The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1807-P. 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; Proposed Rule, July 31, 2024

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 235 member hospitals, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Physician Fee Schedule proposed rule for calendar year (CY) 2025.

HAP is deeply concerned that CMS' proposed payment rate will substantially reduce payments from their current level posing significant risk to patient's access to care and health systems' financial stability, particularly for safety net providers.

However, HAP is pleased to see the agency's continued efforts to retain important telehealth flexibilities permitted during the COVID-19 pandemic as well as the delay in implementing the proposal to change how a split visit is defined. However, we are critically concerned with services at risk for disruption baring Congressional action.

In addition, we incorporate, by reference, all the comments provided in the American Hospital Association's response to the proposed rule.

Thank you for your consideration of HAP's comments regarding this proposed rule. If you have any questions, contact **me** at (717) 561-5317.

Sincerely,

Kate Slatt
Vice President, Policy and Care Delivery

Attachment

HAP Comments—Physician Fee Schedule
Proposed Rule for Calendar Year 2025

CONVERSION FACTOR UPDATE

CMS proposes to cut the conversion factor by 2.8 percent in calendar year (CY) 2025, to $32.36 as compared to $33.29 in CY 2024. This update includes:

- The expiration and removal of a 2.93 percent increase in the Physician Fee Schedule (PFS) conversion factor for CY 2024 (which was provided by the Consolidated Appropriations Act [CAA] of 2023 and CAA 2024)
- A zero percent update factor as required by Medicare Access and CHIP Reauthorization Act of 2015; and
- A budget-neutrality adjustment

HAP echoes the concerns about the impact of these cuts detailed by the American Hospital Association (AHA). As proposed, these reductions are a significant threat to patient access to care and provider financial stability, particularly for safety net providers. Our concerns are heightened because this proposed cut comes in the wake of decreases to physician payment over the last two decades. Inflation and rising input costs have consistently outpaced reimbursement for services covered by the PFS. As a result, HAP urges CMS to do everything it can to minimize the 2025 payment decreases.

TELEHEALTH

New Services for the Medicare Telehealth List for 2025

CMS proposes to do a comprehensive analysis of the provisional codes currently on the Medicare Telehealth Services list prior to adding any requested additions. After the completion of the analysis, CMS will make proposals in future rulemaking.

However, CMS does propose to add 13 services to the Medicare Telehealth Services List for 2025 including home international normalized radio monitoring on a provisional basis (Current Procedural Terminology [CPT] code G0248), caregiver training codes on a provisional basis (CPT codes 97550-97552; 96902-96903; GCTD1-GCTD3; GCTB1-GCTB2, and preexposure prophylaxis of HIV on a permanent basis (CPT codes G0011 and G0013).

HAP supports a comprehensive analysis of the codes currently on the Medicare Telehealth Services list and urges CMS to continue to broaden the potential Medicare services that can be offered utilizing this technology. HAP also supports the 13 additional services proposed to be added to the 2025 list.

Audio-only Services

In CY 2022, CMS acknowledges the positive impact that allowing for audio-only mental health telehealth services have had during the Public Health Emergency (PHE). In this rule, CMS proposes to again amend the definition of "interactive telecommunications system" to include

audio-only communication when used for telehealth services for the diagnosis, evaluation, or treatment of other services furnished to established patients when the originating site is the patient's home. CMS notes that claims for such services should be reported with 93 and/or FQ modifiers as appropriate.

HAP strongly supports making audio-only telehealth services available to other services as its success with mental health has shown it can be a critical way to provide access and deliver important health care services to beneficiaries.

Distant Site and Provider Home Address for Telehealth Providers

CMS proposes to continue the flexibilities granted during the PHE that allowed providers to report/bill from their currently enrolled practice location instead of their home address when services are provided from their home.

HAP urges CMS to permanently grant these flexibilities to providers, especially as health care providers face an unprecedented workforce crisis.

Direct Supervision: In the CY 2021 PFS Rule, CMS finalized its proposal to extend the allowance for providers to provide direct supervision via audio/video technology through the end of the calendar year in which the emergency ends or December 31, 2021, whichever is later. This rule extends this provision through CY 2025. CMS is again seeking comment on quality and safety considerations for virtual supervision.

