September 9, 2024

ELECTRONIC SUBMISSION VIA www.regulations.gov

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

RE: CPR Comments in Response to the Contract Year 2025 Medicare Physician Fee Schedule Proposed Rule (CMS-1807-P; RIN: 0938-AV33)

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to submit comment to the Centers for Medicare and Medicaid Services ("CMS") in response to the Calendar Year ("CY") 2025 Medicare Physician Fee Schedule Proposed Rule ("Proposed Rule"). We offer our recommendations and comments below regarding various provisions in the proposed rule impacting beneficiaries in need of medical rehabilitation care.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the providers who serve them – who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

Overview

In the Proposed Rule, CMS offers numerous proposals impacting provider payment under Medicare. CPR focuses here on two specific provisions in the rule. First, we offer comments on the impact of the annual cuts to the conversion factor for the Fee Schedule, on top of additional structural cuts that will materially impact physician and therapist reimbursement and, thereby, potentially impact patient access to care. The second area we focus on in our comments relates to the treatment of telehealth and telerehabilitation going forward as the federal government considers how to maintain access to these services in a post-pandemic world.

CY 2025 Conversion Factor Impact on Access to Care

As in recent years, CMS again proposes a significant decrease in the conversion factor used to calculate Fee Schedule rates, which will have a major impact on providers across the Medicare program, primarily physicians and rehabilitation therapists. Due to the budget neutrality requirement imposed on the Fee Schedule and the expiration of the statutory increase in PFS payments for 2024, CMS proposes to decrease the overall conversion factor by approximately 2.8%. Compounded by years of substandard inflationary increases to the fee schedule, this most recent decrease presents a significant risk that patient access to care may be negatively impacted.

Traditionally, CPR does not comment directly on provider reimbursement issues. However, as in recent years, the proposed reductions to the conversion factor and resulting estimated cuts to reimbursement across many physician specialties and rehabilitation therapists have the potential to severely impact patient access to care. Therefore, we urge CMS to work with Congress and stakeholders to mitigate or eliminate the impact of these cuts in order to ensure that patients are able to access the medically necessary care they need in the most appropriate settings.

As outlined above, CMS proposes to reduce the Medicare conversion factor by 2.8% in 2025, resulting in decreased fee schedule amounts for services across the board. Providers of rehabilitation care are already facing serious financial strain. Of course, the long-term and residual impact from the COVID-19 pandemic has significantly impacted the financial health of many providers. Further, the Medicare program continues to face a 2% cut in payments due to the impact of sequestration, which came back into full effect beginning July 1, 2022, and will continue until further notice. Without additional Congressional action, there will also be a further 4% cut beginning January 1, 2025, relating to the Statutory Pay-As-You-Go Act (PAYGO). PAYGO cuts were waived for two years under the Consolidated Appropriations Act of 2023, and Congress must act before the end of the year to address this additional significant cut for 2025.

Finally, as we have stated in previous regulatory comments, changes in the payment models for many areas of post-acute care, including the Patient-Driven Groupings Model ("PDGM") and the Patient-Driven Payment Model ("PDPM") in the Medicare home health agency ("HHA") and skilled nursing facility ("SNF") prospective payment systems, respectively, continue to result in decreased access to rehabilitation therapies for patients.

CPR believes that implementation of the proposed cuts to provider payment, along with the expected impact of other non-PFS payment cuts, will decrease patients' access to care. This financial pressure may cause practitioners to close or limit their practices if the full slate of reductions is implemented, limiting patient choice and provider capacity. Patients in rural and underserved areas may be most at-risk if these cuts are finalized, as many of these patients already face barriers in accessing rehabilitation care. In addition, the cuts are likely to have ripple effects beyond the Medicare program, as many private payers and other federal health care programs link their reimbursement rates to Medicare payment levels or discount their rates off the Medicare Fee Schedule.

We therefore urge CMS to use all authorities available to the agency and to work with Congress to ensure that patients are not adversely affected by the proposed reimbursement

cuts and to protect the viability of rehabilitation providers in 2025 and beyond. We also continue to encourage CMS to work with stakeholders and policymakers to identify and implement longer-term "fixes" to this now-annual problem, rather than relying on temporary solutions each year to avoid drastic payment reductions.

