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CMS'S PROPOSED RULE IS AN ADMIRABLE FIRST STEP TOWARD REMOVING HEALTHCARE SUPPLY BARRIERS

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I am pleased to have the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS) request for information on the physician fee schedule proposed rule. I am a senior research fellow and healthcare scholar at the Mercatus Center at George Mason University, and I taught nearly 50 semester-long courses in health economics to midcareer healthcare professionals at five universities between 1999 and 2017. I am the author of "Fortress and Frontier in American Health Care,"[1] and my work focuses on the question of how America can make healthcare as innovative in the next 30 years as information technology was in the past 30 years. The Mercatus Center is dedicated to advancing knowledge relevant to current policy debates. Toward this end, its scholars conduct independent, nonpartisan analyses of agencies' rules and proposals.

There is a lot to like in the proposed rule, especially in the areas of scope of practice and telehealth. I will address those areas in this comment. I encourage CMS to expand, to the greatest extent possible, the options open to patients and providers alike, and I hope that, as a country, America absorbs the positive lessons it has been offered by the pandemic.

Specifically, I suggest three things: (1) to the greatest extent possible, CMS should expand healthcare providers' scope of practice to match the level of their training; (2) CMS should consider structuring telehealth reimbursements in ways that enable teleproviders to exert downward pressure on healthcare prices; and (3) CMS should consider including audio-only consultations as a permanent part of reimbursable telehealth.

COVID-19 has shaken healthcare to an unprecedented extent. It has changed telemedicine from a small, niche corner of America's healthcare system to a dominant component of the delivery

1. Robert F. Graboyes, "Fortress and Frontier in American Health Care" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014).

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system. Increased demands on the attention of healthcare providers—especially localized peak demand—have forced a loosening of the restrictions on the provision of services across state lines and a blurring of the lines between the responsibilities of physicians, nurses, and other allied health professionals. While the circumstances are challenging, the resulting lessons are immensely valuable. By improvising, the healthcare sector and policymakers are learning in real time ways to improve care, to serve more people, and to squeeze more care out of the same number of dollars—and patients are learning a great deal as well.

A decade or so ago, John Cochrane, then a professor at the University of Chicago and now a professor at Stanford University, wrote what has become my favorite quote in healthcare policy: "What's the biggest thing we could do to 'bend the cost curve,' as well as finally tackle the ridiculous inefficiency and consequent low quality of health-care delivery? Look for every limit on supply of health care services, especially entry by new companies, and get rid of it."[2]

COVID-19 has forced the country to learn that lesson, which I often refer to as "Cochrane's Dictum," and this proposed rule is an admirable first step in applying that lesson. My hope is simply that America proceeds prudently, but expansively. The following points elaborate on how to do so.

IT IS BENEFICIAL TO MAXIMIZE THE ABILITY OF PROVIDERS TO PRACTICE UP TO THE LEVEL OF THEIR TRAINING

If the training of physicians, physician assistants, and nurse practitioners allows each to competently and safely perform some hypothetical procedure, then there are benefits to allowing all three to do so rather than limiting the procedure to physicians only. The autonomy provided to the nonphysician providers in some states provides data with which to study the safety and efficiency of such broad grants of scope of practice. For example, the Mercatus Center's Healthcare Openness and Access Project (HOAP) provides state-by-state data on scope of practice for nurse practitioners, behavioral health providers, midwives, pharmacists, and dental hygienists.[3] And now it has months' worth of data from an unplanned experiment in expanding scope of practice across the country.

The proposed rule makes admirable strides in this direction. In CMS's fact sheet published on August 3, 2020,[4] the section "Proposals Regarding Professional Scope of Practice and Related Issues" includes several relevant proposals. Public Health Emergency (PHE) rules adopted during the COVID-19 pandemic allowed certain nonphysician practitioners to supervise some diagnostic tests.[5] The proposed rule would make this temporary authority permanent. The proposed rule would also make permanent the COVID-19-period allowance for physical therapists and occupational therapists to delegate certain services to therapy assistants.[6]

Such moves can simultaneously increase access to care (by de facto enlarging the healthcare workforce) and lower costs (by allowing less expensive providers to perform services previously

2. John H. Cochrane, "After the ACA: Freeing the Market for Health Care" (working paper, 2013).
3. Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes, "Healthcare Openness and Access Project 2020: Prerelease" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, March 2020).
4. "Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021," Centers for Medicare and Medicaid Services, August 3, 2020, https://www.cms.gov/newsroom/fact-sheets/proposed-policy.-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-4.
5. 85 Fed. Reg. 27557 (May 8, 2020).
6. "Proposed Policy, Payment, and Quality Provisions."

reserved for higher-cost professionals). The lower costs, of course, free up resources for use elsewhere in the healthcare sector.

