Submitted Electronically

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 8106
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule (CMS-1807-P; RIN 0938-AV33)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the proposed rule for the Calendar Year (CY) 2025 Medicare Physician Fee Schedule, published in the *Federal Register* on July 31, 2024. AMRPA is the national trade association representing nearly 800 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to by Medicare as inpatient rehabilitation facilities (IRFs). In addition to the inpatient physician services provided in IRFs that are covered by the Physician Fee Schedule, AMRPA members also provide rehabilitation services across the continuum of care, including in hospital outpatient departments, physician offices, comprehensive outpatient rehabilitation facilities (CORFs), and therapy clinics. As part of this continuum of care, our members submit claims under Part B of the Medicare program for a variety of services, including physician visits, physical and occupational therapy services, speech-language pathology, and several other elements of care.

IRFs specialize in treating patients with some of the most complex and serious conditions, such as stroke, traumatic brain injury, and spinal cord injury. Continued medical rehabilitation is an essential component of recovery from these types of conditions, and it is important that CMS keep the need for rehabilitation services for complex and vulnerable patients in mind when modernizing the Medicare program.

There are a number of proposals in this year's rule that would impact access to rehabilitation services for patients in need of continued rehabilitation, and we offer comments on those proposals in the following sections in this letter. We also support several of CMS' proposals that promote flexibility in care delivery and minimize administrative burden, and we encourage CMS to finalize such policies without change. Immediately below, we provide a brief summary of our recommendations, prior to our more in-depth discussion of these issues.

Chris Lee · Chair, AMRPA Board of Directors
Vice President & Chief Operations Officer, Madonna Rehabilitation Hospitals
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

Recommendations:

1. **Negative Adjustment to the Conversion Factor:** Once again, physicians, therapists, and other clinicians paid under the Medicare Physician Fee Schedule are facing significant reimbursement cuts in the coming year. CMS should utilize all authorities to minimize and/or mitigate reductions to the conversion factor and work with Congress to ensure long-term solutions to protect patient access to care.
2. **Telehealth Access & Expansion:** CMS should take all necessary steps to prepare for a smooth transition to CY 2025 if Congress acts to extend PHE-era telehealth flexibilities before the end of the year, including developing an Interim Final Rule, education and training materials, and guidance for providers to avoid any temporary disruptions in access.
3. **Proposals for Medicare Telehealth Under Current Legislative Authority:** Within the agency's current authority, CMS should finalize as proposed its policies regarding audio-only telehealth, direct supervision, and provider billing flexibilities for CY 2025.
4. **Caregiver Training Services:** CMS should finalize as proposed the expansion of Caregiver Training Services codes to include training for direct care services and supports.
5. **Burden Reduction for Certification of Therapy Plans of Care:** CMS should finalize its proposal to allow signed orders to serve as physician certification for therapy plans of care and continue to explore avenues to minimize documentation burden for clinicians.

I. Continued Cuts to Provider Reimbursement Threaten Access for Vulnerable Medicare Beneficiaries in Need of Medical Rehabilitation.

As has been the case for the past several years, Medicare providers paid under the Physician Fee Schedule (PFS) continue to face significant disruptions in payment rates and the cumulative impact of annual cuts to the Conversion Factor. These cuts, initially driven primarily by policy changes for physician outpatient evaluation and management (E/M) code valuations, have resulted in a cascading series of reimbursement cuts of nearly 8% since CY 2020. This reduction does not take into account the ongoing impact of inflation, which has resulted in higher costs for physicians and other providers paid under the Fee Schedule without *any* mitigating increases in reimbursement. AMRPA has consistently raised serious concerns about the impact of these payment cuts on patient access to care, particularly for some of the most vulnerable beneficiaries in the Medicare program.

This year, CMS proposes yet another cut to the conversion factor of nearly 3%. The majority of this reduction is legislatively mandated due to the expiration of previously enacted Congressional assistance, and we recognize that CMS' ability to mitigate this reduction is limited given the requirements of budget neutrality. However, AMRPA wishes to reiterate that these cuts are unsustainable for Medicare providers, especially for those involved in critical rehabilitation services, such as rehabilitation physicians, physical and occupational therapists, speech-language pathologists, and others. These types of payment reductions, especially in light of the Fee Schedule rates finalized in previous years and the ongoing economic difficulties faced by health

care providers across specialties, may result in seriously damaging service cuts and patient access issues.

