Centers for Medicare & Medicaid Services' September 6, 2022 RFI – Make Your Voice Heard

ACOFP is responding to three sections of this RFI:

- Understanding Provider Experiences
- Advancing Health Equity
- Impact of the COVID-19 Public Health Emergency Waivers and Flexibilities

The question stems are in *italics*.

Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.

Question I (4,875 characters)

Examples may include, but are not limited to:

- *Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, retention, maldistribution);*
- *The increasing use of digital health technology on provider well-being and attrition;*
- *Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made;*
- *Impact of CMS policies on patient panel selection, and on providers' ability to serve various populations; and*
- *Factors that influence providers' willingness or ability to serve certain populations, particularly those that are underserved and individuals dually eligible for Medicare and Medicaid.*

Primary care providers are on the frontlines of care, but without proper support, many of our members feel fatigued, burned out and exasperated by our current healthcare system. While there are many factors contributing to physician burnout, ACOFP believes the primary driver is the lack of available family medicine physicians. The following describes our recommended steps to both bolster the family medicine pipeline and protect the existing workforce.

Patients prefer providers who share the same racial or ethnic background as themselves. Junko Takeshita, et. al., *Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians with Patient Experience Ratings*, 3 J. Am. Med. Ass'n Network Open 1 (2020). Additionally, if patients are non-native English speakers, they may seek the few providers in their community who speak their native language. Thus, the burdens of an entire community may fall on a small subset of available physicians.

Physicians who can communicate in the patient's native language take on greater roles than a traditional physician because they are relied upon for other services. For example, family physicians provide guidance and support on a number of social issues, like housing, access to non-healthcare-related programs and translation assistance when a patient is referred to a specialist that is not able to

communicate in the patient's native language. All of these factors place significant burdens on family medicine physicians, adding stress to an already limited workforce caring for a large part of an underserved community. We therefore urge CMS to enact policies that promote a diverse and bilingual physician workforce, including among non-family medicine specialties, and to recognize the added cost of translators associated with caring for an increasingly diverse patient population.

Low reimbursement for primary care and lack of pay parity with specialists for the same services have contributed significantly to the primary care physician shortage. Our members are often reminded that their services are not valued at the same level as those of their peers, even if the services are the same as those provided by other specialty types. Medical students are acutely aware of these differences, and view family medicine as an undesirable specialty given financial pressures. Additionally, because of low primary care reimbursement, family medicine physicians must see more patients in a day to make it financially feasible to operate a primary care practice. These long days only aggravate provider burnout, putting further burden on an already stressed workforce.

Compounding matters are the ever-growing administrative requirements placed on primary care providers. One study documented that 142 family medicine physicians in Wisconsin spent 2.6 hours a day on clerical and administrative tasks. Brian Arndt, et. al., *Tethered to the EHR: Primary Care Physician Workload Assessment Using HER Event Log Data and Time-Motion Observations*, 15 Annals Fam. Med. 419 (2017). Adding to providers' frustrations, plans change their rules and utilization management techniques frequently, which leaves providers constantly guessing if a service or product will be covered for their patient. For example, our members report that some plans are placing onerous utilization management requirements on commonly prescribed generic medications. Such policies inappropriately take clinical decision making out of the doctor's office and take precious time away from patient care. Additionally, plans are adopting CMS' quality measure reporting standards. While consistency across payers is appreciated, each plan has their own data reporting system. Thus, providers are spending even more time uploading data to satisfy the multitude of different plans their patients have.

Finally, while supportive of expanded telemedicine visits, ACOFP notes that expanded telemedicine has had some unintended consequences for providers. First, our providers note that patient expectations have shifted, and patients now demand constant contact with their doctor. Answering every patient's questions after hours is tiring for many physicians, much of which does not meet the criteria for a telemedicine visit and therefore goes unreimbursed. Second, providers note that they increasingly have to serve as IT professionals during telemedicine calls. This takes time away from their primary focus: patient care. Third, providers feel obligated by their practice group to see their patients via telemedicine visits even if they are ill. Some of our members say this prevents them from taking true sick days to recover from their ailment. While the increased availability of telehealth has been positive, more protections are needed to ensure the family medicine workforce is sufficiently supported in providing high-quality patient care.

