Submitted electronically via [CMS Request for Information: Make Your Voice Heard (force.com)]

November 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attention:
CMS-1770-P Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information: Promote Efficiency, Reduce Burden, and Advance Equity within CMS programs

The AAMC (Association of American Medical Colleges) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) *request for information: Make Your Voices Heard.* The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

We appreciate CMS's commitment to engaging with partners, communities, and individuals across the health system to understand their experiences with CMS payment policies and quality programs and how they impact the experience of healthcare. The AAMC also appreciates the waivers and flexibilities CMS provided during the public health emergency. We are committed to working collaboratively with the Agency to improve care delivery and study the lessons learned from the COVID-19 experience to enhance care, improve access and promote equity.

Below are some key issues and recommendations:

SECTION 1: ACCESSING HEALTHCARE AND RELATED CHALLENGES

Identifying challenges individuals currently face in understanding, choosing, accessing, or utilizing healthcare services across CMS program. Recommendations for how CMS can address these challenges through policies and programs

I. Provider Shortages

Background: The supply of health professionals in the U.S. is not keeping pace with the demand for health care services. According to data from the Health Resources and Services Administration (HRSA), as of October 2022, 98 million people reside in a Primary Care Health Professional Shortage Area (HPSA). These communities currently experience a shortage of 17,057 primary care practitioners.[1] A June 2021 report from the AAMC predicts a shortage of up to 124,000 physicians across all specialties by 2034, which includes up to 77,100 non-primary care specialist physicians.[2]We must invest in our country's health infrastructure by helping provide communities with the physicians they need and improved access to care.

Recommendation: AAMC recommends investing in the physician workforce in all specialties by increasing the number of Medicare-supported GME positions. The Resident Physician Shortage Reduction Act of 2021 (S. 834/H.R. 2256) is bipartisan legislation that would take steps to alleviate the physician shortage by providing 14,000 new Medicare-supported GME positions over 7 years. These positions would be targeted to rural teaching hospitals, hospitals serving patients in HPSAs, hospitals in states with new medical schools or branch campuses, and hospitals already training over their Medicare caps. We encourage CMS to support this legislation.

II. Behavioral and Mental Health

Background: Integrated behavioral health (IBH) care involves a multi-disciplinary team of medical and behavioral health providers working with patients and their families to address the medical, behavioral, and social factors that affect health and well-being. Despite the many evidence-based benefits of these IBH models, current payment structures, workforce trained in IBH models, and inadequate interoperability in health information technology are among the implementation challenges. For *example, The Psychiatric Collaborative Care Model* (CoCM) is a behavioral health integration model that enhances primary care by including mental/behavioral care management support, regular psychiatric inter-specialty consultation, and the use of a team that includes the Behavioral Health Care Manager, the Psychiatric Consultant, and the Treating (Billing) Practitioner. The CoCM model promotes care integration within Medicare but does not extend to all insurance plans and/or Medicaid plans. Even within Medicare, the payment codes are severely limited, allowing for only 70 minutes of integrated care the first month, 60 minutes in subsequent months, and 30 minutes of additional time each month. Other effective IBH models face even more reimbursement challenges.

Recommendation: The AAMC recommends that CMS increase Medicaid and Medicare reimbursement rates for all behavioral health providers. Low reimbursement rates limit access to in-network behavioral health specialists. The AAMC also recommends that policymakers establish sustainable financing mechanisms to support IBH expansion at the practice-level. We recommend sufficient reimbursement for the time and resources needed to provide this care and that HHS/CMS explore policies that would expand coverage and payment under this model. AAMC recommends policies to extend Medicare reimbursement to other licensed mental health providers such as licensed clinical social workers, mental health therapists and others. In addition, consideration should be given to funding mechanisms for

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[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas

[2] (https://www.aamc.org/media/54681/download).

certified peer support specialists and community health workers. Medicaid reimbursement of these models is essential to expand access for historically marginalized populations.

