September 2, 2022

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

Re: 2023 Physician Fee Schedule Proposed Rule – Docket No. CMS-2022-0113

Dear Administrator Brooks-LaSure:

Aimed Alliance is a 501(c)(3) not-for-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. We appreciate the opportunity to comment on Docket CMS-2022-0113, the *2023 Medicare Physician Fee Schedule Proposed Rule*. We support:

(1) Applying a balanced approach to maintaining access to telehealth services;
(2) Ensuring physicians are not disincentivized to take on Medicare patients due to lower physician reimbursement rates; and
(3) Continuing access to vaccines through at-home COVID-19 vaccination programs.

I. Coverage of Telehealth Services

Aimed Alliance supports maintaining expanded access to, and coverage of, telehealth services. However, we urge the Center for Medicare and Medicaid Services (CMS) to take a balanced approach to increasing access and coverage by ensuring that health care services provided through telehealth are high quality, effective, safe for patients, and medically appropriate.

First, the proposed rule restates the criteria CMS considers in clinically assessing whether to temporarily add telehealth services on a Category 3 basis. Specifically, in determining whether such services have a reasonable potential likelihood of clinical benefit when furnished via telehealth, CMS considers (1) whether outside of a public health emergency (PHE) there are concerns for patient safety if the service is furnished via telehealth; (2) concerns for whether provision of services via telehealth is likely to jeopardize quality of care; and (3) whether all elements of the services could fully and effectively be performed by a remotely located clinician through an audio-visual appointment.

While Aimed Alliance generally supports the methodological approach for adding services on a Category 3 basis, we are concerned that there is not currently a mechanism to collect this type of data. During the first year of the COVID-19 pandemic, approximately 2.1 million Medicaid services were delivered via telehealth.[1] However, there was limited data tracking on the quality of services received via telehealth during that time. Therefore, CMS should track data

[1] U.S. Government Accountability Office, *Medicaid: CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care,* (Mar. 31, 2022), https://www.gao.gov/products/gao-22-104700.

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on the quality of telehealth services to ensure telehealth visits provide consumers with substantially similar quality of care as in-person visits, and to ensure there is sufficient data to determine when a service has met the criteria to be added on a Category 3 basis.

Moreover, while Aimed Alliance supports implementation of regulatory flexibilities to increase access to telehealth services, such as expanding the scope of originating sites and permitting the use of audio-only communications, CMS should ensure that patients are not improperly incentivized to favor telehealth over in-person visits, and vice-versa. While telehealth can be beneficial for connecting rural communities with specialists who otherwise would be unavailable to patients in these communities, telehealth also has its limitations.[2] For instance, providers have a limited ability to conduct thorough physical exams and tests on their patients during a telehealth visit, thereby potentially limiting the scope of the appointment in certain cases.[3] Additionally, some individuals may have limited digital literacy skills and experience difficulty in using a telehealth portal systems. This can impair the overall quality of the visit if the patient and provider are unable to troubleshoot and resolve technological difficulties quickly or easily.[4] Therefore, CMS should ensure that if either the patient or provider determine they are uncomfortable proceeding with a telehealth visit, they should have the option to do an in-person visit with the same cost-sharing and reimbursement rates.

Lastly, Aimed Alliance supports pausing the in-person requirement for Rural Health Clinics and Federally Qualified Health Centers for 152 days after the end of the PHE for mental health visits. Doing so will ensure that consumers and caregivers have time to plan how they will attend an in-person visit, including arranging for childcare or transportation and meeting other logistical challenges.

II. Decreasing PDF Conversion Factor

Aimed Alliance urges CMS to consider how the proposed decrease to the conversion factor for FY 2023 could impact access to care for Medicare recipients by potentially decreasing the number of Medicare-participating physicians.[5] Many health care providers were negatively impacted financially during the early years of the pandemic and are still recovering. During the first year of the COVID-19 pandemic, physicians reported experiencing an average drop in revenue of 32 percent, with specialty providers being particularly impacted.[6] The financial strain was made worse by growing expenses, as providers incurred higher costs for personal protective

[2] Rural Health Information Hub, *Telehealth Use in Rural Healthcare,* https://www.ruralhealthinfo.org/topics/telehealth .
[3] Aimed Alliance, *Telehealth in a Post-Pandemic World: Preserving Gains and Ensuring Access to In-Person Care,* (2021), https://aimedalliance.org/wp-content/uploads/2021/09/Telehealth-Executive-Summary-FINAL-9.13.21.pdf.
[4] Austin J. Triana, Roman E. Gusdorf, Kaustav p. Shah, and Sara N. Horst, *Technology Literacy as a Barrier to Telehealth During COVID-19* (Sept. 10, 2020), https://www.liebertpub.com/doi/10.1089/TMJ.2020.0155.
[5] Andis Robeznieks, *Across-the-board Medicare physician pay cuts are wrong way forward,* https://www.ama-assn.org/practice-management/medicare-medicaid/across-board-medicare-physician-pay-cuts-are-wrong-way
[6] American Medical Association, *COVID-19 financial impact on physician practices,* https://www.ama-assn.org/practice-management/sustainability/covid-19-financial-impact-physician-practices.