Question II (3,047 characters)

- *Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.*

As noted earlier, there is a significant reimbursement differential between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients. This dissuades medical students from becoming primary care physicians, which only exacerbates our country's primary care physician shortage. Medical students graduate with a median $200,000 worth of debt, *Medical School Graduation Questionnaire*, Am. Ass'n Med. Coll., https://www.aamc.org/media/55736/download (July 2021). Given the pay differential between family medicine and other specialties, many medical students avoid family medicine. We therefore recommend that CMS increase primary care provider reimbursement to be competitive with specialty care.

We also encourage CMS to enact policies to place greater priority on family medicine graduate medical education slots in rural or underserved areas. Physicians often practice within 100 miles of where they completed residency, so the establishment of new residency slots in those areas will positively improve provider willingness to serve in underserved or rural areas. Amelia Goodfellow, et. al., *Predictors of primary care physician practice location in underserved urban and rural areas in the United States: a systematic literature review*, 91 Acad. Med. 1313 (2016). However, 99 percent of Medicare graduate medical education funding goes to programs in urban areas. *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding*, United States Government Accountability Office, https://www.gao.gov/assets/700/690581.pdf (Mar. 2018). By funding more family residency slots, and increasing primary care reimbursement, more medical students will consider a career in family medicine.

In terms of provider well-being, we wish to reiterate our concerns about the onerous administrative burdens that are placed on physicians. Rural and underserved populations often have greater needs, but have less access to necessary care. Administrative burdens for these populations further disincentivize providers from caring for these patients. Further, we restate that there are significant challenges associated with providing culturally competent care. Obtaining translation services and developing an understanding to provide appropriate care goes unrecognized and deters physicians from treating these historically underserved patients.

We also recommend that CMS implement new rules and regulations to improve and ensure consistent implementation of utilization management tools as well as the related appeals process. Specifically, peer-to-peer utilization management meetings are intended to ensure medically appropriate care is provided. However, our members report talking to non-physicians during supposed "peer-to-peer" appeals meetings. This adds to the daily administrative frustrations of our providers and places unnecessary barriers to timely and high-quality care.

Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Question I [4,972 characters]

Examples may include, but are not limited to:

- *Identifying CMS policies that can be used to advance health equity:*
    - *Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services;*
    - *Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences;*
    - *Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias. For example, input on how we might mitigate potential bias with clinical tools that have included race and ethnicity, sex/gender, or other relevant factors. Further, input on potential policies to prevent and/or mitigate potential bias in technology, treatments or clinical tools that rely on clinical algorithms.*
    - *Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid; and*
    - *Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.*

Medicaid Pay Parity. State Medicaid programs offer significantly lower reimbursement rates than Medicare. *Medicaid-to-Medicare Fee Index*, Kaiser Fam. Found., https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/n. Because many providers find it financially unfeasible to accept Medicaid patients, these patients have a hard time finding a provider who will accept their insurance. This ultimately leads to poorer health outcomes for Medicaid beneficiaries. *Increased Medicaid Reimbursement Rates Expand Access to Care*, Nat'l Bureau of Econ. Rsch., https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care (Oct. 2019). We urge CMS to ensure that Medicaid reimbursement rates are more on par with Medicare.

Telemedicine. ACOFP supports greater access to care and strongly believes that expanded access to telehealth services helps ensure that patients receive necessary treatment, even if they are unable to see a provider in person. Expanded telehealth services also has the added benefit of improving health equity, as patients with disabilities and limited means of transportation have more opportunities to interact with their providers. We recommend that CMS continue to cover all forms of telemedicine

visits, including audio-only visits, beyond the COVID-19 public health emergency (PHE), and with pay parity to in-person visits.