Even as the COVID-19 public health emergency (PHE) has ended, health care providers continue to face unprecedented economic headwinds and enduring ripple effects from the pandemic. Staffing challenges remain formidable, with serious shortages of physicians, therapists, nurses, and other critical roles nationwide. At the same time, salaries for therapists and other providers continue to increase at record pace year-over-year since the pandemic, with no signs of slowing, while Medicare rates are moving in the opposite direction. This has in turn worsened workforce shortages, as clinicians leave the workforce and fewer students enter certain health professions as salaries are unable to offset the cost of post-graduate education. Overall, significant inflationary pressures and rising costs for practice expenses and auxiliary staff, combined with the decreasing Medicare reimbursement, have contributed in part to providers being forced to make tough financial choices that will impact patient care; these will only be exacerbated if CMS finalizes additional cuts in 2025.

AMRPA recognizes that there are multiple proposals being considered by Congress to mitigate decreases in the Physician Fee Schedule going forward, including implementation of an inflationary update based on the Medicare Economic Index, more regular reviews of direct cost inputs, lookback adjustments for utilization assumptions, and reforms to the application of budget neutrality. AMRPA is committed to ensuring that physicians and other providers are subject to a sustainable, long-term pay model that appropriately values the clinical services they provide to Medicare beneficiaries. We urge CMS to work closely with Congress to ensure that any Physician Fee Schedule reform legislation can be implemented in a timely and effective manner. We also urge CMS to use all existing authorities to seek to preserve payment updates to the maximum extent possible in CY 2025.

Recommendation:

- **CMS should exercise all available authorities to avoid harmful reimbursement cuts to critical rehabilitation services and work with Congress to implement long-term sustainable reforms for the Physician Fee Schedule.**

II. CMS Must Take All Necessary Steps to Maintain Robust Access to Telehealth Rehabilitation in CY 2025 and Beyond.

AMRPA continues to appreciate the steps CMS has taken to allow the provision of rehabilitation services, including physical therapy, occupational therapy, and speech language pathology services, to Medicare beneficiaries via telehealth since the expiration of the COVID-19 PHE. During the temporary expansion of telehealth over the past several years, rehabilitation providers have consistently reported that the experience of using telehealth to provide certain types of rehabilitation services has been an important aspect of patient access and has been beneficial for both patients and providers. While the majority of rehabilitation services will continue to be provided in-person, telehealth has become an integral part of rehabilitation medicine, and we

continue to believe that such services should remain a permanent, safe, and appropriate option for Medicare beneficiaries and the providers who serve them.

Currently, the legislative authorities provided to CMS during the PHE to expand the use of telehealth in Medicare are set to expire on Dec. 31, 2024. As such, the CY 2025 proposed rule is written with the expectation that most Medicare telehealth policies will revert to the pre-PHE status quo beginning January 1, 2025. This includes most of the important expansions that providers and beneficiaries have become accustomed to, including the ability for all beneficiaries to receive telehealth regardless of their geographic area of residence, the ability to receive telehealth services in the home, and the authority for non-physician practitioners, including therapists, to provide telehealth. AMRPA believes it is critical that Congress act before the end of the calendar year to extend (or make permanent) these flexibilities to ensure that Medicare beneficiaries can continue to benefit from virtual care when appropriate.

Given CMS' rulemaking timeline and the Congressional calendar, we foresee that if Congress *does* act to extend telehealth authorities for CMS, such action may come after the publication of the Physician Final Rule. In such case, we expect it would be necessary for CMS to issue an interim final rule (IFR) or other stopgap rulemaking in order to implement these policies ahead before 2025. We urge CMS to closely monitor Congressional action and take whatever steps necessary to ensure that the agency can act quickly and decisively if legislation is passed before the end of the calendar year. Providers nationwide are already concerned about the potential expiration of telehealth flexibilities and associated administrative confusion; it is essential that the agency do whatever it can to avoid bureaucratic holdups that could fragment the provision of telehealth if Congressional action does not occur until late 2024. If an interim rule is promulgated, we urge CMS to work closely with interested parties to collect feedback and develop clear and consistent messaging and guidance regarding telehealth policies in 2025 and beyond. Regardless of the status of telehealth into 2025, it is critical that CMS communicate clearly and effectively with providers, and we urge the agency to develop plain language guidance and other materials to ensure that all interested parties have necessary and practical information heading into the new year.