Telehealth Proposals under the Physician Fee Schedule

CPR and its member organizations continue to appreciate that the expansion of telehealth has allowed many Medicare beneficiaries to more safely and easily access medically necessary health care, not only by limiting the threat of infection from COVID-19, which was the original intent behind the initial expansion, but also by avoiding numerous other complications and difficulties that have always been associated with in-person medical care. For example, many beneficiaries with mobility impairments have seen tremendous benefit from their ability to receive virtual evaluations and other services, given the complications associated with planning, transportation, and accessibility of in-person visits. Mobility impairments themselves limit physical access to in-person visits to health care providers. Telehealth can dramatically ease the burden of mobility impairment while preserving access to care.

Similarly, many patients in need of cognitive and psychological rehabilitation services have found that virtual services may be more accessible and even potentially more effective, with the potential to cut down on distractions associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continuing access to therapy and other important services, with telehealth visits occurring between intermittent in-person visits in order to maintain the level of care available to the patient. This is particularly effective for the disability and the rural Medicare populations.

Access to telehealth services will continue to provide these benefits which are particularly valuable for beneficiaries with disabilities and others with illnesses and injuries who are in need of rehabilitation. We therefore support increased access to care through the expanded use of telehealth and telerehabilitation to ensure that patients are able to benefit from advances in technology that make virtual care possible.

However, as we have noted in previous comments, it is critical that expansion of telehealth services does not come at the expense of in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

New regulations expanding telehealth must ensure that telehealth is utilized only when clinically appropriate and that beneficiaries who need in-person care do not face additional barriers to access in-person care as a result of telehealth adoption. When either virtual or in-person care is considered to be equivalently appropriate for the patient's clinical needs, Medicare regulations must not promote one over the other, and providers should be prohibited from limiting beneficiaries with disabilities to virtual visits because they cannot or do not wish to

accommodate their disability in the context of an in-person visit. At the same time, Medicare payment policies should not set reimbursement rates for telehealth so low that access to virtual care is significantly limited as well. The decision between virtual and in-person care should be made by the patient and their provider, and both options should be equally available for all Medicare beneficiaries with or without disabilities, including those who need communication or other accommodations to receive equally effective healthcare in person or via telehealth.

We encourage CMS to continue to work under the agency's current authority and with Congress to ensure that patient-centered telehealth is available long-term to as many patients as possible, in as many appropriate forms as possible, while ensuring that telehealth adds to existing forms of available care without replacing or supplanting in-person treatment options.

Dental and Oral Health Services

CPR fully supports CMS' proposal to expand access to dental and oral health services under the Medicare program. Specifically, CMS is proposing to add to the list of clinical scenarios under which traditional Medicare payment may be made for dental services inextricably linked to covered services to include: (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease ("ESRD"); and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with ESRD. Access to dental and oral health services is critically important, especially for Medicare beneficiaries needing weekly dialysis services to treat ESRD. ESRD is a life-threatening condition that impacts nearly 800,000 individuals living in the United States.

For individuals with ESRD who require life-sustaining dialysis services and lifesaving kidney transplantation, dental infections can be potentially devastating and lead to unnecessary delay or even prevent patients from receiving a lifesaving kidney transplant. Accordingly, CPR commends CMS for addressing this issue in the proposed rule, and we encourage CMS to finalize this proposal without modification in the final rule.

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We greatly appreciate your consideration of our comments on the CY 2025 Physician Fee Schedule Proposed Rule. Should you have any further questions regarding this information, please contact Peter Thomas and Michael Barnett, CPR co-coordinators, by e-mailing Peter.Thomas@PowersLaw.com and Michael.Barnett@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ADVION (formerly National Association for the Support of Long Term Care)
Allies for Independence
ALS Association

American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Music Therapy Association
American Physical Therapy Association
American Spinal Injury Association (ASIA)
American Therapeutic Recreation Association
Association of Academic Physiatrists
Brain Injury Association of America*
Christopher and Dana Reeve Foundation*
Disability Rights Education and Defense Fund (DREDF)
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics
National Association of Rehabilitation Providers and Agencies
RESNA
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

**** Indicates CPR Steering Committee Member***