disorders of the lung, as well as sleep disorders. Since the pandemic began, our members have also been integral in the care of COVID-19 patients, both inpatient and outpatient. The proposed rule includes several policy changes and payment revisions that are of direct interest and impact to our members. We offer the following comments to help CMS craft the final 2023 Medicare Physician Fee Schedule rule.

CY 2023 PFS Rate Setting and Medicare Conversion Factor (CF)
ATS and CHEST note with concern CMS's proposal to issue CY 2023 Medicare conversion factor (CF) of $33.0775, a decrease of $1.53 or 4.42 percent from the 2022 CF rate of $34.6062. While we recognize the calculation of the conversion factor is driven by statutory and regulatory requirements, we note inflationary pressures impacting the rest of the U.S. economy are also impacting physician practices and other health care facilities. The proposed 4.42 percent reduction of the conversion factor will put physician practices under increasing economic stress at a time when physician practices are still recovering from the economic challenges posed by the COVID pandemic. We urge CMS to use the maximum extent of its administrative authority to maintain a level funding in the CY2023 conversion factor equivalent to 2022 levels.

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Request for Information on Strategies for Updates to Practice Expense (PE) Data Collection and Methodology

ATS and CHEST appreciate CMS's recognition that the resource-based relative value scale (RBRVS) payment system is working on woefully incomplete and outdated practice expense data. The current data was collected by the American Medical Association as part of a national data collection effort that captured physician practice expense data from 2006. While the data collected by the AMA effort was valid, we share CMS's assertion that the data is old and no longer accurately reflects physician practice expense costs. We support CMS's collaboration with AMA to conduct a new national survey effort to collect updated physician practice expense data. While we support this effort, we also note that conducting such a high-quality practice expense survey is an expensive effort and that the many medical subspecialty organizations that will likely support the survey effort – both as participants in the survey and financial contributors to the survey effort – are still recovering from COVID economic challenges. Many subspecialty organizations may be hard pressed to provide the financial resources to fully participate in a national practice expense survey effort.

Comment Solicitation on Global Surgical Services

The ATS and CHEST agree with CMS's speculation that E/M visits captured within global surgical periods are often not performed. The results from the Rand study are consistent with observations from our members. We recommend CMS continue to review data from both 10-day and 90-day global surgical periods to evaluate the frequency of E/M visits provided as part of surgical global periods and to develop policy options to ensure medical appropriate provision of care for Medicare beneficiaries.

Evaluation and Management (E/M) Visits

We support CMS's proposal to largely adopt the CPT E/M Guidelines as they apply to inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. We support giving physicians the flexibility to choose medical decision making or time to select the correct E/M level

Split (or Shared) E/M Visits

ATS and CHEST appreciate CMS's proposal to delay the new policy on split/shared billing that requires the provider who spent >50 percent of the time in the E/M service to be the billing provider until 2024. We continue to have reservations with the underlying decision to change the allocation of split/shared billing from substantive portion of the encounter to a total time-based allocation. For many E/M services the most valuable component of the services is the medical decision making provided by the physician. While qualified providers can and do provide significant value to the patient encounter, it is most often the medical decision making provided by the physician that advances patient care in the E/M visit and often drives patient outcomes more broadly. Additionally, an experienced physician can frequently complete an

evaluation and management visit more quickly than a less experienced non-physician provider. We urge CMS to work with the medical community to develop a policy proposal that better recognizes the value of medical decision making in split/shared billing.

Request for Information: Medicare Potentially Underutilized Services

Pulmonary Rehabilitation

Many Medicare beneficiaries with obstructive and restrictive airway diseases and patients struggling with respiratory complications from long-COVID would benefit from pulmonary rehabilitation (PR).

