September 3, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

Re: 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

Dear Administrator Brooks-LaSure:

On behalf of the American Society of Echocardiography (ASE), the Society for Cardiovascular Ultrasound Professionals™, we thank you for the opportunity to comment on the CY 2025 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1807-P). ASE is the largest global organization for cardiovascular ultrasound imaging serving physicians, sonographers, nurses, veterinarians, and scientists and as such is the leader and advocate, setting practice standards and guidelines for the field. Since 1975, the Society has been committed to advancing cardiovascular ultrasound to improve lives.

In this capacity as the voice for the cardiovascular ultrasound professionals and patients, we recommend herein that CMS revise its proposed rules on the following:

- Medicare Conversion Factor
- Updates to Practice Expense Data Collection and Methodology
- Expiration of Telehealth Flexibilities
- Office/Outpatient (O/O) E/M Visit Complexity Add-on Code

Medicare Conversion Factor
For Calendar Year 2025, the Conversion Factor is set to decrease by 2.8%, marking the fifth consecutive year of reductions. This cut is primarily due to two factors: (1) the expiration of a temporary 2.93% update to the Conversion Factor at the end of 2024; and (2) a scheduled 0% baseline update for 2025 under the Medicare Access and CHIP Reauthorization Act.

ASE acknowledges that increasing the Conversion Factor will require Congressional action. Therefore, ASE urges the Agency to collaborate with Congress to offset the current decrease planned for FY 2025 and develop a more sustainable solution that allows for inflationary updates. ASE is calling upon both Congress and CMS to ensure predictability and stability in physician payments and mitigate the financial impacts of significant fluctuations in relative weights that may accompany updates. The current Physician Fee Schedule lacks a predictable inflationary update. In contrast, CMS has finalized sizeable increases in most other Medicare CY 2025 payment rates [inpatient hospitals

(2.9%); inpatient rehabilitation facilities (3.0%); hospice (2.9%); Medicare Advantage plans (3.7%)]. Continuing to decrease the Conversion Factor perpetuates the widening gap in reimbursement between healthcare facilities (both inpatient and outpatient) and the physicians/qualified healthcare professionals who diagnose, treat, and manage Medicare beneficiaries' care. The current Medicare Fee Schedule reimbursement system has become unsustainable for echocardiographers and other specialists treating complex Medicare patients. The failure to account for rising practice costs continues to impact the sustainability of private medical practices. To wit: in 2008 only 10% of cardiologists were employed by a hospital or health system, whereas by 2022, this proportion had risen to 90%.[1] The divergent approach to funding the delivery of health care services needs to be addressed to ensure fair compensation for those directly responsible for patient care.

To address this and maintain patient access to care, the ASE proposes an annual inflation adjustment to the conversion factor based on the Medicare Economic Index (MEI) so that practices may keep pace with increasing healthcare costs and evolving medical needs. In the final CY 2024 Physician Fee Schedule, MEI was listed as "the best measure available of the relative weights of the three components in payments under the PFS—work, practice expense (PE), and malpractice (MP)."[2] ASE urges CMS to work with Congress to implement this adjustment, which would ease downward pressure on reimbursements and better reflect the true costs of providing high-quality care.

Updates to Practice Expense Data Collection and Methodology
ASE appreciates CMS's decision to continue delaying the implementation of the 2017-based MEI cost weights, pending the results of the AMA's Physician Practice Information (PPI) Survey. The Society recognizes this delay as a response to advocacy efforts promoting the use of physician practice cost survey data in determining MEI cost weights.

The Society commends the AMA's work on the PPI Survey, a multi-year initiative to measure physician practice costs and direct patient care hours. ASE has actively supported these efforts over the past year by promoting the survey through electronic newsletters, sending standalone emails, displaying slides during Society meetings, and featuring a pop-up announcement on our website. ASE strongly recommends that CMS utilize the results of this survey before updating the practice expense.

Regarding CMS's proposal to contract with the RAND Corporation to analyze and develop alternative methods for measuring practice expense inputs for PFS payment updates, ASE has no major concerns. However, the Society encourages CMS to continue exploring other alternatives, such as analyzing updated PPI data from the AMA PPI Survey, which is scheduled to conclude this summer; and reviewing the survey results, which will be shared with CMS in early 2025. ASE believes considering multiple data sources and methodologies will lead to the most accurate and fair practice expense calculations.

