

# CANCER LEADERSHIP COUNCIL

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

September 27, 2019

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

RE: CMS-1715-P, Medicare Program: CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

The undersigned cancer organizations represent people living with cancer, health care professionals engaged in cancer care, and cancer researchers. We appreciate the opportunity to comment on proposed revisions to the physician fee schedule for calendar year 2020. The proposed rule presents several opportunities for advancing care coordination and management. We applaud the agency for the proposals aimed at enhancing utilization of care coordination codes, and we offer specific comments on those proposals below.

## ***Care Management Services***

In our comments on previous physician fee schedule updates, we have commended the Centers for Medicare & Medicaid Services (CMS) for attempting to improve payment for care management and care coordination through the establishment of a suite of codes for these services. We have also recommended revisions of the definitions of these codes to encourage more utilization of these codes in the cancer care setting.

The persistent feedback from health care professionals has been that the care coordination and management codes carry significant administrative burdens for the amount of payment. We are pleased that CMS has considered the burdens to utilization of the care coordination codes, based on by its own look at claims data and through an external firm's analysis of claims data.

#### *Transitional Care Management Code*

We commend the recommendation of the agency related to services that might overlap with or duplicate the transitional care management services. In the proposed rule, the agency recommends revising billing requirements so that TCM codes could be billed concurrently with other codes. We agree with the analysis of the agency that these codes are often complementary to the TCM codes and that permitting concurrent billing will improve overall quality of care, in part by encouraging the use of TCM codes.

#### *Complex and non-complex Chronic Care Management Codes*

We support the code changes that add time increments for the chronic care management codes and improve payment accuracy.

#### *Typical Care Plan*

The patient advocate signatories to this letter have been significantly involved – including through participation in the cancer care studies conducted by the Institute of Medicine (now National Academy of Medicine) and the implementation of the Oncology Care Model – in the definition of a care plan for cancer patients. We have leaned toward a detailed and comprehensive definition of a care plan, as we think that thorough planning can be the foundation for effective care management and coordination. However, we have been informed by health care professionals that the level of detail that we have supported can be constraining and may create a barrier to care planning instead of facilitating it.

As a result of our experience related to this topic, we appreciate the desire to streamline and focus the care plan definition. We believe that the simpler language proposed by the agency for coordination with resources external to the medical practice is an improvement that will make it easier for health care professionals to adhere to care plan requirements, while still creating a plan that is meaningful and useful for patients.

#### *Principal Care Management (PCM) Services*

We strongly support the establishment of a code and payment for care management services for patients with only one chronic condition. In the preamble to the proposed rule, the agency writes, “We have heard from a number of stakeholders, especially those in specialties that use the office/outpatient E/M code set to report the majority of their services, that there can be significant resources involved in care management for a single high-risk disease or complex chronic condition that is not well accounted for in existing coding.” We believe that this describes very well the situation that confronts those who are providing care to individuals who are living with cancer as a chronic condition, either in active treatment or not in active treatment. These patients require significant services for monitoring the late and long-term effects of cancer and cancer treatment -- side effects that may include cardiac issues, pain, fatigue, anxiety, stress, risks of second cancer, and other issues. We believe that the principal care management service may help align payment with the resources required for care management of cancer survivors after active treatment.

We support the decision to place no restrictions on the specialties that could bill for the principal care management service. We anticipate that care for cancer survivors will often be provided by oncologists, but there are also circumstances where the care will be from primary care providers.

The agency has noted that many patients will have more than one complex chronic condition, with one clinician providing principal care management services and a primary care provider caring for another chronic condition. We anticipate that a specialist might provide principal care management services for a cancer survivor while a primary care provider cares for the patient's diabetes, as one example. We commend the agency for noting and accommodating this situation in the design of the principal care management service.

### ***Coinsurance for Colorectal Cancer Screening Tests***

CMS explains in the proposed rule that it has interpreted the Medicare statute in a way that requires the agency to consider colonoscopy procedures that begin as screening tests but result in the removal and biopsy of polyps as a diagnostic rather than a screening test. The result of this statutory interpretation for the Medicare beneficiary is that cost-sharing (of 20 or 25%, depending on site of care) is applied.

The agency notes that the Congress addressed the applicability of the deductible in the case of the colorectal cancer screening that involves biopsy or tissue removal through a provision of the Affordable Care Act, but the agency says its interpretation of the Medicare statute does not permit waiver of cost-sharing.

The agency suggests a solution to this dilemma of “surprise” cost-sharing for beneficiaries who thought they were having a screening colonoscopy but later found they had a diagnostic colonoscopy. The recommended solution is a requirement that physicians inform their patients that a colonoscopy that requires polyp removal will result in cost-sharing requirements. This action by physicians is intended to eliminate the potential for beneficiary surprise.