Studies have repeatedly and consistently confirmed the beneficial effect PR offers patients with respiratory symptoms. A recent observational study compared the results of PR of a large group of patients with severe impairment post-COVID-19 to individuals typically referred to PR. (Speilmann) The study demonstrated that PR led to significant clinical and functional improvements in individuals who suffered from severe COVID-19 and underlines the importance of post-acute rehabilitation for COVID-19 recovery. Two recent studies of Medicare beneficiaries found significant differences in both the number of rehospitalizations ($p<0.001$) (Stefan) and risk of death ($p<0.001$) over 1 year between those beneficiaries who initiated PR within 90 days of hospitalization. (Lindenauer) While these findings did not include a COVID-19 population, the symptomatology is similar and would suggest that the exercise provided in PR is a promising therapy for long-COVID.

Despite the strong evidence base for PR, utilization rates for remain disappointingly low. While there are many factors that impact PR utilization, the primary driving factor is low reimbursement rates; the practice cost of providing this service outpaces reimbursement. Despite the clinical similarities between PR and cardiac rehabilitation, the payment differential between these two services is significant. CMS recognized the clinical similarity between pulmonary and cardiac rehabilitation in 2022 when it proposed and finalized common definitions between cardiac rehabilitation and PR. Despite noting the clinical parallels between the two services, CMS continues to maintain significantly different reimbursement rates for the two services. Because of these low reimbursement rates, few medical facilities are able offer PR services, creating access problems for many beneficiaries.

We urge CMS to consider raising reimbursement rates for PR services a level equivalent to cardiac rehabilitation in an effort to help increase patient access to this proven effective medical intervention.

Advanced Care Planning

Advanced Care Planning is another valuable service that is underutilized by Medicare beneficiaries. While advanced care planning is underutilized across the general population, it is particularly underutilized by minority groups. The result is that many Medicare beneficiaries are unprepared for the end-of-life choices that they may face. Family members are often asked to make challenging decisions without fully understanding the wishes of the beneficiary. The beneficiary loses autonomy while family members are placed under great stress.

The ATS and CHEST urge CMS to consider a range of options to expand the use of advance care planning including a) increasing the reimbursement rate for advance care planning services; b) conducting a beneficiary-focused education campaign on the availability and benefits of advance care planning; and c) expanding the role advance care planning plays in physician quality measures.

Lung Cancer Screening

ATS and CHEST note the disappointingly low utilization rate of lung cancer screening for patients who meet USPSTF recommendations. While survival rates for many other cancers have significant improved in recent years, lung cancer survival rates have remained low – making early detection of lung cancer the most effective intervention to improve lung cancer mortality. ATS and CHEST appreciate the actions CMS has taken in recent years to both establish a lung cancer screening benefit and to update the screening criteria to more closely align with USPSTF guidelines. We urge CMS to continue its efforts in this area by: a) allowing the Shared Decision Making visit to be conducted either in person or virtually, lowering the barrier for Medicare beneficiaries to take the first step in the lung cancer screening process; b) conducting a national lung cancer screening awareness campaign to encourage more beneficiaries to consider lung cancer screening; c) studying the barriers to lung cancer screening for underserved populations and d) conducting a targeted campaign directed to underrepresented minorities to boost utilization of lung cancer screening.

Preventative Vaccinations

The ATS and CHEST note with great concern recent reports of polio outbreaks in the US. It is troubling that a disease, once widely feared and then considered eradicated in the US, now has a foothold in our society. While the risk of widespread polio outbreak in the US remains small, the local outbreak of polio in New York is a symptom of the public's declining trust in role of vaccines in protecting public health. The cause of the public's declining trust in vaccines are many, including a) unsubstantiated claims of autism links to vaccines, b) partisan response to COVID vaccines, and c) attacks on the credibility of scientists and public health officials. We note HHS has provided funding to CMS to conduct an effort to raise vaccination rates in the adult population. The ATS is pleased to participate in this effort. While we support the HHS's effort, we urge CMS to consider additional steps it could take to increase adult vaccination rates including a) increase reimbursement rates for vaccine administration; b) conducting

ongoing public education campaigns about the value of vaccinations; and c) increasing the quality measure bonus for improving vaccination rates. It is in everyone's best interest for CMS to continue to play a lead role in educating the public about the incredible health benefits provided by FDA approved vaccines.