Background (Provider Shortage): There is currently a shortage of mental health providers. Data from HRSA shows that an estimated 157 million Americans, or 47% of the population, lived in one of 6,469 mental health HPSAs as of October 2022, and the nation needs an additional 7,902 mental health providers to fill these shortage gaps. In many cases, providers that do offer behavioral health services do not accept insurance due to low reimbursement rates, which further exacerbates the shortage of available providers.

Recommendation (Provider Shortage): AMC commends Congress for removing the geographic restrictions and permits the home to be an originating site for telehealth services for the treatment of mental health disorders. Telehealth is a great tool that can be used to offset the impact of the provider shortage and increase access to mental health services. However, the initial 6 month in-person visit requirement and 12 month in-person visit requirement thereafter are medically unnecessary and limit access to care. The AAMC recommends that CMS work with Congress to eliminate the 6 month and 12 month in-person visit requirement.

III. Reproductive Health Care

Background: After the *Dobbs v. Jackson Women's Health Organization* 2022 Supreme Court decision overturning *Roe v. Wade*, some states have begun enforcing abortion bans and restrictions on care and proposing new restrictions that limit access to reproductive health care, thereby creating risks for people who are pregnant and potentially imposing criminal and civil liability on physicians and other health care providers. These restrictions limit access to the full scope of reproductive health care in certain states. Restrictive state laws severely limit a patient's access to comprehensive reproductive health care, interfere in the patient-physician relationship, and override the clinician's responsibility to provide the best medical care for every patient. Further, it is crucial that medical students and resident physicians who desire comprehensive training in the full spectrum of reproductive health care have that available. The *Dobbs* decision may limit the ability to train physicians in providing these critical services in certain states.

Recommendation: The AAMC appreciates CMS's guidance clarifying that EMTALA preempts state laws banning abortion care. This guidance reaffirms the responsibility of health care providers to provide medically necessary evidence-based medical care. Health care workers need clarity on the legal regimes governing the provision of care as well as protection from criminal prosecution**.** when providing these medically necessary services to patients in need of emergency care. We urge CMS to take any steps necessary to ensure that providers can continue to provide these critical services to patients without the threat of civil or criminal liability and that residents and students receive training in order to provide medically necessary care.

IV. Maternal Care

Background: A new report from the March of Dimes shows that the number of US counties without a hospital to provide labor and delivery services and practicing OB/GYNs has grown since 2018 (from 1,085 to 1,119), with nearly 7 million people of childbearing age living in a county with either no or limited maternity care services.[3]Medicaid pays for more than 40% of all births in the US, including a greater share of births in rural areas than other payers. Low Medicaid reimbursement has been cited as a factor leading to the closure of rural labor delivery units, in addition to staffing concerns.[4]Closure of labor and delivery units increased over the course of the COVID-19 pandemic, further greatly limiting access to care, with some analysis suggesting greatest impact on pregnant patients in rural areas and for Black and Hispanic patients. [5]

Recommendation: In addition to addressing broader physician shortages, the AAMC recommends that CMS ensure sufficient payment and network adequacy to support maternal care under its programs to improve access to care. Additionally, CMS should work with state Medicaid partners to expand Medicaid eligibility based on the Federal Poverty Level in expansion states and raise parental income eligibility levels in non-expansion states. Additionally, CMS should work with states to expand the postpartum coverage period as allowed under the American Rescue Plan Act of 2021, and support efforts in Congress to make the expanded coverage mandatory and permanent under all state Medicaid programs. The AAMC also recommends CMS work with federal partners to improve consistency of data currently collected regarding maternal mortality and evaluate options to improve the collection of both social determinants of health data and qualitative data. Lastly, given the significant consequences for failure to comply, and the multiple factors that contribute to maternal health equity, many of which are outside the control of a hospital, the AAMC believes that CoPs are not the right vehicle to achieve this goal. Other policy levers are available, such as its quality reporting programs, to incentivize improvements for maternal health care equity. Additionally, as previously mentioned, there is significant concern with the reduction of labor and delivery units in hospitals and impact on access to care. Additional CoPs could have the unintended impact of further reducing the hospital services available to pregnant patients and exacerbating disparities in care.