Finally, in response to your request for comments on the frequency of updates to direct PE inputs, we would like to remind the agency that the budget neutrality of the PFS often results in unexpected

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[1] Joynt Maddox, Karen E. "Health Economics of Cardiovascular Disease in the United States." *Circulation*, vol. 150, no. 6, 6 Aug. 2024, pp. 419–421, https://doi.org/10.1161/circulationaha.124.068295.
[2] 88 FR 78818

impacts when new or revised data are introduced. Our continued shared goal is to ensure that updates track inflation, are manageable and predictable for medical practices, thereby reducing the risk of negative financial and operational impacts. Therefore, establishing a consistent, transparent, and regular process for updating direct PE inputs will be highly beneficial. Additionally, improving transparency in both short- and long-term plans for data updates is crucial to prevent medical practices from being caught off guard.

Expiration of Telehealth Flexibilities
In the proposed rule, CMS highlighted that Section 4113(e) of Division FF, Title IV, Subtitle C of the CAA, 2023, amends Section 1834(m)(9) of the Act to mandate that the Secretary continue coverage and payment for telehealth services delivered via an audio-only communication system from the day after the end of the public health emergency through December 31, 2024.

These flexibilities allowed for broader access to telehealth services, including the use of audio-only communication, expansion of eligible telehealth providers, and the ability to deliver services to patients in their homes, regardless of geographic location. The expiration of these flexibilities could significantly impact access to care, particularly for vulnerable populations such as rural residents, seniors, and those with limited access to technology. The end of these provisions raises concerns about potential disruptions in care continuity, the reintroduction of barriers to telehealth services, and the potential widening of healthcare disparities. As the healthcare system transitions out of the pandemic, it is crucial to carefully consider which of these flexibilities should be made permanent to ensure equitable access to care for all patients including the vital role in ensuring essential specialist care.

In echocardiography, telemedicine is used in for fetal imaging in common scenarios. Pregnant people can experience several barriers that impact their ability to attend their visits in person such as distance, transportation, financial limitation, etc. The most common barrier that makes it not advisable to travel is because of medical issues that may arise within the pregnancy (e.g. rupture of membranes, preterm labor). These conditions make it unsafe for the patient to travel to a pediatric hospital for a scan and consult. Instead, it's more common and advisable for patients to be seen locally with their primary cardiologist for their scan, and use telemedicine for additional expertise and counsel, rather than need to be seen with the planned surgical center which at times can be hundreds of miles (even states) away.

We appreciate CMS's commitment to maintaining continuity in telemedicine coding and coverage and strongly encourage collaboration with Congress to carefully consider the broader implications of future policy changes on both healthcare practices and patients.

Office/Outpatient E/M Visit Complexity Add-on Code
ASE welcomes CMS's proposed policy revision to allow payment for the office/outpatient (O/O) evaluation and management (E/M) visit complexity add-on code G2211. This code would be payable when the same practitioner reports the O/O E/M base code on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service provided in the office or outpatient setting.

This change will particularly benefit cardiologists who use CPT Modifier -25 when seeing patients on the same day they perform an echocardiogram or other cardiovascular imaging procedure. In line with guideline-directed care, cardiologists often need to see patients who require echocardiograms prior to their visit (such as those with severe aortic insufficiency[3]). To save patients from traveling and scheduling appointments on two separate days, specialists frequently have chronically managed patients undergo an echocardiogram and then see them for a visit on the same day. For these cases, the reversal of CMS's previous policy would be advantageous, streamlining care delivery and reducing patient burden.

Conclusion
Thank you for the opportunity to comment on the CY 2025 Physician Fee Schedule Proposed Rule and issues concerning echocardiography. We appreciate the ongoing dialogue concerning these important issues, as well as CMS' significant effort in the proposed rule. If you have any questions about our request or if we may provide any additional information, please contact Katherine Stark, ASE Director of Advocacy, at kstark@asecho.org.

Sincerely

Theodore Abraham, MD, FASE
President, American Society of Echocardiography

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[3] Zoghbi, William A., et al. "Recommendations for noninvasive evaluation of native valvular regurgitation." *Journal of the American Society of Echocardiography*, vol. 30, no. 4, Apr. 2017, pp. 303–371, https://doi.org/10.1016/j.echo.2017.01.007.