

CMS Request for Information (RFI)
Make Your Voice Heard: Promoting Efficiency and Equity Within

The U.S. Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is currently seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE). Please find the responses provided by the Health Policy and Advocacy Committee (HPAC) and work group members below.

1) CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. They are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, or utilizing services (including medication therapies) across CMS programs.

- 1) Despite the effectiveness of pulmonary rehabilitation (PR), less than 4% of Medicare beneficiaries with COPD having access to PR. (1) Barriers to PR include variable access particularly in rural settings, limited uptake, low reimbursement (approximately 50% of that paid for cardiac rehabilitation), and poor awareness of benefits among clinicians. (2) The 'Hospital without Walls' waiver has permitted virtual PR services for persons with COPD GOLD 2-4 and more recently COVID-19. This enables PR for persons unable to access center-based PR, including those living in rural or remote settings. However, the lack of long-term coverage of remote PR beyond 90-day PHE increments and CMS' plan for eventual termination of outpatient hospital-based programs creates a significant challenge to effective patient care, outcomes, access, and uptake. An important clinical opportunity during the PHE has been the option for virtual MD supervision of PR. This has offered the needed flexibility to support virtual PR patient visits and maximize physician access. However, the temporary status of this important clinical component undermines the benefits and value of PR to both patients and clinicians.

1. Nishi SP, Zhang W, Kuo YF, Sharma G. Pulmonary Rehabilitation Utilization in Older Adults With Chronic Obstructive Pulmonary Disease, 2003 to 2012. *Journal of cardiopulmonary rehabilitation and prevention*. 2016;36(5):375-82.

2. Rochester CL, Vogiatzis I, Holland AE, Lareau SC, Marciniuk DD, Puhan MA, et al. An Official American Thoracic Society/European Respiratory Society Policy Statement: Enhancing Implementation, Use, and Delivery of Pulmonary Rehabilitation. *Am J Respir Crit Care Med*. 2015;192(11):1373-86.

- 2) Approximately 1 million or more patients who received home respiratory equipment and supplies during the PHE and for whom standard medical necessity documentation was not created under the CMS waiver could be forced to schedule an additional physician visit within a very short period of time after the PHE ends just to get their documentation updated. This will be an unnecessary burden on patients and physicians that disrupts access issues.
- 3) The widespread implementation of telemedicine revolutionized American healthcare delivery, improving access for all. However, improved access still does not mean equal or even equitable access, due to imperfect telephone communications, lack of broadband for video access, and basic affordability even

in areas with adequate communications infrastructure. Some specialties (e.g., surgical/interventional) still require an in-person evaluation for the decision to proceed. But most cognitive services can be performed telephonically, thereby improving access. Even initial diagnostic evaluations can often be completed telephonically, with a patient interview supplementing a preceding record review to allow formulation of a diagnostic plan, and scheduling of an in person encounter to review the diagnostic results and agree upon a therapeutic plan. There are widespread, systemic shortcomings and even complete failings in America that produce disparities. Access to healthcare is adversely impacted by transportation inequities (including the corresponding costs) and risk of crime. Access to health is adversely impacted by poor nutrition, including affordable access to a more healthy/nutritious diet. The ability to save costs, reduce transit time, and improve safety by accessing healthcare from one's own home will produce legion benefits to Americans. Even in bad weather (hurricanes, blizzards) and natural disasters (flooding, earthquakes), and daily circumstances (traffic, transportation challenges) healthcare access via telehealth is beneficial and should be facilitated for both patients and providers to be delivered from their respective homes.

- 4) Many patients suffer from chronic respiratory diseases — particularly COPD. Acute exacerbation of COPD, which many times leads to hospitalization, is a main burden on healthcare systems. Pulmonary rehabilitation has shown a promising effect on preventing future exacerbation and hospitalization. Many patients have challenges to access pulmonary rehabilitation programs and if they do access them, they feel constrained to a limited covered visits by CMS. Because of this, vital medical interventions (i.e., pulmonary rehabilitation), we request CMS to consider increasing the limits of covered pulmonary rehabilitation sessions for COPD patients and other chronic respiratory diseases.
- 5) The cost of inhalers represents a major burden. Patients aren't able to afford basic inhalers and do not use these medications, which they need to improve their quality of life. Because of this, some providers prescribe inhalers that are not appropriate for that patient because it is the only affordable option and preferable to no treatment at all. Additionally, the limit for pulmonary rehab sessions is too low despite the significant benefit many patients receive from this therapy and the lifetime burden of disease they face.

