Kansas Hospital Association

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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 Overpayment

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

On behalf of our 121 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the Medicare Physician Fee Schedule (PFS) for calendar year (CY) 2025.

KHA is a non-profit membership organization. Our membership includes 82 Critical Access Hospitals, 3 Rural Emergency Hospitals, 19 Rural Sole Community and Medicare Dependent Hospitals, and 18 Urban Hospitals.

Calculation of the CY 2025 PFS Conversion Factor

KHA is very concerned regarding the more than 3% decrease in physician payments compared to CY 2024. The one-time 2.93% payment increase from the CAA, 2024 was a great benefit, but with that not extending into 2025, this causes significant issues towards sustainability. KHA recognizes that CMS faces limitations with the conversion factor, but we urge Congress to take legislative action to provide inflation adjustments to the conversion factor to enable reimbursement that reflects increasing costs year over year, particularly in the past several years. Physician payment must be fixed for a multi-year basis moving forward. The alternative is untenable.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Audio-Only Communication Technology To Meet the Definition of "Telecommunications System."

KHA strongly supports CMS' proposal to modify its definition of "telecommunications system" to include audio-only technology for any telehealth service furnished to a beneficiary in their home when a practitioner is technically capable of using audio-video technology, but the beneficiary does not consent to or does not have the ability to use audio-video communications. Audio-only telehealth is a critical tool for increasing access to care for Medicare beneficiaries. Kansas has many areas, particularly in rural parts of the state, that lack appropriate broadband infrastructure to enable video communications. Audio-only telehealth visits enable residents to seek telehealth care even without strong broadband services. **KHA urges CMS to finalize this policy and further expand its reading of § 1834(m)(2)(A) to permanently allow for audio-only telehealth for all services beyond any congressional extension.**

Additionally, we encourage Congress to take action to extend Medicare telehealth flexibilities to remove the barriers imposed by originating site restrictions. We believe it important for all providers to be able to provide telehealth services furnished by audio-only services instead of only those eligible pre-Public Health Emergency.

Distant Site Requirements

KHA supports the proposal to continue allowing flexibility of permitting distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. KHA believes this is important to maintain privacy and security of practitioners who work from home and furnish telehealth services.

Direct Supervision Via Use of Two-Way Audio/Video Communications Technology.

KHA thanks CMS for the proposal to continue the flexibility of services required to be furnished under the direct supervision of the supervising physician or other practitioner can be "directly supervised" and satisfied through "immediate availability" and that immediate availability can be through virtual presence using two-way, real-time audio/visual technology for diagnostic tests, incident-to services, pulmonary rehabilitation services, and cardiac and intensive cardiac rehabilitation services. We further support making this flexibility permanent for certain low-risk services. We urge CMS to finalize both proposals.

Teaching Physician Billing for Services Involving Residents with Virtual Presence

KHA supports CMS' proposal to continue the current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only when the service is furnished virtually. We believe that this flexibility allows residency programs to remain well equipped to train residents, particularly when furnishing virtual services to patients.

Requests to Add Services to the Medicare Telehealth Services List for CY 2025

We recognize that CMS does not desire to propose to revise the status of codes from provisional to permanent in this proposed rule due to intent to conduct a comprehensive review. KHA encourages CMS to permanently add cardiovascular rehabilitation and pulmonary rehabilitation services to the Medicare Telehealth Services List (CPT codes 93797, 93798, 94625, 94626) once that comprehensive review is undertaken. We additionally encourage the comprehensive review to make permanent the codes referenced for therapy/audiology/speech language pathology.

KHA also supports the removal of the frequency limitations for the proposed codes for CY 2025. We believe that physicians and providers should be allowed to use their own clinical judgment to determine the visit setting, frequency of the visit, and the type of treatment that are the best fit for each patient's individual situation. These frequency limitations being lifted during the PHE have been a strong example of the benefits of flexibilities that can increase the quality of patient care while also increasing access to care. KHA urges CMS to permanently remove the frequency limitations for all calendar years after 2025 in the final rule.

Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136))

KHA thanks CMS for taking action to address health-related social needs and how both the American health care system and other community supports can best work together to improve the determinants that make up each individual person's health. We are supportive of efforts like these codes to provide additional reimbursement for work that health care facilities are expected to engage in, but as issues have arisen, we are grateful that CMS is seeking information on these services. A concern we have heard from members is that while the provider can now get reimbursed for providing the service, a cost is charged back to the patient through raising their coinsurance amount or going toward their deductible. Due to a wRVU value on these codes, which is necessary, there are unintended consequences when providers use these codes but then have to collect the money from the patient. Providers may be forced to decide whether they should bill for these codes to help the patient but then require the patient get hit harder financially.