We do not believe that physician education about diagnostic colonoscopy cost-sharing is an adequate solution for the individual beneficiary or for public health. Colonoscopy holds the promise of cancer prevention, if polyps are removed early, and colonoscopy also leads to early diagnosis of colon cancer. These colonoscopy results lead to better outcomes for beneficiaries and save Medicare resources. However, concerns about cost-sharing for diagnostic colonoscopy can serve to hinder beneficiary utilization of colonoscopy. Eliminating cost-sharing requirements – for diagnostic colonoscopy in a manner already provided for screening colonoscopy – is in the best interest of Medicare beneficiaries and the Medicare program and we believe it can be accomplished by a careful interpretation of the statute.

We recommend that the agency try again to interpret the Medicare statute in a way that is consistent with Congressional intent as expressed in the preventive services provisions of the Affordable Care Act, so that cost-sharing is eliminated for all colonoscopies, including those that require polyp removal.

### ***Opportunities for Bundled Payments Under the PFS***

The agency states in the proposed rule, “We are seeking public comments on opportunities to expand the concept of bundling to recognize efficiencies among physicians’ services paid under the PFS and better align Medicare payment policies with CMS’s broader goal of achieving better care for patients, better health for our communities, and lower costs through improvement in our health care system.” The agency also suggests that it has considerable flexibility for development of payments under the physician fee schedule.

We are pleased to respond to this request for comments regarding new opportunities for bundling of payments and services. The signatories to this letter have been parties to the Oncology Care Model (OCM) in various ways. Physicians represented by our organizations are current participants in the OCM, and the stakeholder organizations signing this letter have offered advice regarding the design, implementation, and evaluation of the OCM. We bring this experience to our recommendation that cancer survivorship care be the subject of a bundled system of care and payment.

It is time for bold experimentation in cancer survivorship care delivery and payment. Cautious and modest care reform steps are not serving survivors well.

Cancer survivors have been described by the Institute of Medicine as “lost in transition” as they move from active cancer treatment to management of their chronic cancer condition, which the cancer community refers to as the period of cancer survivorship. Cancer survivors are “lost in transition” because they leave active treatment with limited knowledge of the therapies they received (via a summary of their treatment), without a clear understanding of which provider will take care of them after active treatment, with serious health care challenges associated with potential late and long-term effects of cancer and cancer treatment (including possible second cancers), and without a plan for monitoring and addressing these potential late and long-term effects.

Cancer is a chronic condition, and survivors live with their disease and with treatment for their disease from diagnosis through the end of their lives. Even those who are cured may still experience late and long-term effects of cancer treatment. Others diagnosed with cancer may never be cured but will die with rather than from their disease.

Although there has been some experimentation by health care professionals, health systems, and patient advocacy organizations regarding models of survivorship care, there is no clarity about preferred models, and too many cancer survivors are still “lost in transition.” Survivorship care experimentation has not provided definitive answers, but it has provided important insights about how to deliver and improve care.

We acknowledge that designing a survivorship care bundle of care will be challenging, for a number of reasons. The experience of survivors is diverse and their health challenges may be widely divergent, depending on their specific diagnosis and treatment. However, there are detailed guidelines for management of care in survivorship, guidelines that will assist in defining care bundles. The availability of guidelines suggests that there is the potential for utilizing of electronic health records – made available in some form to patients – for better management of survivorship care.

We also believe that cancer survivorship is an area where patient self-management of care is possible. We think that the role of patients in managing their care should be a guiding principle in designing a survivorship bundle of care.

Among the other issues to be considered in a cancer survivorship care model are the trigger for initiation of the model, the length of the model and the ability to “renew” the model in light of the long-term nature of cancer survivorship, the scope of services to be included in the bundle (whether non-survivorship care should be included or not), and any limits on the choice of health care provider who will manage the care bundle. We believe that a survivorship care transition visit – where critical questions about who will be the care provider and the scope of necessary services will be discussed – might serve as the trigger for the survivorship care bundle. This concept could at a minimum serve as a launching point for discussion of the trigger for the bundle.

### ***Payment for Evaluation and Management (E/M) Visits***

We commend the agency for the process it has undertaken since it finalized the CY 2019 rule to inform revisions of payment for evaluation and management (E/M) visits. We understand that the agency has heard from a wide range of stakeholders and has considered carefully the recommendations of the American Medical Association/CPT editorial committee.

The E/M changes outlined in the proposed rule, which will be implemented in 2021, include retaining separate E/M codes instead of collapsing the codes to two, changing documentation requirements to focus on medical decision-making and time, establishing an add-on code for

extended visits, and adjusting RVUs for E/M codes. We believe the decisions of CMS, significantly in concurrence with AMA/CPT recommendations, serve beneficiaries with cancer better than the plan offered in the CY 2019 proposed rule, and we appreciate the willingness of the agency to make changes to its plan in response to the needs of beneficiaries and those who care for them.

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We appreciate the opportunity to comment. We look forward to continued dialogue with the agency regarding a bundled payment model for cancer survivorship care.

Sincerely,

**Cancer Leadership Council**

*CancerCare*  
Fight Colorectal Cancer  
Hematology/Oncology Pharmacy Association  
LUNgevity Foundation  
Lymphoma Research Foundation  
National Coalition for Cancer Survivorship  
Ovarian Cancer Research Alliance  
Prevent Cancer Foundation  
Sarcoma Foundation of America  
Susan G. Komen