

OUR MISSION:

To advance access to the gift of hearing provided by cochlear implantation through research, advocacy and awareness.



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The Honorable Seema Verma
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244-1850

Dear Administrator Verma:

Thank you for the opportunity to provide comments on the CMS Proposed Rule, *CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies* (the Proposed Rule) [CMS-1736-P]. We have confined our comments to address policies related to the impact of revaluations for evaluation and management (E/M) codes and the proposal to extend coverage of certain telehealth services past the COVID-19 public health emergency (PHE).

The American Cochlear Implant Alliance (ACI Alliance) is a non-profit organization with the mission to address barriers to cochlear implantation by sponsoring research, driving heightened awareness and advocating for improved access to cochlear implants for patients of all ages across the United States. ACI Alliance members are hearing care clinicians including surgeons, audiologists, speech-language pathologists (SLPs) as well as scientists, educators, adults with hearing loss, and family members.

Reduction in Reimbursement Rates

We support CMS efforts to increase reimbursement for physician services that have historically been undervalued, such as office/outpatient evaluation and management (E/M) visits, and we recognize that due to statutory budget neutrality requirements, when increases are made to some codes, reductions must be made to others. However, we are deeply concerned that the 7% - 9% average reimbursement cut to speech-language pathology and audiology services will have detrimental effects for these practices, particularly when providers are already struggling with limited operational budgets due to the COVID-19 pandemic.

Speech-language pathologists and audiologists providing services outside of a hospital setting offer an important service option, particularly for older patients who have difficulty navigating large hospital settings. During the ongoing PHE, many “non-essential” procedures, which make up most of the income for these non-hospital institutions, have been halted or delayed, causing

significant financial hardship for facilities that were already facing budgetary challenges. Implementing the proposed reductions to the conversion factor and related cuts to reimbursement for key rehabilitation therapists (as well as the physician specialties engaged in cochlear implantation) will impact the ability of some providers to remain operational and/or offer services to Medicare beneficiaries.

The conversion factor adjustment will lead to an estimated 7% cut for audiologists and 9% cut for speech-language pathologists. These cuts will have significant, and potentially detrimental impacts on the availability of hearing health services for the Medicare population, particularly those living in rural and underserved areas where access to specialty care is already limited. The proposed rate reduction will make it significantly more challenging for these medical professionals to provide services to Medicare beneficiaries because they are not able to tap into the increased E/M codes to help offset these reimbursement reductions.

With respect to specific services related to cochlear implantation (CI), the proposed cuts to the reimbursement rates for codes 92601, 92602, 92603, 92604, 69930, 69949, 69990, 92584, 92585, 92586, and 95867 will have lasting impacts. Due to ongoing issues with the COVID-19 pandemic, this added financial pressure could mean a further degradation of services for those who are dependent upon access in non-hospital settings, especially when many patients avoid going into larger facilities to protect themselves from potential COVID-19 infection. As noted in the Proposed Rule, rural and underserved communities need improved access; cutting reimbursement may force private providers to reassess accepting Medicare patients in order to remain in business.

We ask that you reconsider these proposed cuts and do all you can under CMS's current authority to eliminate or significantly reduce this financial burden.

Adding Telehealth Services Under Medicare

We appreciate the opportunity to provide comments on authorization for additional Medicare telehealth services. The Proposed Rule indicates that telehealth services that are provided as part of the cochlear implant procedure—and the rehabilitation services related to CI—are among those that will not be extended past the PHE. Having these services available virtually during the PHE has demonstrated the benefit of telehealth services for cochlear implantation for everyone – patients and providers. Not only has infection risk been mitigated during delivery of services in the COVID timeframe, outcomes of CI patients have been maintained and even improved.

Access to telehealth services should remain in place for patients who are unable, or find it difficult, to leave their home—even for medical appointments. Telehealth also addresses the ability to serve those who have limited access to specialized providers in their community such as cochlear implant clinicians who may not exist in many rural or lower socio-economic communities.

Cochlear implant clinicians report that they are seeing improved outcomes with telehealth as patients are more compliant about attending appointments. Physicians note that they have experienced very few missed telehealth appointments during the PHE. One clinician reported

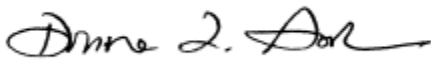
that, “Patients seen under telehealth are on-time as they don’t need to fight traffic and find parking.” Another clinician, whose practice include septuagenarian and octogenarian Medicare beneficiaries, noted that, “Transportation for this population can be difficult. During the regular winter flu season when weather can also be a complicating factor, getting to the clinic can be difficult. Providing telehealth services reduces risks for all—patient and provider—and has not affected quality of care.” Telehealth also provides the ability to easily communicate with both patient and family members who can ensure that follow-up is appropriate for an elderly patient.

One clinic recently noted that although physicians can provide and bill for time spent on counseling via telehealth for cochlear implant patients, audiology counseling is not covered. It was felt that having this option would improve outcomes and reduce the risks of travel for older adults.

We therefore ask that you consider adding cochlear implant services, CPT codes 92601-92604, to the list of expanded telehealth services. Doing so will ensure that Medicare beneficiaries with hearing loss, who may otherwise struggle to access cochlear implant services because of transportation, accessibility, mobility or location challenges, are able to access safe and medically necessary care.

Thank you for your consideration of our comments. We are happy to answer any questions you might have.

Sincerely,



Donna L. Sorkin MA
Executive Director
American Cochlear Implant Alliance

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