Illinois Health and Hospital Association

September 4, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: CY 2025 Medicare Physician Fee Schedule Proposed Rule (CMS-1807-P)

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) values the opportunity to comment on the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) proposed rule. IHA appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts in developing this proposed rule, particularly provisions related to the extension of certain telehealth-related waivers enacted during the COVID-19 public health emergency (PHE), expansion and integration of behavioral healthcare services, and continued commitment to the development of payment mechanisms that support health equity.

Telehealth Services

IHA strongly supports the proposed flexibility allowing interactive audio-only telecommunications technology when any telehealth service is furnished to a beneficiary in their home and when the patient is not capable of, or does not consent to, the use of video technology. We support similar telehealth flexibilities for opioid use disorder treatment services, including furnishing periodic assessments via audio-only telecommunications. This permission will improve access to care for patients in areas with weaker broadband penetration rates. Broadband penetration rates can be considerably lower in rural counties, where access to primary and behavioral healthcare is limited.

IHA supports CMS' proposed continuation of several permissions established during the COVID-19 PHE, including authorization for distant site practitioners to use their currently enrolled practice address on the CMS 1500 form instead of their home address through CY 2025 when providing telehealth services from their home. This continued permission is critical for practitioners' privacy and safety. We also support CMS' continued suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services for CY 2025.

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Claims data suggests that less than 5% of beneficiaries received one or more of these services as a telehealth service. Additionally, lifting the restriction has not led to an increase in utilization that would indicate telehealth services have supplemented, rather than supplanted, in-person services. Given this data, we urge CMS to consider permanently lifting these limitations and permit practitioner discretion regarding the appropriateness of telehealth services based on patient acuity and complexity.

To address rapidly changing workforce needs, we support CMS' continued permission for specified practitioners to provide virtual direct supervision to auxiliary personnel, when required. Similarly, CMS' continued allowance of virtual supervision by teaching physicians for services provided by residents in teaching settings will create needed flexibility for the healthcare workforce. We also encourage CMS to consider modifying the primary care exception to include additional preventive services and higher level evaluation and management (E/M) services, improve patient continuity of care, increase utilization of high-value services and support primary care resident workforce development.

Behavioral Health Services

IHA strongly supports the establishment of separate coding and payment describing safety planning interventions for patients in crisis, including those with suicidal ideation, at risk of suicide, or at risk of overdose. We also support creating new G-codes to facilitate interprofessional consultations by practitioners currently limited by statute to services for the diagnosis and treatment of mental illness, including Clinical Psychologists, Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors. This expansion of services would improve behavioral healthcare integration into primary care.

Lastly, we support CMS' consideration of coverage and payment for community-based crisis stabilization units, Certified Community Behavioral Health Clinics, and other alternative settings to emergency departments, with necessary licensed and certified practitioners. In recent years, Illinois Medicaid has begun covering these settings to increase access to behavioral healthcare and divert crisis and non-emergent care from hospital emergency departments, when appropriate. Medicare coverage in these settings is critical to advance equity in access to healthcare services, and also works toward the long-standing goal in healthcare delivery to ensure patients receive the right treatment, at the right time, and in the right place.

Health Equity

IHA fully supports and appreciates CMS' continued commitment to the development of payment mechanisms under the PFS to improve the accuracy of valuation and payment for services furnished by physicians and other healthcare practitioners, especially in the context of evolving models of care and addressing unmet social needs that affect the diagnosis and treatment of medical problems. We agree that social risk factors influence both diagnosis and treatment of medical conditions and add additional complexity for providers delivering care. In this context, we support CMS' focus on receiving additional feedback from community partners

providing services, and agree that payment policies such as the Health Equity Adjustment not only align with ongoing activity by CMS, but continue to support the role CMS wants providers to play in addressing whole-person health.

Ms. Brooks-LaSure, thank you again for the opportunity to comment on this proposed rule. Please direct questions or comments to Lia Daniels, Senior Director, Health Policy and Finance, at 630-276-5461 or ldaniels@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association