With this in mind, while CMS needs to ensure appropriate provider reimbursement, CMS also needs to consider patient impact. KHA encourages CMS to exempt these codes from cost sharing to remedy this issue. Many patients that may benefit from these codes are poor and asking them to pay for additional services is counterintuitive. Providers cannot charge them more for services that will help make them healthier – if patients owe more, they will seek care from providers less.

- *We are seeking comment on any related services that may not be described by the current coding that we finalized in the CY 2024 PFS final rule and that are medically reasonable and necessary "for the diagnosis or treatment of illness or injury" under section 1862(a)(1)(A) of the Act.*

We believe it would be relevant and necessary to add the service of helping patients navigate insurance (Medicare enrollment process, etc.). Many patients refuse to seek medical care, or do not complete their treatment plans, due to financial constraints. If auxiliary personnel under the direction of a billing practitioner could help patients navigate the complex process of insurance and paying for medical care, that could improve the rate of patients successfully completing their treatment plans and therefore improve the health of our communities.

Additionally, we encourage CMS build out codes that address issues that makeup HRSNs to ensure that hospitals can identify and address the needs of patients within our communities. CMS could build these based on the Homelessness Z Codes that have been implemented previously. Codes for addressing HRSNs will enable hospitals to better connect patients with resources and fixing underlying issues to reduce readmissions and to improve the health and life outcomes of patients.

Lastly, we recommend adding professional Care Management and Discharge Planning as billable services when incorporated into the discharge plan by an acute-care hospital. We believe this can be a major readmission reduction strategy.

- *How can CMS improve the accuracy of valuation and payment for these services and what else it could consider to be included in this newly established code set?*

We believe that incentives should be established for providers to assess the percentage of patients who visit their practice/hospital. Assessing patients is a significant undertaking, including a financial expense, but obtaining that data can help all facilities better understand where resources should be allocated. CMS could incentivize providers/hospitals to partner with community-based organizations and other community resources such as homeless shelters and food banks to create a stronger pathway for patients that screen positive to actually receive resources that address their SDOH needs.

- *Ways to identify specific services and to recognize possible barriers to improved access to these kinds of high-value, potentially underutilized services by Medicare beneficiaries:*

In addition to incentives for providers, CMS could provide grants for hospitals to partner with community resources to provide assistance to patients with SDOH concerns. Hospitals play a key role in caring for patients, however issues like SDOH often require the collaboration with external partners to truly resolve SDOH issues for patients. If supports are not instituted to involve more of the community outside of the hospital, patients risk not truly having their concerns addressed and thus a cycle that does little to lift the patient out of their underlying issues.

We also encourage CMS to explore the creation of an electronic platform for providers and community resources to share bi-directional information sharing that is secure. A system is necessary for noting and directing patients to resources that will help them address their underlying needs. This kind of platform can help reduce frustrations of patients in navigating resources available to help them.

- *We are also interested in hearing more about what types of auxiliary personnel are typically furnishing these services, including the certifications and/or licensure that they have.*

The State of Kansas has approved a Community Health Worker certification that trains Community Health Workers (CHWs) to be prepared to furnish these services. There are multiple pathways for those interested in becoming a certified CHW to obtain certification. The education pathways require CHWs to complete the Kansas Department of Health and Environment (KDHE) approved CHW core curriculum training through the Kansas CHW Coalition or a certified Kansas CHW education provider. This requires a minimum of 100 classroom hours and 60 service-learning hours. The workforce pathway requires CHWs to complete 800 hours over three years plus three letters of recommendation to document work and/or volunteer experience. There is also reciprocity with the State of Missouri for those that take a Missouri approved CHW core curriculum training.

The Kansas CHW Core Curriculum Training is built on twelve core competencies based on the national CHW core competency list.

- *We are also interested in whether there are nuances or considerations that CMS should understand related to auxiliary personnel and training, certifications or licensure barriers or requirements that are specifically experienced by practitioners serving underserved communities. This could include settings such as community mental health centers, community health clinics including FQHCs and RHCs, tribal health centers, migrant farmworker clinics, or facilities located in and serving rural and geographically isolated communities including the U.S. Territories.*

Sending someone to be trained in the CHW educational pathway is essentially a full-time job as it is basically college. This can be challenging for some areas to send personnel and take time off work, or the health care facility may still desire to pay the personnel for their wage while going to school. This is not reimbursable, which can create challenges for greater expansion of the number of CHWs throughout Kansas.