Z-Codes of the ICD-10. Z-codes document patients' social determinants of health and are an integral part of making data-driven decisions. Documenting Z-codes is a time-intensive process for which federal health programs currently do not provide reimbursement. We recommend that payment policy changes be made to compensate providers for documenting Z-codes.

Cross-Border Care. For Medicaid beneficiaries, crossing state lines for care is a burdensome process for both patients and providers. One ACOFP member noted that seeking specialist care outside the state is near impossible to get approved, and her state's Medicaid program would rather send the patient to a more distant specialist within the state than approve an out-of-state specialist visit that is much closer in distance. Appeals pursued by the provider are time-consuming and a poor use of time. We encourage CMS to adopt policies that require states to facilitate cross-border visits for Medicaid beneficiaries.

Need for translators. There is a severe shortage of qualified translators and bilingual staff to assist patients with limited English proficiency. Sheila Mulrooney Eldred, *With Scarce Access to Interpreters, Immigrants Struggle to Understand Doctors' Orders*, Nat'l Pub. Radio, www.npr.org/sections/health-shots/2018/08/15/638913165 (Aug. 15, 2018). For these patients, every interaction in the healthcare system is a frustrating experience. An ACOFP member noted that one day, she scheduled five home visits with American Sign Language (ASL) patients. However, an interpreter only showed up to one visit because of a shortage of ASL interpreters, and the other four home visits had to be rescheduled. To remedy the shortage, we recommend that CMS provide reimbursement or implement incentives to reward providers and facilities that hire multilingual staff. Additionally, if patient satisfaction surveys affect reimbursement, then surveys must be given to patients in a wide variety of languages in order to ensure fairness for the provider being assessed. We recommend that CMS implement and enforce policies that ensure that patient surveys are offered in languages that are representative of the community.

Use of Race in Diagnostic Tools. The use of race in diagnostic tools is an outdated practice that risks adverse outcomes and poor health status of certain populations. We support efforts to eliminate the inappropriate use of race in diagnostic tools that are used in CMS programs.

Enrollment. Patients receive a deluge of brokerage calls during open enrollment period, which overwhelm patients and create unnecessary stress. Further, the brokers are sometimes uneducated about their own plan's coverage or make blatant misrepresentations and omissions. If a patient relies on a broker's false information, the patient may not receive the care they need until the next enrollment period. Additionally, these calls lead patients to switch plans more often, which—in turn—leads to patients switching providers more frequently. The discontinuity of care adversely affects patient care and adds to an additional provider burden as they attempt to untangle past medical records. We recommend that CMS implement more stringent oversight over CMS program health plans marketing, including direct solicitations to beneficiaries. Finally, we recommend that CMS consider policies that will reimburse provider time when they are forced to provide health literacy education to patients. Picking a health plan can be complicated, and patients often have no one to turn to but their family doctor for information.

Question II [3,523 characters]

- *Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs.*

The diversity of a community must be reflected in its providers. Ultimately, patient care suffers when diverse providers leave underserved and underrepresented communities. A study published in the *Journal of the American Medical Association Network Open* showed that patients prefer providers who shared the same racial or ethnic background as themselves. Junko Takeshita, et. al., *Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians with Patient Experience Ratings*, 3 J. Am. Med. Ass'n Network Open 1 (2020). Besides higher patient satisfaction, race-concordant physician visits last longer than race-discordant visits. Lisa Cooper, et. al., *Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race*, 139 Annals of Internal Med. 907 (2003). Similarly, a 2017 study showed that medical students showed less explicit and implicit bias towards LGBT patients when they witnessed positive role modeling by LGBT physicians. Sean Phelan, et. al., *Medical School Factors Associated with Changes in Implicit and Explicit Bias Against Gay and Lesbian People Among 3492 Graduating Medical Students*, 32 J. Gen. Internal Med. 1193 (2017). These studies reinforce the importance of having diverse providers with respect to race, ethnicity, sexual orientation and other non-traditional backgrounds. We therefore recommend that CMS develop policies, including financial incentives, that promote a diverse provider population.