Recommendation:

- **CMS should take all available steps to prepare administratively for potential Congressional expansion of telehealth authorities past their current expiration date.**

III. CMS Should Finalize Proposed Tweaks to Telehealth Policies in Absence of Broader Congressional Authority.

While the agency is limited by the bounds of statutory authority regarding the long-term expansion of telehealth, we appreciate that CMS continues to propose policy changes within current authority to continue to refine and improve the Medicare telehealth program. AMRPA generally supports these proposals as outlined below and encourages the agency to finalize them.

Audio-Only Telehealth
Currently, CMS defines "interactive telecommunications system" for purposes of regulating Medicare telehealth to include, at a minimum, audio *and* video equipment permitting two-way, real-time interactive communication between a patient and a distant site practitioner. During the PHE, CMS allowed the use of audio-only technology to furnish certain services, such as evaluation and management services via telephone, behavioral health counseling, and services related to mental health disorders.

In this year's rule, CMS proposes to modify the definition of interactive telecommunications system in order to allow the use of interactive, audio-only technology, when a service is furnished to a beneficiary in their home. The new definition would also require that the distant site practitioner be technically capable of real-time, audio-visual communication, but the *patient* is not capable of, or does not consent to, the use of video technology.

AMRPA supports the finalization of this policy as proposed. Based on reports from our member hospitals and their affiliated outpatient departments and clinics, the regular use of audio-only telehealth for rehabilitation services is limited; however, for those beneficiaries with a need for audio-only telehealth (especially those located in rural areas or with limited broadband access), we believe it is important that CMS provide sufficient flexibility to allow these patients to still receive virtual care, even without a video component.

Telehealth Supervision Policies
CMS currently requires certain services to be furnished under minimum levels of supervision by a physician or other practitioner. "Direct Supervision" currently requires the supervising practitioner to be "immediately available" to furnish assistance throughout the service, though it does not require the supervisor to be present in the room where the service is performed. CMS has typically interpreted this requirement to mean in-person, physical availability (i.e., not virtual). During the PHE and through the end of CY 2024, CMS has temporarily allowed the direct supervision requirement to be fulfilled by a supervisor's virtual presence, using two-way, real-time, audio/visual technology. CMS now proposes to extend this flexibility through CY 2025, though the agency notes concerns regarding patient safety and quality of care.

We believe that this flexibility is appropriate for 2025, though we appreciate the agency's continued attention to quality and patient safety concerns.

Provider Billing Flexibility
CMS currently maintains a temporary flexibility for telehealth practitioners to bill using their currently enrolled location (i.e., their hospital or office location), rather than reporting their home address on Medicare bills when providing telehealth services from the provider's home. Stakeholders have urged CMS to extend this flexibility or make it permanent to ensure that practitioners' privacy and safety are protected. CMS now proposes to continue this flexibility through CY 2025 while CMS "considers various proposals" to protect telehealth practitioners.

AMRPA supports the extension of this flexibility and encourages CMS to make this permanent. If telehealth remains a permanent part of the Medicare program, providers will continue to offer

telehealth services from their homes when appropriate, which supports access to care while decreasing burden on providers (such as, for example, by allowing providers flexibility to offer follow-up or care coordination visits outside of normal office hours more easily). When availing themselves of this flexibility, providers should not be required to publicize their home address. We believe continuing to report the currently enrolled Medicare location on bills and other documentation is an appropriate balance to ensure providers' privacy and security.

Recommendation:

- **CMS should finalize its proposal to include audio-only communications in the definition of interactive telecommunications system.**
- **CMS should finalize its proposal to allow direct supervision via real-time, audio/visual telehealth in 2025.**
- **CMS should finalize its proposal to allow providers to bill their currently enrolled Medicare location when providing telehealth services from the home.**

IV. Expansion of Caregiver Training Services Code Set Will Recognize Important Pre- and Post-Discharge Services Provided by Rehabilitation Clinicians.

In the CY 2024 final rule, CMS finalized new codes for caregiver training services (CTS) and allowed Medicare reimbursement for these services. These codes are intended to allow treating practitioners to report and receive payment for training furnished to a beneficiary's caregiver(s) specifically to assist the patient in carrying out the treatment plan. These services are furnished without the patient's presence, and currently require the patient's consent for the caregiver to receive the training, documented in the medical record. Practitioners who frequently practice in IRFs, including physicians and physical or occupational therapists, can provide these services, and they can also be provided in an outpatient setting.

