CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS ADDRESSING PUBLIC POLICY ISSUES IN CANCER

September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1770-P, Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks LaSure:

The undersigned cancer patient, health care professional, and research organizations appreciate the opportunity to comment on the calendar year 2023 Medicare physician fee schedule proposed rule. In the comments below, we focus on the potential impact of the proposed rule on patient access to quality cancer care.

Cancer patients require access to a multidisciplinary system of care to ensure that they receive all necessary elements of cancer treatment and access to long-term survivorship care. Multidisciplinary cancer treatment depends on the contributions and talents of medical oncologists and hematologists, surgical oncologists, and radiation oncologists. Cancer patients also require complex supportive care delivered during treatment to help them deal with the side effects of cancer and cancer treatment. At the end of active treatment, cancer patients may transition to survivorship care that depends on specialists and primary care physicians and includes monitoring, follow-up care, and intervention. These interventions may include further treatment upon recurrence or a second primary cancer or to address the late and long-term effects of cancer treatment.

The Medicare physician fee schedule is designed in a way that serves to discourage the system of multidisciplinary care that cancer patients need from diagnosis and across the continuum of care. Rules of budget neutrality, for example, mean that a well-designed and well-deserved boost in payment for primary care providers caring for cancer patients may result in an automatic reduction in reimbursement for a specialist providing a critical element of care to cancer patients. Furthermore, reimbursement reductions that are triggered by Medicare physician fee schedule rules may be so substantial to undermine the delivery of cancer care and to create barriers to patients' access to care.

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We understand that the Centers for Medicare & Medicaid Services (CMS) may not have discretion regarding application of budget neutrality rules, and we will acknowledge in our comments below that legislative action may be necessary to resolve certain patient access issues that we identify.

We also suggest that calendar year 2023 will remain an especially difficult year for many physicians who are still grappling with the lingering (or worse) effects of the coronavirus pandemic. For physicians treating cancer patients, the effects of the pandemic will be felt for many years to come. In addition to the increased costs of providing care associated with supply chain issues, there is the impact of cancer patients being diagnosed later than pre-pandemic and presenting with more advanced disease. Patients with more advanced disease may require more resource-intensive care of greater cost and may have significantly worse outcomes. Reductions in reimbursement to physicians treating cancer patients may harm those physicians' practices and create barriers to care for patients. The results for patients may be grave.

Medicare Conversion Factor

CMS has proposed a conversion factor of $33.0775, which is a decrease of 4.42 percent from the calendar year 2022 conversion factor. The reduction in the conversion factor is in large part the result of an expiring 3 percent increase under the Protecting Medicare and American Farmers from Sequester Cuts Act. An additional 1.5% of the conversion factor reduction is associated with a budget neutrality adjustment triggered by several evaluation and management code changes.

The reduction in the conversion factor will mean a reduction in payment for some physicians, reductions coming while physicians are still struggling with the effects of the pandemic.[1]

If changes in the proposed conversion factor are not possible under current law, we urge Congress to provide relief for CY 2023 while long-term physician fee schedule reforms are considered.

Impact on Reimbursement to Oncologists

CMS estimates that in calendar year 2023 the changes in the physician fee schedule will have a negative 1 percent overall impact on the hematology/oncology specialty and a negative 1 percent overall impact on the radiation oncology specialty. These estimates neglect to include the 3 percent reduction in the conversion factor. As a result, the CMS estimate is an underestimate of the real impact of the physician fee schedule on all oncologists. In addition, the impact will depend on the geographic location of an oncology practice and the mix of Medicare services billed by the practice.

[1] A recent analysis shows that inflation- and utilization-adjusted radiation oncology Medicare reimbursement was down 27% from 2010-2019, with additional cuts since. Hogan J, Roy A, Karraker P, et al. Decreases in Radiation Oncology Over Time: Analysis by Billing Code. Radiation Oncology*Biology*Physics. Vol 114, Issue 1, p 47-56. May 21. 2022. In addition, radiation oncologists report that overhead costs have increased 10-20 percent from this time 2021.

We are concerned that the impact of the physician fee schedule changes on oncologists will in turn result in access challenges for cancer patients. There may be additional consolidation of practices, closure of practice sites and entire practices, and other changes that will affect patient access.

The combination of ongoing erosion in payment, a challenging economic environment, and escalating administrative burden may force some practices to close, despite a strong desire to remain a source of care for their community.

We reiterate that the impact of physician fee schedule changes – including evaluation and management changes, the application of budget neutrality, and the impact of the conversion factor – should be reconsidered because of their significant impact on certain physicians that may translate to patient access obstacles.