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equipment (PPE) to protect staff and patients from the spread of COVID-19.[7] In response to the negative financial impacts on health care providers, CMS increased the reimbursement rate by 3 percent for the CY 2022 Physician Fee Schedule as required by the Protecting Medicare and American Farmers From Sequester Cuts Act. However, the proposed rule would revoke this additional financial support for health care providers, as required by statute. While the national COVID-19 pandemic response has slowed, many providers' pandemic-related costs have not completely decreased. They may still be purchasing large amounts of PPE and may now be seeing many patients who deferred care in 2020 and 2021.[8]

In addition to financial burdens, providers are also experiencing high rates of burnout. One survey from April 2021 found that 71 percent of primary care physicians experienced high-levels of burnout from responding to the COVID-19 pandemic.[9] Another report found that 44 percent of providers were also leaving practices.[10]

Health care providers are already in a difficult position and may simply choose to stop taking Medicare patients in lieu of higher reimbursements from privately insured patients. For instance, one study found that where Medicaid reimbursement rates were similar to Medicare reimbursements, providers were more likely to care for Medicaid patients.[11] Similarly, when providers are faced with taking a Medicare patient over a privately insured patient with higher reimbursement rates, they may be more likely to take the patient with the higher reimbursement rate than the patient with the lower Medicare rate. In addition, Medicare patients also have higher administrative expenditures per capita compared to those on other types of insurance.[12] Thus, it may be easier and more cost-effective for some providers to simply remove Medicare enrollees from their patient rosters.

In conclusion, maintaining the CY 2022 reimbursement rate for CY 2023 may help support providers' efforts to recover from the financial toll of the pandemic response; ensure clinics are able to properly rehire staff at their offices to meet the needs of their patients, and ensure providers continue to provide services for Medicare patients. Therefore, Aimed Alliance encourages CMS to consider how lower reimbursement rates for CY 2023 could impact patient

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[7] PWC, *Medial cost trend: Behind the numbers 2022*, https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html .
[8] PWC, *Medial cost trend: Behind the numbers 2022*, https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html .
[9] Commonwealth Fund, *How Primary Care Is Faring Two Years into the COVID-19 Pandemic*, (Feb. 23, 2022), https://www.commonwealthfund.org/blog/2022/how-primary-care-faring-two-years-covid-19-pandemic.
[10] Commonwealth Fund, *How Primary Care Is Faring Two Years into the COVID-19 Pandemic*, (Feb. 23, 2022), https://www.commonwealthfund.org/blog/2022/how-primary-care-faring-two-years-covid-19-pandemic.
[11] Les Masterson, *Medicaid reimbursement, not expansion status, affects doctors' acceptance of new patients,* https://www.healthcaredive.com/news/medicaid-reimbursement-not-expansion-status-affects-doctors-acceptance-o/552476/ .
[12] Emily Gee, *Excess Administrative Costs Burden the U.S. Health Care System,* https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/#:~:text=However%2C%20Medicare's%20per%20capita%20administrative,in%20other%20forms%20of%20insurance.&text=Even%20if%20one%20compares%20higher,and%20private%20coverage%20is%20large.

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access to care, and to develop alternatives to financially support providers treating Medicare enrollees.

III. Preventive Vaccine Administration Services

Aimed Alliance supports continuing to fund the at-home COVID-19 vaccination program during CY 2023. In 2020, the growth rate of homebound older adults doubled, with the population growing to an estimated 4.2 million homebound adults in the United States.[13] Individuals who are homebound include individuals who need a caregiver or medical equipment such as crutches, a walker, or wheel chair to leave their home, or those who are unable to leave home because their health care provider believes their condition or illness could worsen if they did.[14]

Homebound individuals may also have a higher risk of experiencing health complications related to COVID-19. As such, it is essential that health care professionals can visit homebound patients to administer COVID-19 vaccinations and boosters. Therefore, Aimed Alliance supports CMS continuing to fund the at-home COVID-19 vaccination program to protect vulnerable homebound patients from the virus and its variants.

IV. Conclusion

In conclusion, Aimed Alliance supports expanding access to telehealth services, but encourages CMS to continue using a balanced approach by expanding access to telehealth while also focusing on quality of care. Furthermore, we urge CMS to reconsider how it can support health care providers who are still recovering from the financial strain brought on by the pandemic, and we applaud the agency for recognizing the importance of the at-home vaccination program.

Sincerely,

Ashira Vantrees
Counsel

[13] Mackenzie Bean, *Number of homebound, older adult in US doubled in 2020, study finds* (Aug. 23, 2021), https://www.beckershospitalreview.com/post-acute/number-of-homebound-older-adults-in-us-doubled-in-2020-study-finds.html .
[14] CDC, Vaccinating Homebound Persons, https://www.cdc.gov/vaccines/covid-19/clinical-considerations/homebound-persons.html .

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