SECTION 2: UNDERSTANDING PROVIDER EXPERIENCES

Identifying challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, operations, or communications on provider well-being and retention. Recommendations for CMS policy and program initiatives that could support provider well-being

I. Harmful Impact of Payment Cuts on Physicians

Background: As currently structured, the Medicare physician payment system is on a path that places Medicare beneficiaries' access to physicians in jeopardy. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a six-year freeze on updates to physician payment from 2019 through 2025 during which there would be no updates to Medicare payments to physicians. Beginning in 2026,

[3] (https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx)
[4] (https://www.gao.gov/products/gao-23-105515)
[5] (https://www.vox.com/22923432/maternity-wards-hospitals-covid-19-pandemic)

the law specifies that clinicians participating in advanced alternative payment models (AAPMs) who also meet certain thresholds would receive an update of 0.75 percent and those who are not in AAPMs would receive a 0.25 percent update. These updates are well below the rate of inflation. CMS proposed in the CY23 Physician Fee Schedule rule a dollar conversion factor (CF) of $33.08 to update the payment rates. This represents approximately a 4.42 percent reduction from the 2022 conversion factor. On top of this 4.42 percent CF reduction, on January 1, 2023, physician practices are facing additional payment cuts from the imposition of a 4 percent PAYGO sequester reduction.

We are deeply concerned about the impact of these significant cuts and the minimal future updates. Payment reductions of this magnitude would pose a major problem at any time, but at a time when teaching physicians and other health care professionals are continuing to respond to multiple public health emergencies and associated longer-term challenges, such as historic workforce shortages, these cuts will be extremely harmful. The ongoing COVID-19 pandemic has caused significant disruption to physician practices, who are still recovering from the pandemic's financial impact. For example, continued implementation of infection control protocols has increased the cost of providing care. Practices have had to purchase additional personal protective equipment (PPE), update cleaning protocols, maintain adequate social distancing, create physical barriers, and undertake other costly measures with increased costs due to inflation.

Even prior to the pandemic there were major concerns about physician well-being which the pandemic only exacerbated. Physician well-being is low due to many factors, including concerns regarding their health and safety and that of their staff and family, increased hours of care, workforce shortages, and challenges with providing care during a pandemic that requires additional procedures and protocols. Payment for services should be commensurate with the services provided. An 8.5 percent cut in physician payment will add to the stress and is likely to trigger further retirement or reduction in physician services during a time when physicians are needed the most in their communities.

Recommendation: We are concerned about the impact that the significant physician payment cuts will have on physicians and their patients. With the growing Medicare population, access will become a bigger problem. **Given the unprecedented challenges faced by physicians over the past few years, and the critical importance of patient access to health care services, we encourage CMS to support efforts to ensure that Congress passes legislation that provides a 4.42 percent CF adjustment for 2023 and waives the 4 percent statutory PAYGO reduction.** This would help to ensure that physicians and other health care providers can continue to provide high quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Looking ahead, we believe that there are ongoing structural problems with the Medicare Physician Fee Schedule that must be addressed. Medicare provider payments have been constrained for many years by the budget neutrality system which has led to arbitrary reductions in reimbursement. The updates to the conversion factor have not kept up with inflation, while the cost of running a medical practice has increased significantly. The payment system should ensure financial stability through a baseline positive annual update that reflects inflation in practice costs and eliminates or replaces budget neutrality requirements to allow for appropriate changes in spending growth. The payment system should also recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of the Medicare and the health care system (e.g., preventing hospitalizations that would increase Part A costs). We would welcome an opportunity to work

collaboratively with Congress, CMS, and other stakeholders to make changes to the payment system. In addition to addressing payment, we would welcome the opportunity to work together on ways to reduce burn-out and improve clinician well-being.