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

- 1) The major issues contributing to well-being are flexibility in scheduling and support. When providers are constantly working long hours in high burden of patients without a break that is morally distressing. The administrative burden is another aspect of care that leads to provider burnout and should be minimized as much as possible.
- 2) Many providers report overworking and impacted work-life balance. This is due to the shortage of providers in general, which put them again in a vicious cycle of taking more work. This is often called the "Quadruple Aim" and CHEST supports CMS' efforts to increase focus on providers' mental well-being.

3) CMS wants to further advance health equity across their programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities.

- 1) CMS covers tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries, regardless of whether the patient has signs and symptoms of tobacco-related health problems. The coverage includes two individual tobacco cessation counseling attempts per year; each attempt may include a maximum of four intermediary (> 3 minutes) or intensive (> 10 minutes) counseling sessions. While the total annual benefit will cover up to 8 counseling sessions per Medicare beneficiary, the reimbursement rate is so low it precludes many clinicians from counseling individuals. In addition, the counseling must be furnished by a qualified physician or other Medicare-recognized practitioner. Certified tobacco treatment specialists, regardless of whether they are Medicare-recognized practitioners, should be allowed to bill for tobacco dependence counseling. Further Medicare reimbursement for tobacco treatment counseling should be increased. Telehealth is positioned to continue to address barriers for marginalized people and connect them to vital and lifesaving services. Access to clinical care by telehealth is critical for implementing tobacco cessation services for those suffering from tobacco use disorder and healthcare providers who are dedicated to this work.
- 2) We encourage CMS to continue to seek ways to improve lung cancer screening across its programs (Medicare, Medicaid, Exchanges), particularly with respect to marginalized populations, who are disparately targeted by tobacco companies, have low rates of enrolling in screening programs, despite eligibility, and face increased risk of death, as noted by the recent proclamation and declaration of Lung Cancer Awareness month by the administration.
- 3) Healthcare disparities are a real problem cause by social determinants of health — and subconsciously missed or ignored. One of the main difficulties with socioeconomic healthcare disparity is that marginalized people don't like to share their shortcomings. It is imperative that a governing body (e.g., CMS) incentivize providers to invest more proactively in developing trust with their patients that better enables the development of care plans that can be feasibly followed.

4) 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.

- 1) From pulmonary rehabilitation perspective, waivers and flexibilities issued during the COVID-19 PHE were beneficial for both patients and providers and did not impact required elements of healthcare provision and supervision of service. An example of such flexibility is the CMS expansion of direct supervision to include virtual care through audio/visual real-time communications technology, which was practical and helpful — and probably resulted in similar outcomes whether these services were provided in-person or via telehealth. In addition, we agree with what CMS clarified during the pandemic that for the physician providing pulmonary rehabilitation supervision, being "immediately available" does not need real-time

presence or supervision of the service via interactive technology throughout the performance of pulmonary rehabilitation. More data are coming to highlight the role of telemedicine. While we believe that the pandemic will end, telehealth is here to preserve — for good reasons. We suggest that CMS continue to be flexible with virtual care regardless of the COVID-19 PHE status.

- 2) The acceleration of telemedicine has been a win. For some clinical visits, a telemedicine appointment is a pragmatic way to provide the right care at the right time for patients minimizing frictions and increasing accessibility. For instance, I think our sleep medicine colleagues have been very effective in use of telemedicine as they are able to remotely access clinical data, interpret it, and communicate findings to patients via telemedicine. Where we struggle in our clinic is in providing telemedicine for our entire catchment area which spans three states, and as such, would require multiple licensures with present laws. This may be an area for re-evaluation.
- 3) In addition to above, audio-only telehealth visits allowed us to care for patients who have had challenges with video technology, an issue with patients at our large safety-net hospital.
- 4) It was great being able to administer lifesaving medications and vaccines free of charge and not having to worry that cost was a limiting factor in patients utilizing medicines.