In addition, CMS proposes to permanently allow audio/visual technology for direct supervision for the following:

- The underlying HCSPCS code has been assigned a PC/TC indicator of 5
- CPT code 99211

HAP strongly urges CMS to permanently allow direct supervision via audio/video technology.

Outpatient Therapy, Diabetes Self-management Training, and Medical Nutrition Therapy

There are several important remote health care services that risk disruption without Congressional action. These services, which include outpatient therapy, diabetes self-management training, and medical nutrition therapy, were allowable remotely under CMS' Hospital Without Walls policy. During the COVID-19 PHE, CMS created this policy to allow hospitals to reclassify patient's homes as temporary extension sites during the state of emergency.

HAP has significant concerns about a potential impact in the event that Congress fails to act to ensure these important services remain accessible to beneficiaries. HAP urges CMS to evaluate all possible avenues to maintain all current waivers that have benefited both patients, providers, insurers, and others significantly since the beginning of the PHE.

Payment for Telemedicine Evaluation and Management Services (E/M)

Last year, 17 new codes for reporting telemedicine E/M services were added to the draft CPT codebook by the CPT Editorial Panel. CMS has stated that there is no need for these codes under Medicare and proposes to continue utilizing the existing office/outpatient E/M codes currently on the Medicare telehealth services list when billed with the appropriate place of service code, and when applicable, the appropriate modifier to identify if the services is furnished via audio-only technology. CMS also proposed to add a status indicator of "I" to the new telehealth E/M codes to denote that there is a more specific code that should be used for purposes of Medicare.

CMS is also seeking feedback on how CMS could mitigate negative impact from the expiring telehealth flexibilities.

HAP is encouraged by CMS' continued efforts related to making telehealth services accessible to its beneficiaries. HAP urges CMS to continue to make broad, permanent adoption of any services that were acceptable during the pandemic, given that only services that did not pose significant patient safety concerns were added to the list during this time.

ADVANCING ACCESS FOR BEHAVIORAL HEALTH SERVICES

Proposed New Payments for Services Delivered to Patients at High-risk for Suicide or Overdose

CMS proposes to create separate coding and payment for services furnished in the emergency department or other crisis settings for patients with suicidality or at risk of intentional suicide by overdose allowing providers to implement a wider range of evidence-based protocols. CMS proposes to broaden the range of reimbursable services by creating or enhancing payment structures for safety planning intervention, post-discharge follow-up contact intervention (FCI), digital treatment, and interprofessional consultations.

HAP appreciates and strongly supports broadening the scope of reimbursable behavioral health services and the agency's consideration of innovative treatment strategies. HAP would encourage CMS to consider payment structures that recognize lived experience as well as clinical training in Medicare reimbursement models, particularly as they relate to safety planning interventions and post-

discharge follow-up contact intervention. HAP supports the proposal to reimburse providers for digital treatment for mental health services as health systems in Pennsylvania report that digital treatment options allow them to increase access to care and maximize the impact of their existing providers by allowing them to focus more of their time on more clinically complex parts of the patient's treatment plan. Similarly, HAP supports the agency's proposals to add new G-codes for consultations between mental health providers and practitioners—further enabling all members of the care team to maximize access to services.

Comment Solicitation on Payment for Service Furnished in Additional Settings

In the CY 2024 Outpatient Prospective Payment System final rule, CMS adopted payment for intensive outpatient (IOP) services furnished in hospital outpatient departments, Community Mental Health Centers, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Opioid Treatment Programs (OTP). In this proposed rule, CMS seeks comment on whether and how IOP and other behavioral health services are furnished in other settings, including freestanding substance use disorder treatment facilities, crisis stabilization units, urgent care centers, and Certified Community Behavioral Health Clinics.

In Pennsylvania, there is a growing need for crisis services among seniors. Over the last couple of years, HAP has been working with government agencies and community partners across the state to help build and strengthen a crisis network for older adults. A payment model that incorporates intensive outpatient therapy furnished in additional settings would help to support and sustain the infrastructure our members are trying to build, particularly in rural areas where we are exploring how to best move services closer to the people who need them most.