II. EHR-related Clinician Burden

Background: Clinicians increasingly cite EHR use as a cause of burnout, due to extended work hours to meet documentation requirements, clerical workload, and disruptions to workflow. It is often difficult for physicians and other health care professionals to locate important information in the medical record about the patient's current condition, recent changes, and the plan of care in the medical record. The medical record has become bloated to meet billing rules, which has led to difficulties in following the care and proposed management of patients and has impeded physicians' ability to focus on delivering high quality care.

Recommendation: The AAMC recommends that CMS work with health IT vendors and payers to address the three primary sources of EHR burden: EHR usability, documentation requirements, and ordering services and prior authorization. Health IT vendors should be engaged to ensure they understand clinician user experience of the EHR to design EHRs that account for physician-driven clinical workflows and thereby reduce user burden. Regarding documentation, we recommend that CMS partner with clinical stakeholders and payers to encourage the adoption of best practices related to documentation requirements, including the potential to waive certain requirements in alternative payment models where appropriate. For example, waiving the need to re-document information already contained in the medical record. Finally, CMS should work with stakeholders, including the Office of the National Coordinator for Health Information Technology (ONC), to standardize data and processes around ordering services and related prior authorization, to evaluate process and clinical workflow factors contributing to burden associated with prior authorization, and to support automation of ordering and prior authorization processes through adoption of standardized templates and data elements.

III. Medicaid Reimbursement

Background: Low Medicaid reimbursement rates challenge health care providers because they mean that providers often are underpaid for the care that they give patients. Low Medicaid reimbursement can have a significant impact, leading to differential experiences accessing care for Medicaid patients in comparison to individuals with Medicare or private insurance coverage.[6]

Recommendation: The AAMC recommends that CMS reconsider whether payment rates should be a metric of Medicaid access to care. By statute, the Medicaid program requires states to pay at rates that ensure equal access for Medicaid patients, but this is not included in CMS evaluation of access to care. CMS should consider levers to incent states to increase Medicaid reimbursement rates in order to ensure equitable access to care for Medicaid patients.

SECTION 3: ADVANCING HEALTH EQUITY

[6] (https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue)

Identifying CMS policies that can be used to advance health equity. Recommendations for how CMS can promote efficiency and advance health equity through policies and programs.

I. Data for Health Equity

Background: The AAMC believes that data is critical to understanding current inequities in our health care system and to advancing evidence-based solutions to eliminate those inequities. More and more health care providers are requesting patient self-reported demographic data and screening for health-related social needs (HRSNs) to better capture all factors that contribute to an individual's health status. Improved HRSN data can be used to improve payment and risk-adjustment models and to stratify quality metrics to better understand inequities in outcomes and care experience. However, that data is rarely shared and is generally not available to foster broader learning health system collaborative approaches and solutions. The use of community-based data also shows promise and could be paired with individual information to help inform potential health care and community interventions and investments to eliminate inequities. One issue for data reporting and aggregation is the lack of interoperable systems and important stakeholders working in siloes; for example, public health departments may have robust community data that is inaccessible to providers. Providers struggle to seamlessly share data across care teams or networks, creating a burden on patients to self-report HRSNs at more and more clinical encounters. The burden on patients and providers will only compound as policies increasingly require redundant collection of information on patients' individual circumstances and experiences to improve patient outcomes. We must commit to evaluate initial data collection policies and refine to ensure we are obtaining and sharing actionable information and keeping patients central to the efforts to use data to address inequities.