- *We are also interested in any comments from interested parties across provider types and from practitioners in geographically isolated communities (for example, rural, tribal, and island communities) and otherwise underserved communities about coding Z codes on claims associated with billing for CHI, PIN, and SDOH risk assessment codes.*
    - *We recognize that when screening for social needs, such needs may be identified and are interested in learning whether practitioners are also capturing unmet social needs on claims using Z codes for social risk factors or in some other way, and any barriers or opportunities to increase coding of Z codes when social risk factors screen positive.*

Rural areas often lack resources that are necessary for patients to address their respective needs. While CHWs in Kansas work diligently to connect patients to each and every resource needed, it is not always easy or possible to accomplish. Transportation in rural communities is limited, and some CHWs have begun providing transportation for the patient themselves. Other communities may have a food bank helpful to address food

insecurity, but it has limited hours and is only open one day per week. Another facility has several patients with bed bug infestations, but the community has little resources to address that.

Additionally, establishing new billing codes requires extensive coordination and resources, which is a significant undertaking for hospitals, particularly those in rural or underserved areas. Hospitals and clinics need to provide specialized training for medical billers and coders to ensure they accurately apply these codes, which is an additional resource-intensive task. There is also provider education necessary to ensure providers are well-versed in making appropriate referrals and creating care plans to align with these codes. This requires substantial effort and ongoing education.

- *Given the Agency's broader policy goals of increasing access to care, we are requesting information from interested parties and commenters on anything else that we should consider in the context of these codes and what else we could consider to be included in this newly established code set.*

KHA reiterates that adequate reimbursement to providers for screening for, documenting and addressing health related social needs is critical. An assessment of the CAH cost reporting requirements to ensure that cost report requirements don't disincentivize providers from addressing HRSN's is also needed.

Additionally, we believe a potential barrier under the existing codes is that CHWs are limited to providing services relating to SDOHs identified by billing practitioner. We have heard concerns that the billing practitioner may not always learn the full scope of issues that patients may be encountering that contribute to limiting the ability to diagnose or treat the problems of patients. **We encourage CMS to consider expanding the CHI codes to enable auxiliary personnel to provide services to the patient beyond what is initially discovered in the qualifying visit.** Auxiliary personnel may be better suited to communicate with patients to pull back the layers of the problems at hand. For example, if the billing practitioner is not fluent in Spanish but is treating a Spanish speaking patient, the patient may mention an issue of housing insecurity but not going into details about other issues at hand, but once the patient is speaking with a Spanish-fluent auxiliary personnel the patient may mention that there are other SDOH issues like food insecurity that need to be added and addressed to effectively provide care to the patient.

Other challenges to highlight include the results from an American Health Information Management Association (AHIMA) 2023 comprehensive research survey regarding SDOH. Some key results CMS should keep in mind to address with future rulemaking include[1]:

- Challenges in collecting data:
  - Lack of standardization and integration of the data into an individual's medical record
  - Insufficient training and education on how to capture, collect, code, and use SDOH data

[1] https://www.ahima.org/media/03dbonub/ahima_sdoh-data-report.pdf

    - Limited use of SDOH data to communicate between health care providers and community-based organizations
- 93% said they lack a trained workforce
- 73% reported there is patient distrust. Patients are unsure what will happen with the data
- 41% reported an inability to address SDOH needs
- 78% of coders stated they were unable to find SDOH information in patient records

To address the lack of a trained staff, CMS and Congress should consider how funding and technical support can be provided to train providers and business office staff on how to best collect, code, and use social needs information. CMS can consider leveraging existing frameworks to create a learning collaborative to share best practices and guidance on how to collect, code, and best use the information obtained.

CMS should also consider providing financial incentives to providers, Medicare Advantage plans, Medicaid plans, and commercial payers to collect and share SDOH data amongst one another. This type of incentive would better ensure that relevant stakeholders are working together to meet the needs of patients.

We also request that CMS align these efforts with its approach to Medicare telehealth services, ensure these services are modality neutral, and allow providers and beneficiaries to choose the most appropriate modality, whether virtual or in-person. For example, a practitioner may determine during an initiating CHI visit (virtual or in-person) that a beneficiary may be experiencing food insecurity. The practitioner could connect the beneficiary to a community health worker, whether contracted or otherwise, familiar with local programs and able to help. Connecting to these local programs can be just as easily accomplished via virtual methods and as effective.

Advanced Primary Care Management (APCM) Services (HCPCS Codes GPCM1, GPCM2, and GPCM3).

KHA thanks CMS for its work on improving primary care delivery. Coordinated, whole person primary care is essential for beneficiary health and wellbeing. However, we note that some practice-level capability requirements around performance measurement for participation may serve as a barrier to some providers' participation. Furthermore, patients may be deterred from participating because of cost-sharing.

Several Kansas facilities have engaged in care management services, particularly Chronic Care Management (CCM). Due to cost-sharing requirements, some patients are unhappy with the service, and there is a growing likelihood that some providers may end their care management services.

- *Use of QMB status and multiple (two or more) chronic conditions as the basis to bill for APCM Level 3 (GPCM3)*

Providers may be incentivized to use current care management programs like CCM rather than APCM for patients with multiple chronic conditions. We encourage CMS consider an add-on payment or other modifier for QMBs with two or more chronic conditions as the Level 3 billing code to make this code relevant for potential utilization as opposed to its current definition.