Allowing providers to practice to the full extent of their training effectively gets rid of the sort of limits on supply described by Cochrane. A general rule for consideration might be that if there is no empirical reason to limit scope of practice, then don't. Empirical evidence, of course, comes both from state-by-state comparisons and from before-COVID-19 and during-COVID-19 comparisons.

REIMBURSING FOR TELEHEALTH IS EXCELLENT; REIMBURSING AT PARITY CAN BE PROBLEMATIC

The proposed rule also makes considerable strides in the area of telehealth. It adds new services to the list of those that are reimbursable (e.g., group psychotherapy). In some cases, it allows more frequent use of telehealth (e.g., one nursing facility televisit per 3 days—or perhaps more often—instead of one visit per 30 days).

In August, in light of increased demand for telehealth services in the midst of the pandemic, CMS, in the words of Advisory Board, "waived restrictions to encourage broad adoption of telehealth and reimbursement parity for the duration of the public health emergency."[7] With parity, a physician would be paid as much for a televisit as for an in-person visit. Shortly after CMS solicited comments on the proposed rule, it was noted in the medical news that no determination had yet been made on whether such parity would be permanent.[8] Whether to set reimbursement fees at parity depends to some extent on the perceived relative value of televisits compared to in-person visits.

But another issue worthy of consideration is whether a rigid parity undermines one of the great virtues of telemedicine—the capacity to reduce costs because of, say, lower brick-and-mortar costs or the heightened ability of telephysicians to smooth demand across broad geographic areas.

In the aforementioned HOAP paper, my coauthors and I write the following (of Medicaid, not Medicare): "We take it as beneficial that in some states Medicaid will pay for telemedicine. But [payment] parity itself is problematic. One argument for telemedicine is that it is less costly than traditional office visits. Therefore, if Medicaid pays the same amount for both, it may be depriving telemedicine practices of the ability to compete on the price dimension to push costs downward."[9]

It would be worthwhile to consider whether, in lieu of rigid parity (i.e., telephysicians are paid the same as in-person physicians), a more flexible version of parity might be in order. For example, telephysicians could be allowed to charge up to the level of parity but could, if costs of provision were lower, charge less in order to expand their market share. The economic literatures on *reference-based pricing* and *reward-based programs* (which reward patients for choosing lower-cost providers) offer a rich vein of ideas to explore in this regard.[10] With reference-based pricing, the payer (Medicare in this case) agrees to pay up to a certain price, but possibly less. With reward-based programs, patients receive direct financial benefits for using lower-cost providers.

7. Advisory Board, "The 2021 Medicare Physician Fee Schedule Proposal: What You Need to Know," *Daily Briefing*, August 5, 2020.
8. Susan Morse, "CMS Proposes Telehealth Changes under Trump Executive Order," *Healthcare Finance News*, August 4, 2020.
9. Rhoads, Bryan, and Graboyes, "Healthcare Openness and Access Project 2020," 14–15.
10. John O'Shea, "How to Increase Transparency and Promote Value in Healthcare" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, June 2020).

AUDIO-ONLY SERVICES HAVE SUBSTANTIAL BENEFITS

Finally, a minor point on telehealth. The proposed rule states the following:

> In the March 31st COVID-19 IFC, we established separate payment for audio-only telephone evaluation and management services. While we are not proposing to continue to recognize these codes for payment under the PFS in the absence of the PHE for the COVID-19 pandemic, the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection, such as a doctor's office. . . . We are seeking comment on whether this should be a provisional policy to remain in effect until a year after the end of the PHE for the COVID-19 pandemic or if it should be PFS payment policy permanently.[11]

It is well worth considering whether audio-only services ought to become a standard part of the services reimbursed by Medicare. Billable hours on telephone consultations have long been a standard and valuable component of services in many other fields, such as law. In the long months of the COVID-19 pandemic, a great number of medical consultations have no doubt been conducted over the phone. The COVID-19 pandemic will give researchers a vast reservoir of data on the effectiveness of audio-only consultations. It will be more than worthwhile to comb those data for answers.

I am pleased to highlight these ideas—and especially the research papers from the Mercatus Center—to inform CMS's efforts in improving access to quality care.

11. "Proposed Policy, Payment, and Quality Provisions."