Recommendation: As CMS pursues policies to support the collection and reporting of standardized patient self-reported demographic data and HRSN data, the AAMC recommends that the agency consider incentives for providers to improve data collection. One prime area for incentives is through improvement of risk adjustment models to include HRSNs in payment models, including quality performance programs. CMS could evaluate the impacts of including such data in payment through models run by the Innovation Center. Regarding community-level data, the AAMC urges CMS to evaluate the opportunity to partner with local and state public health departments, who may have robust data that supports neighborhood stratification. To improve data reporting and sharing, CMS should partner with the ONC to evaluate interoperability standards to "roll-up" more granular data into related ICD-10 z-codes that could be more easily reported through claims processing. Such data could then be evaluated for incorporation in a minimum set of HRSN data elements. Health IT vendors could be required to support this effort through the EHR certification program. Overall, data collection and systems for social risk factors at both the individual and community level should be used in conjunction to best identify inequities and guide interventions for improvement. Regarding data used to stratify current quality metrics used in CMS programs, the AAMC recommends that CMS maintain confidential reporting of stratified performance for providers to support provider efforts to use measurement to inform improvement. Publicly reporting stratified measure performance is premature. CMS must first thoughtfully examine how patients and communities interpret inequity measurement. Finally, any public reporting should be adopted once providers have had a chance to understand results through confidential reporting and CMS has established that public reporting is easily understandable and accessible to patients and their families.

II. Mitigating Potential Bias in Technologies or Clinical Tools

Background: Bias is a real concern, and one that is best addressed in the research and development phase of a given software algorithm or AI-based technology. In comments to the White House OSTP in 2021 on an implementation plan for a national AI research resource we noted that there are formidable barriers to the implementation of an inclusive AI research infrastructure. [7] This is due to the long-standing and systemic discrimination, biases, and inequities that exist in the U.S. – all of which are present in the many overlapping sectors that converge upon the field of AI. Data demonstrate that the U.S. clinical and research enterprise is likewise marbled with biases and inequities, which can potentially preclude the formation of an equitable AI framework that, when operationalized, benefits all communities. Specific to innovative technological solutions for clinical practice, the background coding is typically a "black box," and prevents end users (clinicians) from identifying the human biases that are baked in. In the case of medical innovative technologies, clinicians must be trained on the use of the tool, including how to interpret its outputs, and to understand potential areas of bias when incorporating the tool into clinical practice.

Recommendation: The AAMC recommends that CMS consider collaboration with external stakeholders and other federal policymakers, such as the OSTP, NSF, NIH, and FDA, that might be better suited to evaluate potential bias in technology and best understand how the agency could incorporate bias review into its programs and operations. We believe the recent efforts by the Innovation Center to inventory potential biases in three of its models is a helpful tool to evaluate screening patients for eligibility or standard processes within a model that lead to unintended differential impacts and could be expanded to review more models and CMS programs.[8]

III. Prior Authorization:

Background: An HHS OIG report earlier this year raised concerns regarding Medicare beneficiaries' access to certain medically necessary care under the Medicare Advantage (MA) program through analysis of prior authorization denials.[9] The OIG's findings included that 13% of MA plans' denials met Medicare coverage rules for traditional Medicare and that at times, plans used clinical criteria not contained in Medicare coverage rules. Medicare beneficiaries should have equitable access to care regardless of whether coverage is through traditional Medicare or an MA plan. Surveys of physicians demonstrate that prior authorization policies are not in the best interests of patients and can have detrimental effects on their care and clinical prognosis – more than 80% of physicians reported that patients abandon treatment due to prior authorization burden and 34% of physicians report that prior authorization led to a serious adverse event for a patient in their care.[10] While not covered in the OIG's report, CMS has begun to adopt limited prior authorization requirements for certain services in fee-for-service Medicare.

Recommendation: The AAMC urges CMS to evaluate impacts of prior authorization denials in the Medicare Advantage program on equitable access to care and act on the HHS OIG's findings. CMS should review and strengthen its oversight of the MA program and issue new guidance on appropriate use of

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[7] (https://www.aamc.org/media/56226/download)
[8] (https://www.healthaffairs.org/do/10.1377/forefront.20220630.238592)
[9] (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp).
[10] (https://www.ama-assn.org/system/files/prior-authorization-survey.pdf)

clinical criteria in medical necessity reviews and Medicare coverage rules for MA plans. CMS should direct MA plans to improve prior authorization processes to reduce delays, including addressing review and system errors. We also encourage CMS to support efforts by Congress to better regulate the use of prior authorization in MA and streamline prior authorization processes. Finally, CMS should evaluate the use of prior authorization in fee-for-service Medicare to better understand whether its adoption has limited beneficiaries' timely access to medically necessary care.