Liquid Supplemental Oxygen

The ATS and CHEST recognize that provision of supplemental oxygen does not fall under the purview of the Medicare Physician Fee Schedule. However, we wanted to take the opportunity to remind CMS of persistent barriers to supplemental liquid oxygen that exist in the Medicare program. We note that supplemental oxygen is essential for the treatment of patients with many serious respiratory conditions (e.g., severe COPD, pulmonary fibrosis, alpha-1 antitrypsin deficiency, sarcoidosis) and further that ongoing research has demonstrated the benefits of supplemental oxygen. Recent clinical practice guidelines recommend the use of supplemental liquid oxygen for patients who require oxygen at flow rates of >3 liters per minute during exertion. Below is the recommendation from the recent ATS clinical practice guidelines for supplemental oxygen.

> **In patients with chronic lung disease who are mobile outside of the home and require continuous oxygen flow rates of >3 L/min during exertion, we suggest prescribing portable liquid oxygen (LOX) (source: Home Oxygen Therapy for Adults with Chronic Lung Disease. An Official American Thoracic Society Clinical Practice Guideline 2020)**

Under DME competitive bidding, reimbursement rates for liquid supplemental oxygen have plummeted, and so has beneficiary access to liquid oxygen. The tables below show the use of supplemental oxygen by oxygen type since its inclusion in the competitive bidding program. There is a precipitous decline in both portable and stationary liquid oxygen systems starting with the implementation of DME competitive bidding. We are unaware of any other explanation for the change such as a change in the frequency of diseases that would require supplemental oxygen or any change in treatment options that would be responsible for the dramatic change in liquid supplemental oxygen use.

Portable Liquid Systems			
Year	Charges	Claims	Patients
2010	$14,127,684	491,253	40,938
2011	$12,439,576	442,027	36,836
2012	$9,728,130	337,668	28,139
2013	$6,814,689	250,125	20,844
2014	$4,368,905	173,161	14,430
2015	$2,455,215	128,727	10,727
2016	$2,020,306	97,690	8,141
2017	$1,330,437	73,255	Data not currently available
2018	$1,019,326	52,329	
2019	$1,359,171	35,850	
2020 (partial)	$998,054	24,875	

Source: Medicare claims data

Stationary Liquid Systems			
Year	Charges	Claims	Patients
2010	$67,355,848	386,645	32,220
2011	$59,497,447	349,775	29,148
2012	$46,893,878	271,233	22,603
2013	$31,983,339	199,486	16,624
2014	$19,536,044	136,656	11,388
2015	$10,829,115	99,252	8,271
2016	$ 7,482,476	71,377	5,948
2017	$ 3,786,098	49,733	Data not currently available
2018	$ 2,685,145	33,028	
2019	$ 1,993,260	22,583	
2020 (partial)	$ 1,580,330	16,392	

Source: Medicare claims data

Due to the low reimbursement rates, most DME suppliers have abandoned the liquid oxygen market. The few DME companies that do provide liquid oxygen are refusing to accept new Medicare patients and many Medicare patients who had liquid oxygen systems have had the liquid oxygen system taken away and replaced with stationary oxygen concentrators.

The ATS and CHEST recommend CMS take steps to restore Medicare beneficiary access to liquid supplemental oxygen by a) addressing low liquid oxygen reimbursement rates, and b) following up with DME companies who no longer provide liquid oxygen to understand and address other commercial barriers prevention the provision of liquid oxygen.

Critical Care & E/M on the same day
ATS and CHEST appreciate CMS's clarification that an E/M service can be provided and billed for on the same day as an emergency room service or critical care services under certain circumstances and with appropriate use of the -25 modifier.

Sincerely,

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