



September 6, 2022

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

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

RE: CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies Proposed Rule [CMS-1770-P; RIN: 0938-AU81]

Dear Administrator Brooks-LaSure:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Proposed Rule entitled, *CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies* (the Proposed Rule). This letter focuses on the Centers for Medicare and Medicaid Services' (CMS) proposals to expand certain telehealth services beyond the end of the declared COVID-19 Public Health Emergency (PHE) as well as the proposed changes to the Physician Fee Schedule (PFS) conversion factor and related reimbursement rates which, we believe, could have a negative impact on patient access to physician and rehabilitation services.

CPR is a coalition of more than 50 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 the 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 in need of medical rehabilitation services.

Overview

In the Proposed Rule, CMS offers numerous significant proposals impacting provider payment under Medicare. CPR focuses here on two specific provisions in the rule – the treatment of telehealth as the federal government prepares for the expiration of the PHE, and the impact of cuts to the conversion factor for the Fee Schedule, on top of other structural cuts that will materially impact physician and therapist reimbursement and, thereby, potentially impact patient access to care.

Expansion of Telehealth under the Physician Fee Schedule

The agency continues to expand the provision of telehealth in the Medicare program by extending the duration of time that services are temporarily included on the telehealth services list during the PHE (but not those that have been added on a Category I, II, or III basis) for 151 days following the eventual end of the PHE. CMS notes that this aligns Medicare policies with the requirements of the Consolidated Appropriations Act, 2022. CMS is also extending certain flexibilities for the same period of time, including the waiver allowing telehealth to be furnished in any geographic area and any originating site setting (including the beneficiary's home); allowing the provision of audio-only telehealth for certain services; and allowing a wider range of providers (including physical and occupational therapists, audiologists, and speech-language pathologists) to furnish telehealth services. However, CMS does not discuss additional permanent action to expand telehealth beyond the end of the 151-day post-PHE period.

We note that, as in past years, the telehealth proposals in the Proposed Rule are necessarily limited by the authority CMS currently possesses to expand telehealth beyond the duration of the PHE. However, as the Medicare population remains accustomed to the widespread adoption of telehealth over the last two years, we also recognize that Congress is in the process of considering permanent extensions of CMS' authority, or even mandating a longer-term or permanent expansion of telehealth in the Medicare program. Accordingly, we encourage CMS to consider our comments below not only with regard to the policies in the Proposed Rule, but for future rulemaking impacting telehealth in the Medicare program.

CPR and its members continue to appreciate that the rapid 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, 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.

Even as the PHE expires and the threat of COVID-19 eventually lessens, telehealth will continue to provide these benefits which are particularly valuable for beneficiaries with disabilities and in need of rehabilitation. We therefore support increased access to care through the expanded use of

telehealth past the expiration of the PHE to ensure that patients are able to benefit from advances in technology that make virtual care possible.

However, 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 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. 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 (some private plans have already begun to decrease telehealth reimbursement during the ongoing PHE). 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 Medicare beneficiaries.

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.

Impact of Proposed Changes to Evaluation and Management Values and 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 2022, CMS proposes to decrease the overall conversion factor by approximately 4.4%. This 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 more than 4% in 2023, resulting in decreased fee schedule amounts for services across the board. Providers of rehabilitation care are already facing serious financial strain. Of course, the ongoing impact of the PHE has significantly impacted the financial health of many providers. Further, the Medicare program is currently facing a 2% cut in payments due to the impact of sequestration, which came

back into full effect beginning July 1, 2022. Without additional Congressional action, there will be a further 4% cut beginning January 1, 2023, relating to the Statutory Pay-As-You-Go Act (PAYGO).

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 2023 and beyond. We also encourage CMS to work with stakeholders and policymakers to identify longer-term “fixes” to this now-annual issue, rather than relying on temporary solutions each year to avoid drastic payment reductions.

We greatly appreciate your consideration of our comments on the CY 2023 Physician Fee Schedule Proposed Rule. Should you have any further questions regarding this information, please contact Peter Thomas and Joe Nahra, CPR co-coordinators, by e-mailing Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ALS Association
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Medical Rehabilitation Providers Association
American Music Therapy Association

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American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
American Therapeutic Recreation Association
Amputee Coalition
Brain Injury Association of America *
Center for Medicare Advocacy *
Christopher & Dana Reeve Foundation *
Disability Rights Education and Defense Fund
Epilepsy Foundation
Falling Forward Foundation *
Lakeshore Foundation
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics
National Association of Rehabilitation Providers and Agencies
National Association of State Head Injury Administrators
National Disability Rights Network (NDRN)
National Multiple Sclerosis Society *
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
United Cerebral Palsy
United Spinal Association *

**** CPR Steering Committee Member***