Coverage for Colorectal Cancer Screening

We commend CMS for proposals related to colorectal cancer screening. The proposals include reducing the minimum age for certain colorectal screening tests to 45 years and providing coverage for one follow-on screening colonoscopy after a Medicare-covered, stool-based colorectal cancer screening test returns a positive result. In addition, CMS proposes eliminating beneficiary cost-sharing requirements for these tests.

If finalized, these proposals may help address the gaps in screening access, improve screening rates, and improve outcomes because colorectal cancer is diagnosed at an earlier stage.

CMS used its communications capability during the pandemic to inform Medicare beneficiaries regarding COVID-19 vaccine availability and to urge vaccination. We recommend that the agency use that same communications capacity to alert Medicare beneficiaries to changes in colorectal cancer screening coverage (when these proposals are finalized) and to urge beneficiaries to undergo screening, if appropriate.

Request for Information on Payment for Dental Services

We applaud the efforts of CMS to clarify payment policies for dental services. Dental services are currently covered when dental services are an integral part of a covered primary procedure or service provided by another physician treating the primary medical illness. There may also be dental service coverage when the dental service triggers hospitalization because of the beneficiary's underlying medical condition or clinical status or because of the severity of the dental procedure. Decisions about dental coverage are made on a claim-by-claim basis, a process that can be slow and burdensome and that some have found much too restrictive.

Clarification about Medicare coverage policies, including whether the service will be covered on an outpatient or inpatient basis, will be of benefit first and foremost to head and neck cancer patients who require extensive dental work as part of their treatment. Other cancer patients, as a result of their underlying medical condition and clinical status, will likely also benefit from clear and predictable dental coverage standards.

CMS is seeking advice on dental coverage, and medical, surgical, and radiation oncologists are providing detailed advice to the agency regarding the needs of cancer patients.

Extending Telehealth Flexibilities After the Public Health Emergency

We support the actions of CMS to protect access to certain telehealth services for 151 days after the end of the Public Health Emergency (PHE) and to extend coverage of other services through CY 2023. CMS proposes to implement several telehealth provisions in the Consolidated Appropriations Act, 2022, including:

- Extending coverage of services temporarily added to the Medicare Telehealth Services list during the PHE for a period 151 days after the end of the PHE; and
- Extending for a period of 151 days after the end of the PHE several telehealth policy flexibilities that have been established by program instruction or other sub-regulatory guidance (these include but are not limited to the originating site flexibility, audio-only flexibilities, and eligible telehealth practitioner flexibilities).

The agency also proposes to extend coverage for some "category 3" telehealth services through calendar year 2023. Category 3 services are those covered on an interim basis until data can be gathered to help determine whether they should become category 1 or 2 services and covered by Medicare.

These actions by CMS are important interim steps, but we urge a permanent solution to the issue of Medicare coverage of telehealth services. As Congress and the agency consider permanent actions to address telehealth access, we urge that careful attention be paid to quality assurance and quality measurement of telehealth services. Patients and health care professionals may both benefit from clear telehealth coverage and reimbursement policies, but they must also be assured that these policies will support quality care. Continued coverage of audio-only services will also protect access to critical services in certain circumstances.

The issue of licensure to provide telehealth services across state lines must be addressed in a comprehensive telehealth solution, but we realize that is beyond the scope of the annual physician fee schedule update.

Alternative Payment Models for Cancer Care

We support the development and implementation of alternative payment models that will support well-coordinated and high-quality cancer care. Although the calendar year 2023 changes that we recommend above are crucial for equitable and adequate payment for cancer care, the long-term solution to payment for quality cancer care is payment through an episode-of-care model or models providing equitable, well-planned, and coordinated care of high quality. In separate communications with the agency, we have identified and will continue to describe the critical elements of cancer alternative payment models.

In its consideration of cancer care models to date, CMS has focused on episodes of active treatment. Although we understand this initial focus, we urge that the agency expand its consideration of models to include alternative approaches to survivorship care. The health care needs of many survivors are significant, and they would benefit from alternative models of

survivorship care. The month of September is both Blood Cancer Awareness Month and Childhood Cancer Awareness Month (preceded and followed by awareness months for other specific groups of cancer patients), a month that directs attention to cancer survivors who may live for a long time after diagnosis and treatment but who may confront serious survivorship issues requiring aggressive intervention and care as Medicare beneficiaries. It is an apt time to note the need for new approaches to survivorship care.

We appreciate the opportunity to comment on the CY 2023 Medicare physician fee schedule proposed rule.

Sincerely,

Cancer Leadership Council

Academy of Oncology Nurse & Patient Navigators
American Society for Radiation Oncology
Association for Clinical Oncology
Association of Oncology Social Work
Cancer*Care*
Cancer Support Community
Children's Cancer Cause
College of American Pathologists
Hematology/Oncology Pharmacy Association
International Myeloma Foundation
LUNGevity Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer Research Alliance
Prevent Cancer Foundation

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