SECTION 4: IMPACT OF THE COVID-19 PUBLIC HEALTH EMERGENCY WAIVERS AND FLEXIBILITIES

Impact of waivers and flexibilities and preparation for future health emergencies on health care providers, suppliers, patients, and other stakeholders. Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE

The waivers and flexibilities established during the PHE allowed hospitals and providers to increase access and improve care. The AAMC strongly supports the waivers and flexibilities established during the COVID -19 PHE and recommends that the following waivers and flexibilities be made permanent:

I. Geographic Restrictions on Telehealth:

Background: During the PHE, CMS has paid for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home. This has allowed patients to remain in their home, reducing their exposure to COVID-19 and the risk that they expose another patient or their physician. It also means that certain patients who find travel to an in-person appointment challenging can receive care, which may be particularly important to patients with chronic conditions or disabilities who need regular monitoring. It also helps those who, because of their job, lack of care for dependents, transportation issues, and other limitations, find it difficult to attend an in-person visit to receive care.

Recommendation: The AAMC acknowledges that CMS does not have the authority to make permanent changes related to limitations on geographic locations and originating sites for telehealth. We encourage CMS to work with Congress to permanently eliminate the geographic site requirements and allow the home to be an originating site.

II. Telehealth Across State Lines:

Background: During the PHE, CMS has reimbursed providers for telehealth services to Medicare beneficiaries across state lines with agreement from the individual states. This waiver created an opportunity to improve patient access to services and to improve continuity of care for patients who relocated or traveled to receive treatment or other services from a specialist in another state.

Recommendations: The AAMC recommends that CMS continue allowing payment for telehealth services across state lines. We encourage CMS to work with states to participate in interstate medical licensure compacts or other mechanisms that would allow care delivery across state lines after the pandemic ends.

III. Audio-Only:

Background: During the PHE, CMS has paid for audio-only telehealth services. Reports suggest that lack of video services or discomfort regarding the use of video may particularly affect certain populations, some of whom have high-risk and chronic conditions, including older adults, those with low socioeconomic status, those in rural communities, and certain races and ethnicities. In addition, patients in rural areas and those with lower socioeconomic status are more likely to have limited broadband access, making it more difficult to receive telehealth services by audio and video interactions. For these patients, the only option to receive services remotely is via phone.

Recommendations: AAMC recommends that CMS permanently allow payment for audio-only telephone-only evaluation & management codes. Data from the Clinical Practice Solutions Center (CPSC), which contains claims data from 90 physician faculty practices, shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020. The proportion of telephone/audio-only visits increased with the age of the patient. This demonstrates the importance of continuing to allow equitable coverage and payment for telephone services to Medicare beneficiaries.

IV. Eligible Telehealth Providers:

Background: During the PHE, CMS expanded the definition of eligible providers of telehealth to include physical therapists, occupational therapists, speech-language pathologists, and audiologists. These health care professionals have proven that they are able to furnish care via telehealth effectively, safely, and efficiently to patients. Expanding the definition of eligible providers has increased access to safe and effective care. If providers cannot furnish telehealth services to patients, there likely will be lapses in care that may negatively impact patient health.

Recommendations: We encourage CMS to work with Congress to permanently expand the definition of eligible telehealth providers to include PT, OT, SLP and audiologists. The COVID-19 pandemic has exacerbated the already strained workforce. While addressing the workforce shortage will require a multipronged approach, including innovation in care delivery, greater use of technology, efficient use of all health professionals on the care team, expanding the definition of eligible telehealth will expand beneficiary access to care.

V. Payment to FQHCs and RHCs for Telehealth Services

Background: During the PHE, CMS permitted payment for telehealth services when RHCs and FQHCs serve as the distant site. RHCs and FQHCs were able to effectively furnish telehealth services and treat patients via telehealth during the PHE. If FQHCs and RHCs are no longer able to furnish telehealth services, access to care could be limited, which may negatively impact patient health.