To achieve a diverse provider population, medical schools and teaching hospitals must recruit diverse medical students and residents. Resident physicians are often on the frontlines to those in underserved, underrepresented and rural communities. Recruiting a diverse student and provider population is not an easy task, but given its importance, medical schools and teaching hospitals should be rewarded for successfully recruiting a diverse provider community. Therefore, we recommend that CMS take steps to develop financial incentives that reward medical schools and teaching hospitals that recruit and retain a diverse medical staff.

Resident physician wellness is critical to patient care in underserved communities; as one ACOFP member said, "If you're not taking care of your Black residents, you're not taking care of your Black patient population." However, residency programs are a grueling experience; one in four medical residents have a positive depression screening at any time during their program. Douglas Mata, et. al., *Prevalence of Depression and Depressive Symptoms Among Resident Physicians*, 314 J. Am. Med. Ass'n. 2373 (2015). There is evidence that specific initiatives make a meaningful impact on resident wellness, such as hiring more support staff, Lenny Salzberg, *Physician Well-Being: Improving Office Efficiency*, 471 FP Essentials 16 (2008), but these reforms will involve expensive and systemic changes. We therefore recommend that CMS implement policies that financially reward teaching hospitals that implement meaningful wellness programs for medical residents. We believe these programs will have beneficial downstream effects to community health.

Finally, we encourage CMS to collect data to understand why providers leave underserved and underrepresented communities. By understanding why providers leave (e.g., low reimbursement, lack of specialist care, complex patient population, etc.), CMS can better develop policies that encourage providers to practice in underserved and underrepresented communities.

Question III [4,984 characters]

- *Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.*

Reimbursement.

A significant reimbursement gap still exists between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value that primary care services provide patients. To help address these concerns, we recommend that CMS support reimbursement policies that reward care provided by family physicians, who are proven to ensure high-quality care and improved patient outcomes at lower cost. Equalizing reimbursement across settings of care and between primary care and specialty care will help ensure family physicians have the resources to improve quality and reduce costs.

Specifically, we want to focus CMS' attention on the low reimbursement of home visits, lactation services and wellness visits. Due to low reimbursement, some of our members offer these services at a financial loss, even though they play an outsized role in health outcomes and in promoting health equity. For example, home visits are critical services for patients who lack the means of transportation, or who are disabled. However, these visits have overly strict requirements and are poorly reimbursed. Thus, patients do not get the care they need, which leads to poor health outcomes and poor health status. Additionally, wellness visits are not reimbursed by time, thus disincentivizing providers from spending more time with patients who might need more counseling. Therefore, we encourage CMS to increase reimbursement in primary care services, especially for home visits, lactation services and wellness visits.

Comprehensive primary care does not start and end with the physician. Often, a multidisciplinary team of providers—such as social workers and nutritionists—are critical personnel needed for holistic care. Well organized multidisciplinary teams have been shown to improve patient satisfaction and reduce physician burnout. Brandi Leach, et. al., *Primary Care Multidisciplinary Teams in Practice: A Qualitative Study*, 18 BMC Family Practice 1 (2017). We recommend that CMS consider providing practices with financial incentives to retain such staff in their offices. While also providing better care, a multidisciplinary primary care model can reduce overall health care costs by preventing unnecessary emergency department visits. Joshua Breslau, et. al., *Impact of mental health based primary care program on emergency department visits and inpatient stays*, 52 Gen. Hosp. Psychiatry 8 (2018). On a similar note, having a patient give a clinical laboratory specimen at a provider's office would be more efficient for both the patient and the provider. CMS should consider providing a financial incentive to providers who can develop an infrastructure to collect clinical laboratory specimens in their office.

Finally, we note that providers often spend a significant amount of time caring for patients and are unable to bill for it. Examples include answering patients' questions on Medicare Advantage plans or staying with an actively suicidal patient until help arrives. CMS programs currently do not provide reimbursement for these types of activities even though they are integral for patient wellbeing. We recommend that CMS reimburse physicians for these unexpected, but critical, services.

Paperwork.

