



September 13, 2021

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
US Department of Health & Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: CMS-1751-P Medicare Program: CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates: Provider and Supplier Prepayment and Post-Payment Medical Review Requirements**

Dear Administrator Brooks-LaSure,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2022 Medicare Physician Fee Schedule (PFS) proposed rule (Proposed Rule). As the largest provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies.

CSC supports and advocates for policies that improve equitable, timely, and affordable access to comprehensive, high-quality health care coverage. Many of the provisions CMS requests comments on and which CSC addresses below speak to these important premises.

**Telehealth**

This Proposed Rule is necessarily influenced by the COVID-19 pandemic and the resulting and ongoing Public Health Emergency (PHE). Whether due to restrictive safety measures implemented to protect patients from possible exposure to COVID-19 or patients' own measures to limit their or their loved one's exposure to the virus, the pandemic has challenged access to care in an unprecedented manner, thereby propelling telehealth and tele-mental health to the forefront. Expanded coverage and flexibilities for telehealth and tele-mental health services have enabled cancer patients to see providers from the safety of the homes and ensure continuity of care when in-person care was either not available or presented a heightened risk for people vulnerable to a poor outcome from exposure to the virus. A CSC COVID-19 survey found that 76% of respondents reported engaging in telehealth visits during the pandemic in 2020. Further, despite the relaxing of COVID-related restrictions and the returning option for in-person health care, recent data from these same respondents indicates that 53% have still engaged in telehealth. The preliminary data presented in the Proposed Rule revealing that over 24.5 million out of 63 million Medicare beneficiaries had a telehealth visit during a seven-month period in 2020 further supports the invaluable role of telehealth.

### Mental Health Telehealth Services

CSC advocates for policies and regulations that preserve and promote patient choice, as well as respect and enhance the patient-provider shared decision-making process. We also support appropriate and purposeful guardrails that ensure quality, comprehensive care is provided to patients. With these principles in mind, we begin by noting that while **we strongly support the permanent removal of the geographic restrictions and the addition of the beneficiary's home as a permissible originating site** under Section 123 of the Consolidated Appropriations Act (CAA) for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a mental health disorder, **we do not support the requirement of an initial in-person, non-telehealth visit with a provider within 6 months of a telehealth service.** This requirement fails to promote patient choice, respect and enhance the patient-provider shared decision-making process and provide appropriate or purposeful guardrails. Such a requirement may, in fact, serve as a deterrent to some beneficiaries seeking the care they need. **We also caution against adding the requirement of an in-person, non-telehealth service at least every six months after mental health telehealth (tele-mental health) service(s) is provided.** The need (or lack thereof) and timing of any prior or subsequent in-person, non-telehealth mental health service should be a decision that rests between the patient and provider and takes into consideration the patient's diagnosis, current mental health status, accessibility concerns or limitations (economic, physical, or mental), and exposure to potential risks such as COVID-19.

### Definition of Interactive Telecommunications Systems

The Proposed Rule amends the prior **definition of interactive telecommunications systems in connection with Medicare telehealth to include audio-only communication technology** when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes. The availability of audio-only tele-mental health services ensures access to mental health care services for people who lack the cognitive ability to use video platforms and for people who lack broadband access (*Psychiatrists Use of Telepsychiatry During COVID-19 Public Health Emergency Survey Results*, 2021). Audio-only services also provide essential mental health care access to people of low-income who may depend on a land-line and lack the means for a computer or smart phone and for people with physical disabilities for whom video platforms are difficult or impossible to navigate. **CSC strongly supports the change in definition to include audio-only technology for delivery of mental health care services in the home but opposes the definition's limitation to "established patients"** which requires patients to have had an evaluation and management (E/M) or other face-to-face service (Centers for Medicare & Medicaid Services, 2021). Remaining consistent with our concerns expressed above, CSC urges CMS to eliminate all requirements for in-person, non-telehealth visits for tele-mental health services, audio or otherwise.

### Requirement for Practitioners to Have Two-Way, Audio/Video Communications Capability

CSC advocates for a patient's choice to select the method of delivery (in-person, audio/video, or audio only) for their mental health care. To ensure patients have these choices, we **support limiting the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications**, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology. Expanding patients' access to mental health care services means patients should have the full breadth of options readily available to them on how they wish to receive that care. Requiring practitioners to have the capability to furnish two-way, audio/video communications ensure that patients will receive the benefit intended behind offering alternate and flexible means delivery methods.

### Extending Coverage of Certain Category 3 Telehealth Services Through the End of CY 2023

As mentioned previously, CSC supports appropriate and purposeful guardrails that ensure quality, comprehensive care is provided to patients. For this reason, **we support extending coverage of some telehealth services through CY 2023** to gather more information regarding the utilization, clinical appropriateness, and value of these services to help determine whether sufficient evidence is available for permanent coverage under Category 1 or 2 services. However, CSC believes the determination of the clinical appropriateness of audio-only telehealth should be one that rests with the patient and provider and no requirement for additional documentation will or should substitute for that shared decision-making. As with all health care services, providers must use their clinical training and professional judgment to do what is in the best interest of their patient and the same standards should apply to audio-only tele-mental health services.

### **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**

#### Mental Health Services Furnished via Telecommunications Technologies

RHCs and FQHCs play a crucial role in providing vulnerable populations with equitable, timely, and affordable access to comprehensive, high-quality health care. **CSC applauds revising the current regulatory language to allow RHCs and FQHCs to report and receive payment for mental health visits conducted via real-time telecommunications technology** (including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology) as they do for in-person visits.

