CANCER LEADERSHIP COUNCIL

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

September 6, 2013

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

Re: CMS-1600-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Submitted electronically at http://www.regulations.gov

Dear Ms. Tavenner:

The undersigned organizations representing cancer patients, physicians and other health care providers, and researchers appreciate the opportunity to comment on the proposed rule that addresses Medicare Part B payment policies for calendar year 2014. We share the goal that the payment system should encourage quality improvement, foster innovation in care delivery, preserve beneficiary access to care, and protect the Medicare program for the long term.

"Misvalued Services" and Payment Limits

The Centers for Medicare & Medicaid Services (CMS) has recommended that payment for a number of services provided in the physician office or other non-facility settings be capped at the rate of payment for those services in the outpatient prospective payment system (OPPS) or ambulatory surgery center (ASC). For certain of these 200+ services, the cap will result in significant reductions in the rate of payment in the physician office beginning in January 2014.

CONTACT: 2446 39TH STREET NW · WASHINGTON, D.C. 20007
Phone: 202-333-4041 · www.cancerleadership.org

CMS indicates that it has identified these codes as "misvalued" because the total payment for the service when furnished in a physician office or other non-facility setting exceeds the total Medicare payment when the service is furnished in a hospital outpatient department or ambulatory surgery center. The agency expresses the position that OPPS or ASC data are more reliable than physician office data and agency decisions should be based on those data. CMS also states that it would generally expect payments to facilities to be greater, because of the greater overhead costs and more significant regulatory requirements that hospitals must meet. The agency uses assertions about the reliability of hospital cost data and the expectation of higher payments in facilities to justify its proposal to cap payments for certain codes, a proposal that will reduce payments for care in the physician and non-facility setting.

We are not persuaded by the agency's attempts to justify its payment capping proposal. CMS does not make an effective case for the greater reliability of hospital data. Neither does the agency offer a logical explanation for its decision to limit payments for services in the physician office. Instead, CMS has identified those codes for which payments in the physician office are greater than in the OPPS, while acknowledging that this is not generally the case, and proposed to adjust those payments.

If a "site neutral" payment plan is implemented in the piecemeal fashion that CMS has proposed through its caps on payments, there is potential for disruptions in care and increases in patient cost-sharing burdens. The payment caps in the proposed rule for 2014 would have a significant impact on pathology, radiation oncology, and laboratory services that are important for cancer patients. We are concerned about the possibility that access to quality cancer care will be negatively affected if the 2014 proposal is finalized, but we have a more fundamental concern about the manner in which CMS is seeking to make these payment adjustments. We do not dispute that payment adjustments may be appropriate in some cases, but we are not persuaded by the reasoning for the limits on payments for more than 200 codes in 2014.

Complex Chronic Care Management Services

We are pleased that CMS has encouraged a number of experiments, demonstrations, and reforms that facilitate care planning and coordination and has also sought changes to the physician fee schedule that will encourage care planning and coordination. In earlier comments, we commended the agency proposal for transitional care management codes that were implemented on January 1, 2013. These services may provide cancer patients discharged from acute care facilities access to care planning and coordination that will improve their survivorship care and the monitoring and treatment of late and long-term treatment effects. In our comments on the 2013 fee schedule proposal, we

urged that specialists be permitted to bill for these services and also noted that many cancer patients would not be eligible for transitional care management.

CMS has taken another important step in care management by proposing, for implementation in 2015, a new code for non-face-to-face complex chronic care management services. This recommendation represents an acknowledgement of the amount of time and the comprehensive and complicated coordination and planning services that are required – outside the scope of evaluation and management (E/M) services – to manage patients with multiple complex chronic conditions. We believe that many cancer survivors will qualify for and benefit from this service. Cancer is increasingly a chronic disease, and many cancer patients have other chronic conditions in addition to their cancer diagnosis.

The agency has proposed aggressive standards for billing for the complex chronic care management service, including use of certified electronic health records, use of written protocols in delivery of services, consent from the patient for care management, and provision of the annual wellness visit in advance of the complex chronic care management service. We urge that these standards be carefully evaluated in the year before implementation of the new service to ensure that they do not create obstacles to the utilization of the care management service.

We recommend that CMS complement the complex chronic care management service with establishment of a cancer care planning and coordination service. This service would be available to cancer patients after diagnosis to facilitate informed treatment decision-making, encourage detailed planning of active treatment and palliative care, and ensure coordination of all providers and elements of care. In addition, this service could replace the annual wellness visit as a prerequisite for the complex chronic care management service. The cancer care planning service will enable the practitioner to capture the information – including the patient's current health care providers and an assessment of the patient's health status and health care needs – for complex chronic disease management.

We believe, based on the experience of oncologists and cancer centers that have pioneered the practice of cancer care planning and coordination, that this service will improve health care for the individual and rationalize the use of cancer care resources. It will also contribute to the success of the complex chronic care management service.

We appreciate the opportunity to comment on the proposed update of the physician fee schedule for 2014. We look forward to working with the agency on additional cancer care delivery and payment reforms.

Sincerely,

Cancer Leadership Council

American Society for Radiation Oncology
American Society of Clinical Oncology
Bladder Cancer Advocacy Network
Cancer*Care*
Cancer Support Community
College of American Pathologists
Fight Colorectal Cancer
International Myeloma Foundation
Kidney Cancer Association
The Leukemia & Lymphoma Society
LIVE**STRONG** Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
National Lung Cancer Partnership
Ovarian Cancer National Alliance
Prevent Cancer Foundation
Sarcoma Foundation of America
Susan G. Komen Advocacy Alliance
Us TOO International Prostate Cancer Education and Support Network

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