- *Should proposed elements of APCM and practice capabilities be modified or removed*

The new required elements for APCM may deter some providers from participating in APCM. For example, while many providers that are currently in care models likely already provide patient population-level management, other interested providers may not have the financial resources or staff availability to analyze and use the data to risk stratify the services based on diagnosis, claims, and services needed. While we do not propose an alternative to this or any of the proposed required elements, we believe it is important for CMS to consider the ability or lack of ability by providers to meet the required elements to drum up participation in APCM services.

New Codes for Advanced Primary Care Management (APCM) Services

KHA thanks CMS for allowing RHCs to furnish APCM services to their beneficiaries. We ask that CMS monitor and evaluate the use of APCM services at RHCs to help reveal any potential barriers to uptake. We note that that practice-level capability requirements around performance measurement for participation may serve as a barrier to participation for certain RHCs. Further, patients may be deterred from participating because of cost-sharing. We would appreciate CMS' diligence in monitoring RHCs' usage to inform whether future tweaks to APCM services would make them more accessible in rural settings.

Telecommunications Technology

KHA thanks CMS for its proposal to continue to pay RHCs for telehealth visits whether or not Congress extends telehealth flexibilities. **We support the adoption of the alternate proposal of payment for RHCs** to be paid under their specific methodology at the per visit payment rate by amending the definition of a "visit" to include audio-video telehealth rather than continuing payment at the current rate based upon the average amount for all MPFS telehealth services.

In-Person Visit Requirements for Remote Mental Health Service Furnished by RHCs and FQHCs

KHA supports the additional extension of the in-person requirement visit for remote mental health services. The extension will enable providers and beneficiaries to have a longer glidepath to implementing the in-person visit requirement after subsequent delays in implementation.

Payment for Preventive Vaccine Costs in RHCs and FQHCs

KHA supports CMS' proposal to pay RHCs for Part B preventive vaccines at the time of service. We believe this policy helps to alleviate cash flow issues for rural providers by being able to bill at the time of service. This gives providers an interim payment that is not otherwise accessible in the current policy.

Productivity Standards

KHA supports CMS' proposal to remove productivity standards for RHCs and agrees that it is duplicative given the payment limits established in the Consolidated Appropriations Act of 2021.

Proposed Changes to the RHC and FQHC Conditions for Certification and Conditions for Coverage (CfCs)

KHA supports CMS' proposal to amend the provision of services conditions for certification and coverage to include new language stating that RHCs must provide primary care services. Additionally, we support the proposal to include language from the RHC statute stating that RHCs are not rehabilitation agencies or facilities primarily for the treatment of mental diseases. We believe that if implemented correctly, this will allow RHCs to expand their provision of both specialty care and behavioral health care to meet the needs of their community. Currently, RHCs are surveyed based on the total number of hours spent providing primary care versus specialty and behavioral health care and can be cited if their hours spent providing the latter exceed 50%. This is extremely limiting and RHCs need more flexibility to meet beneficiary need, particularly around behavioral health services.

KHA urges CMS to define "facility primarily for the care and treatment of mental diseases." This approach would simplify the RHC survey process and provide clear guidance for RHCs. CMS should define "a facility primarily for the care and treatment of mental diseases" as clinic types that provide behavioral health care only, including certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. There is precedent for this approach as RHCs also cannot be "rehabilitation agencies" which is a term that CMS defines elsewhere.[2] This straightforward approach would make the survey process around meeting this requirement easy to implement and cite. So long as the RHC provides primary care services there should be no citation for providing any level of behavioral health care because any RHC providing primary care could not qualify as one of the facilities listed above. **CMS should include this language in subsequent interpretive guidance and in 42 C.F.R. § 491.2** as follows:

> *"Facility for the treatment of mental diseases* means a certified community behavioral health clinic, community mental health center as defined in 42 C.F.R. § 410.2, standalone opioid treatment program as defined in 42 C.F.R. § 8.2 and certified under § 8.11, or a facility that only provides intensive outpatient services as defined in 42 C.F.R. § 410.44."

Thank you for the opportunity to offer comments on this proposed rule and for your consideration of our comments. We urge CMS to consider the changes outlined above in the CY 2025 proposed rule in order to serve our patients to our best ability.

[2] https://www.cms.gov/medicare/health-safety-standards/certification-compliance/outpatient-rehabilitation-providers#:~:text=Rehabilitation%20Agency%20%2D%20An%20agency%20that,a%20team%2C%20specialized%20rehabilitation%20personnel.

If you would like additional information, please contact Shannan Flach at sflach@kha-net.org or Jaron Caffrey at jcaffrey@kha-net.org.

Sincerely,

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