Recommendations: AAMC acknowledges that CMS does not have the authority to make the changes related to payment of FQHCs and RHCs for telehealth services. We encourage CMS to work with Congress to permanently continue payment for telehealth services furnished by FQHCs and RHCs.

VI. Virtual Direct Supervision

Background: During the PHE, CMS allowed direct supervision for services billed "incident to" a physician service to be met through virtual supervision. Virtual supervision policies have been critical in reducing exposure to COVID-19 and enabling expanded access to health care services. Continuing these policies

once the PHE ends will reduce risk of exposure to all infectious diseases (e.g., coronavirus, seasonal flu, and others), and increase access to care.

Recommendations: The AAMC recommends that CMS allow direct supervision through virtual supervision on a permanent basis. Our members have found virtual supervision has been safe and effective, and improved access to care. For example, virtual supervision allows physicians to supervise APPs across multiple campuses, which increases patients' access to care.

VII. Teaching Physician Virtual Supervision

Background: During the PHE, CMS made changes to the billing requirements that enabled payment to teaching physicians to bill under the fee schedule when residents provide services to patients (in-person or via telehealth) that are supervised virtually by the teaching physician. The expansion of the teaching supervision requirements to allow virtual supervision afforded patients greater access to care and offers additional training opportunities.

Recommendation: The AAMC recommends that virtual supervision of residents qualify for payment under the fee schedule without being restricted based on location. At a minimum, we recommend allowing virtual supervision of residents not only in rural communities, but in all underserved communities to expand access to safe and effective medically necessary care. These medically underserved communities would greatly benefit from the expanded access to care. The AAMC also believes that enabling virtual supervision of resident services is crucial to expanding access to safe and effective care while enhancing the resident's skills. Additionally, as part of their training, it is essential for residents to have experience providing telehealth visits while supervised as they will be providing such services in the future when they practice independently. Any risk to quality of care and utilization can be prevented by establishing clearly outlined policies, procedures, and training. The AAMC has created competencies in telehealth across the learning continuum.[11] Ultimately, billing occurs under the teaching physician; therefore, the teaching physician is responsible for ensuring that all services are appropriately furnished.

VIII. Remote Physiological Monitoring

Background: During the PHE, CMS allowed monitoring days for RPM services to decrease from 16 to 2, allowing individuals who would benefit from shorter periods of monitoring to receive care. In many cases, short-term monitoring can be provided virtually.

Recommendation: The AAMC recommends permanently extending and finalizing the RPM waivers. The 16-day requirement prevents physicians from using these codes when clinically the patient would require less than 16-days of monitoring. Allowing fewer than 16-days of data transmission by a patient in a given month greatly increases access to care and promotes high value use. Similarly, allowing new patients to receive RPM services further improves access to care.

IX. Acute Hospital Care at Home (AHCAH)

Background: CMS launched the Hospital Without Walls program in March 2020 to allow hospitals to provide services beyond their existing walls to expand care capacity and to develop sites dedicated to COVID-19 treatment. AHCAH is an expansion of this initiative that allows eligible hospitals to have

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[11] . (https://www.aamc.org/data-reports/report/telehealth-competencies)

regulatory flexibility to treat certain patients, who would otherwise be admitted to the hospital, in their homes and to allow such hospitals to receive Medicare payment under the IPPS. AHCAH programs have become a valuable resource to both alleviate capacity issues and provide patients access to care.

Recommendation: The AAMC urges CMS to work with Congress to support the Hospital Inpatient Services Modernization Act (H.R. 7053/ S. 3792), legislation that would extend the current Acute Hospital Care at Home waiver for two years after the end of the COVID-19 Public Health Emergency (PHE).

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org, Ki Stewart at kstewart@aamc.org or Phoebe Ramsey at pramsey@aamc.org.

Sincerely,

Rosha C. McCoy MD

Rosha Champion McCoy, MD, FAAP
Acting Chief Health Care Officer

cc: David J. Skorton, MD
CEO and President