Medicare Coverage and Payment for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

In the proposed rule, CMS indicates it would extend PHE-era flexibilities to allow OTPs to perform periodic assessments via audio-only telecommunications on a permanent basis when video is not available. The agency proposes to make permanent telecommunication flexibilities under the Medicare OTP benefit by allowing OTPs to bill the intake add-on code when the initiation services for methadone are furnished via two-way audio-video communication technology. CMS would also add value to the payment rate for intake activities to include OTP-performed risk assessments for social determinants of health as required by Substance Abuse and Mental Health Services Administration standards and would establish new add-on codes for new FDA-approved opioid agonist and antagonist medications.

HAP is supportive of payment methodologies that optimize a provider's ability to care for patients suffering from opioid use disorders via telemedicine. Health systems in Pennsylvania report that the expanded treatment options made available

during the PHE broadened access to care and supported consistency in treatment. HAP is pleased that CMS intends to make permanent these important payment provisions.

MEDICARE PARTS A AND B OVERPAYMENT PROVISIONS OF THE AFFORDABLE CARE ACT

In 2022, CMS proposed rules regarding standards for "identified overpayment" under Medicare Parts A, B, C, and D. The agency has not yet finalized proposals on overpayments under Parts A and B, however after reviewing comments, is retaining the proposals for Parts A and B in that rule and is now making additional proposals regarding the deadline for reporting and returning overpayments.

The Affordable Care Act requires overpayments be reported and returned either 60 days after which the overpayment was identified or the date any corresponding cost report is due (whichever is later). Overpayments retained after the deadline for reporting and returning is considered an obligation under the False Claims Act.

CMS is now proposing to replace "reasonable diligence" with "knowing" and "knowingly" with the thresholds being "has actual knowledge," "acts in deliberate ignorance of the truth or falsity of the information," or "acts in reckless disregard of the truth or falsity of the information." In addition, CMS also proposes circumstances which would suspend the deadline for reporting and returning overpayments in order to allow time for providers to investigate and calculate overpayments. This may occur if a person is on notice of a potential overpayment but has not yet completed a good-faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment; and if the person conducts a timely, good-faith investigation to determine whether related overpayments exist. In such cases, deadlines would be suspended until the investigation is concluded and overpayments are calculated or 180 days after the date where the initial overpayment was identified (whichever is earlier).

HAP is concerned with the proposed changes and encourages CMS to maintain the process that has been implemented and used by providers since the overpayment rule was issued: 1) Identify credible evidence of an overpayment (audit, whistleblower, etc.), 2) Allow sufficient time for a comprehensive investigation (extremely important to providers), 3) calculate the overpayment, and 4) refund the overpayment within 60 days of identifying the specific amount.

The proposed 180-day window for investigations is not sufficient for large health care providers, such as hospitals and health systems to fully investigate and calculate overpayments. Additionally, the health care workforce shortage has been widely documented, so small to mid-size hospitals will also struggle to with this timing. Additional flexibility is needed to support providers that are making good-

faith efforts to investigate and calculate overpayments but may not be able to complete this process in six months.

As proposed in the 2025 rule, CMS changes seem to be creating a more complex provider process to essentially reach the same result. Furthermore, the proposed changes would require additional administrative work to re-educate staff and to update policies and procedures. Absent facts and data showing problems with the current process, HAP urges CMS not to move forward with the proposed changes for Parts A and B overpayments.

RURAL HEALTH CLINICS (RHC) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

RHCs are currently required to provide primary care services for more than 50 percent of hours spent on services at the clinic. In the proposed rule, CMS is seeking to address stakeholder concerns that this provision impacts RHCs' ability to meet the needs of their communities with respect to specialized care.

CMS is proposing to require RHCs to provide primary care services, however, it would no longer enforce the standard that RHCs be "primarily engaged in furnishing primary care services." It would also discontinue the survey process to ascertain if the majority of hours were spent on primary care services.

CMS clarifies that RHCs may participate in the provision of specialty or behavioral health services in addition to providing primary care services. The agency also seeks comment on the potential impact to access to primary care, behavioral health, and specialties services as a result of the proposed change.

HAP supports the non-enforcement of the primary care standard in lieu of providing additional, critically needed services in rural communities and appreciates CMS' concern regarding the impact to primary care services in those same communities. HAP supports additional evaluation of the proposal as it is implemented.