Now, CMS proposes to implement additional CTS codes specifically for "direct care services and supports." These could cover topics such as (but not limited to), techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control. CMS notes that this type of training would focus on providing the caregiver with specific clinical skills, rather than strategies or techniques to facilitate functional performance in the home or community (the currently covered CTS codes). CMS proposes that the existing CTS codes, as well as the new CTS codes if finalized, would also be added to the Medicare Telehealth Services List with a provisional status for CY 2025.

AMRPA supports the proposal to implement new CTS codes for direct care services. Our members report that much of this training for caregivers is already taking place in rehabilitation settings, especially as patients prepare for discharge from an inpatient rehabilitation hospital and within follow-up visits post-discharge. Allowing providers, including non-physician practitioners, to record and bill for these services will help appropriately capture reimbursement for services provided and support necessary education for caregivers. If deployed in the correct circumstances, we believe such caregiver training can help decrease readmissions and result in

higher quality outcomes for patients. We also agree with CMS' proposal to allow CTS codes to be billed via telehealth when clinically appropriate.

Additionally, we encourage CMS to continue developing new education and training tools for providers to increase awareness and understanding of the new and existing CTS codes and the appropriate clinical circumstances in which to bill them. While we recognize these codes have only been available for CY 2024, reports from the field indicate there has not been widespread uptake of these codes in rehabilitation settings. We also encourage CMS to report on utilization trends in future years' rulemaking as additional data is collected.

Recommendation:

- **CMS should finalize its proposal to establish new coding and payment for caregiver training for direct care services and supports in CY 2025.**

V. CMS Should Finalize Its Proposal to Reduce Unnecessary Administrative Burden on Therapists and Physicians.

Currently, Medicare payment for *outpatient* therapy services can only be made if a physician certifies that the services are required, that the services are furnished while the individual is under the care of a physician, and that a plan for furnishing such services was established by a physician or qualified therapist. A physician, nurse practitioner, physician assistant, or clinical nurse specialist with knowledge of the case must sign the initial plan of care with a dated signature or verbal order within 30 days from the first day of treatment, and recertification is required at least every 90 days.

Now, CMS proposes that a signed and dated order or referral from a physician or non-physician practitioner for therapy services, combined with documentation of such order or referral in the medical record and "further evidence" that the therapy plan of treatment was transmitted to the appropriate clinician, will be considered sufficient to demonstration the required certification of these conditions (i.e., treated as equivalent to a dated signature on the plan of treatment).

AMRPA strongly supports this proposal, which will significantly reduce administrative burden on therapists, physicians, and auxiliary staff. As CMS recognizes in the proposed rule, this requirement has long been an unnecessarily time-consuming and resource-intensive hurdle for therapists, which burdens not only the therapists who must dedicate time to tracking down physician signatures, but also those physicians and their office staff who must then field constant outreach from therapists seeking necessary signatures. In fact, one AMRPA member reported sending out an average of more than 700 plans of care for signature per month, but only getting 50-60 back with signatures without additional efforts. By instituting this common-sense proposal, CMS can make a meaningful impact on clinician burden without jeopardizing quality of care. We urge CMS to consider avenues to build on this proposed reform, including removing the signature requirement on recertifications of plans of care, in future years' rulemaking.

AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Recommendation:

- **CMS should finalize its proposal to remove the signature requirement on therapy plans of care, when there is a signed and dated order from a physician.**

***

AMRPA appreciates CMS' attention to our comments and the agency's efforts to engage stakeholders as it continues to modernize the Physician Fee Schedule. AMRPA and our members remain committed to working with CMS to create a more patient-centered Medicare program. If you have any questions regarding our comments, please contact Joe Nahra, AMRPA Director of Government Relations and Regulatory Policy at (202) 207-1123 or by email at jnahra@amrpa.org.

Sincerely,

Chris Lee
Chair, AMRPA Board of Directors
Vice President and Chief Operations Officer – Madonna Rehabilitation Hospitals

Sandeep Singh, MD
Chair, AMRPA Physician Advisory Committee
Chief Medical Officer and Senior Vice President of Medical Affairs
Good Shepherd Rehabilitation Hospital

John Rockwood
Chair, AMRPA Outpatient and Therapies Committee
President, MedStar National Rehabilitation Network
Senior Vice President, MedStar Health