Providers are burdened by unnecessary and time-consuming paperwork requirements. Instead of focusing on patient care, providers spend a significant amount of time on administrative tasks, leading to burn out and provider shortages. This is more acutely felt in small, rural, and solo practices that do not have the resources to manage paperwork requirements. Further, providers' paperwork requirements are further exacerbated by ever changing rules and utilization management techniques from CMS and health plans participating in CMS programs. We recommend that CMS limit providers' paperwork requirements by taking steps to: (1) regulate utilization management in plans, (2) promote electronic medical records integration with plans' utilization management policies and (3) streamline paperwork requirements across plans.

Osteopathic Manipulative Treatment (OMT).

OMT is a clinically appropriate, efficient and affordable pain management treatment. *See, e.g.*, Jacek Cholewicki, el. al., *The effects of osteopathic manipulative treatment on pain and disability in patients with chronic neck pain: A single-blinded randomized controlled trial*, PM&R, pubmed.ncbi.nlm.nih.gov/34719122/ (Oct. 31, 2021). OMT is an underutilized service, while more expensive treatments are often prescribed first.

ACOFP recommends that CMS support efforts to increase access to, and knowledge of, OMT as a pain management treatment option. CMS also should improve coverage and reimbursement policies for OMT to ensure doctors of osteopathic medicine (DOs) continue to train in and certify as OMT providers. Finally, the clinical benefits OMT provides should also be considered when determining OMT reimbursement.

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Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Question I (3,349 characters)

Examples may include, but are not limited to:

- *Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on providers, suppliers, patients, and other stakeholders.*

Overall, ACOFP believes that CMS' COVID-19 public health emergency (PHE) waivers and flexibilities were a success for both providers and patients. For our members, CMS' telemedicine waivers were by far the most impactful reforms to their practices, and we encourage CMS to keep these flexibilities even after the end of the PHE.

The expanded use of telemedicine during the PHE improved access to care for many of our member's patients. As noted earlier in our response, ACOFP supports greater access to care and strongly believes expanded access to telemedicine services can ensure patients receive necessary treatment even if they are unable to see a provider in person. Expanded telemedicine waivers has also led to new opportunities. One ACOFP member noted that she can now attend her patients' specialist visits via video. She said that participating in specialist visits, particularly for individuals with poor health literacy, can lead to a more productive specialist visit for the patient.

However, our members found that video-based telemedicine visits can be limiting for patients. ACOFP members described how patients with poor digital literacy would get frustrated in trying to connect to a video telemedicine visit. Additionally, some of our members noted that patients with poor digital literacy will recruit their family and friends to help them with telemedicine visits. Our members are concerned about patient privacy when these individuals set up—and sometimes attend—patients' telemedicine visits. Additionally, for some rural patients and providers, video calls are simply not feasible because of the lack of broadband infrastructure. Thus, we recommend that CMS take steps to ensure audio-only telemedicine visits continue to be available at current reimbursement levels. We will expand on this recommendation in the next section of our response.

Additionally, ACOFP appreciates the Office of Civil Rights' (OCR) decision to temporarily halt enforcement of the use of non-HIPAA-compliant software for telemedicine calls. Before OCR's decision, physicians were limited to a narrow set of video conferencing applications, which were not widely familiar to patients. These restrictions, compounded with some patients' poor digital literacy, frustrated both providers and patients. We hope that CMS will work with OCR to ensure that improved access to care is not hindered by overly burdensome HIPAA regulations.

Finally, while we are supportive of expanded telemedicine visits, there is a new expectation that physicians will be available 24/7 to answer patient messages and communications. Being constantly "on

call" can lead to provider burnout. Additionally, expanded telemedicine has led to some inefficiencies, as some patients log in late, and doctors have to navigate their calendars between the types of patient encounters. We believe many of these challenges can be attributed to "growing pains." We note, however, that over the past two years, both doctors and patients have learned to navigate these differences more seamlessly. Further, many of our members have invested significantly in telehealth capabilities during the pandemic. Therefore, we urge caution in removing these flexibilities, given likely permanent changes in patient expectations and physician capabilities to appropriately deliver care via telehealth.