#### Transitional Care Management (TCM)

Continuity of care is critical to ensuring patients' health and well-being. This is especially true for older adults who may have multiple chronic health conditions. Any delays or disruptions to receiving appropriate care threatens outcomes for patients. RHCs and FQHCs play an essential role for populations who depend on them as their primary source of health care. These entities play multiple concurrent roles for vulnerable and at-risk patients, thus warranting and necessitating RHCs and FQHCs ability to bill for TCM and other care management services furnished to the same beneficiary during the same service period.

### **Beneficiary Coinsurance for Additional Procedures During Colorectal Cancer Screening**

At the onset of the pandemic, cancer screenings plummeted, with screening for cancers of the breast, colon, and cervix down between 86% and 94% in March of 2020 alone (Mast & Munoz, 2020). There is broad concern that these delayed or missed screenings will result in some cancer cases being diagnosed at a later stage increasing the likelihood of a poorer prognosis. The National Cancer Institute (NCI) predicts that over the next decade we will see almost 10,000 excess deaths from breast and colorectal cancer alone because of pandemic-related delays in cancer screening and treatment (Sharpless, 2020). These statistics demonstrate the importance of receiving timely and appropriate cancer screenings. This Proposed Rule's changes to beneficiary coinsurance for additional procedures furnished during the same clinical encounter as a colorectal cancer screening will, over time, **help eliminate a cost-sharing burden that was imposed on patients for obtaining a potentially life-saving cancer screening.**

While not addressed in this Proposed Rule, a similar disincentive remains in place for people whose screening colonoscopy served its intended purpose – finding and removing a precancerous polyp(s). In these instances, all subsequent colonoscopies performed to timely identify and remove any new precancerous polyp(s) are automatically classified as “diagnostic” colonoscopies that impose required cost-sharing obligations on patients. This is true despite the fact that the goal of each subsequent

colonoscopy is the same as a “screening” colonoscopy – to provide early detection and removal of any precancerous polyps. Medicare beneficiaries should be encouraged, not penalized, for routinely seeking services that can prevent cancer and its resulting physical and psychosocial harm to patients, as well as significant financial costs to both patients, caregivers, and the health care system.

### **Vaccine Administration Services**

To limit potential for exposure to COVID-19, many cancer patients and caregivers have quarantined at home during the pandemic. Of course, the need to remain at home or the inability to travel outside of the home is neither limited to cancer patients nor the COVID-19 pandemic. The importance of safe and timely access to preventative and potentially life-saving vaccines for those confined at home is clearer now than ever before. Qualified health professionals who are trained and authorized to administer the range of vaccines offered should be compensated for their service as they would be if administering the vaccines in their office or at their site of care, plus additional compensation at a reasonable rate to account for their time and travel. The pandemic demonstrates the value, in costs and lives, of prevention.

### **Health Equity**

CSC is committed to supporting efforts to advance and achieve health equity. Health disparities are not a new problem in health care or cancer care. Major recognitions of health care disparities in the United States began nearly three decades ago.

Despite cancer innovations in diagnostics and therapeutics and decades of federal initiatives challenging health disparities, cancer care disparities persist in every aspect of care. For instance, Black women have a 7% lower risk of cancer diagnosis but a 13% risk of cancer death, and Black men have higher incidence and death rates than white men for all cancers combined (DeSantis et al., 2019). It is imperative that all people impacted by cancer or other conditions have an opportunity to achieve the best health outcomes, no matter who they are or where they live.

**CSC acknowledges the value of the three core priority areas of the CMS Equity Plan for Improving Quality in Medicare:** (1) Increasing understanding and awareness of health disparities; (2) developing and disseminating solutions to achieve health equity; and (3) implementing sustainable actions to achieve health equity. However, these priorities cannot be achieved until CMS establishes a consistent and accurate reporting method that captures the information necessary to eradicate health disparities and achieve equity. CMS notes that self-reported race and ethnicity data are the gold standard for classifying an individual according to race or ethnicity. Once successfully implemented, self-reporting will allow stratification of quality measures such as condition/procedure-specific readmission by race and ethnicity which CMS states it seeks to achieve. CMS acknowledges that it does not currently collect self-reported race and ethnicity for the Medicare programs, but instead gets its data from the Social Security Administration which has not proven accurate or comprehensive.

**We support the use and incorporation of the broad definition of equity** established in the Executive Order 13985 (Exec. Order No. 13985, 2021). To better understand and address health disparities, the definition CMS has chosen to adopt must be uniformly incorporated into a mechanism that patients will consistently use across all Medicare programs to self-report their demographic data. Once collected and stratified, this data will help reveal inequities for which solutions can be devised to achieve and sustain equity.

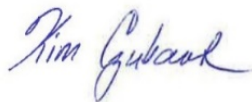
## CY 2022 Conversion Factor

Without the 3.75 percent increase provided by the CAA, and adjusting for the budget neutrality, the CY 2022 conversion factor (CF) is estimated to be \$33.58, or approximately 3.75 percent lower than the CY 2021 CF of \$34.89. As discussed throughout these comments, the COVID-19 pandemic has imposed a new reality that our society and health care system is ill-prepared to effectively address. Serious consideration should be given to what, if anything, can be done to ensure primary care providers receive the necessary compensation to serve the growing needs of their patients during this PHE and beyond.

## Conclusion

Thank you again for the opportunity to share these comments. We look forward to working with the Centers for Medicare & Medicaid Services to ensure all Medicare beneficiaries have access to high-quality, comprehensive, and affordable health care coverage. If you have any questions or would like to discuss these comments in more detail, please reach out to Kim Czubaruk at [kczubaruk@cancersupportcommunity.org](mailto:kczubaruk@cancersupportcommunity.org).

Sincerely,



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