Question II (4,922 characters)

- *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.*

Telemedicine.

ACOFP supports greater access to care and strongly believes expanded access to telehealth services can ensure patients receive necessary treatment, even if they are unable to see a provider in person. Earlier in our responses, we broadly recommended that CMS continue its telemedicine flexibilities. However, in this section, we want to offer two more specific telemedicine recommendations: continued support for audio-only telemedicine and continued waivers for the use of non-HIPAA-compliant software for telemedicine visits.

First, audio-only telemedicine visits would greatly improve access to care, as many Americans either do not have access to broadband internet or do not have the hardware to support video telemedicine visits. Until Congress appropriates more funding for broadband connectivity, these Americans have little-to-no options in accessing video telemedicine visits.

Even if individuals have broadband service available in their homes, they may not own the hardware or services to operate a video telemedicine visit. Only 55%–60% of Americans aged 65 or older have broadband access or a smartphone. Sarah Nmouri, et. al., *Addressing Equity in Telemedicine for Chronic Disease Management During Covid-19 Pandemic*, N. Eng. J. Med. Catalyst, https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123 (May 4, 2020). These Americans represent 18 percent of the population and are more likely to need intensive chronic disease management. *Id.*

Further many individuals, especially the elderly, do not have the digital literacy to participate in a video telemedicine call. Forty-seven percent of adults aged 50–80 expressed concerns about using technology to connect to a telehealth visit. *National Poll on Health Aging*, Univ. of Mich. https://deepblue.lib.umich.edu/bitstream/handle/2027.42/151376/NPHA_Telehealth-Report-FINAL-093019.pdf (Oct. 2019).

However, individuals have greater access to phones than to the internet. Ninety-seven percent of Americans have a cell phone, including 92 percent of Americans aged 65 or older and 94 percent of rural Americans. *Mobile Fact Sheet*, Pew Rsch. Ctr., https://www.pewresearch.org/internet/fact-sheet/mobile/ (Apr. 7, 2021). By allowing audio-only telemedicine visits, more Americans can access the care they need.

Finally, audio-only telemedicine visits promote health equity. Compared to white patients, Latino, Asian and Black patients are more likely to interact with their providers through audio-only telemedicine visits than through video. Madjid Karimi, et. al., *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services*, HHS Assistant Sec'y for Planning and Evaluation, https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf (Feb. 2022).

In sum, we believe expanded telemedicine access and, specifically, audio-only telemedicine access will improve care and reduce health disparities. Therefore, we recommend that CMS continue telemedicine flexibilities more broadly, but also continue to allow audio-only telemedicine visits at current reimbursement levels. Because not all primary care visits are amenable to audio-only visits, we also encourage CMS to find ways to provide hardware to patients in need so they can participate in video telemedicine visits.

Second, ACOFP recommends that CMS work with OCR and allow continued waivers of non-HIPAA-compliant software for telemedicine calls. Maintaining this flexibility would reduce some barriers to digital literacy and reduce overhead and compliance costs for small family medicine practices.

Scope of Practice.

ACOFP is concerned about the expanded scope of practice of mid-level providers during the PHE. Physician-led care teams are the gold standard for care delivery as mid-level providers do not have the same training or capabilities as physicians. Decades of evidence show that physicians are better positioned to deliver high-quality care because of their demanding education and professional training requirements, and—as a result—beneficiaries experience better health outcomes and Medicare realizes overall savings from healthier seniors. While the use of non-physician practitioners may be appropriate under certain circumstances and with adequate physician supervision, it is not an equivalent substitute to the use of family physicians.

ACOFP acknowledges that states are free to enact their own scope of practice laws. However, CMS can enact their own scope of practice rules for their own programs and for reimbursement policies that differ from state law. We urge CMS to protect the value and quality of physician-led care teams. Medicare beneficiaries should not be told that care provided by mid-level providers is equivalent to that of a physician-led care team, nor should that be the only available option in areas where family medicine physicians are in short supply.