

CANCER LEADERSHIP COUNCIL

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

September 10, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1693-P, Revisions to Payment Politics Under the Physician Fee Schedul
and Other Revisions to Part B for CY 2019

Dear Administrator Verma:

The undersigned cancer organizations of the Cancer Leadership Council (CLC), representing patients, health care professionals, and researchers, are writing to express serious reservations regarding the proposed revisions to Medicare payment for evaluation and management (E/M) services in calendar year 2019 and other recommended changes. We commend the Centers for Medicare & Medicaid Services (CMS) for its interest in improving the quality of the interaction between the physician and patient in evaluation and management office visits, but we are concerned that some of the payment changes proposed for 2019 will have the opposite effect.

Medicare payment policies are of critical importance to the cancer community because approximately 60 percent of cancer diagnoses occur among Medicare beneficiaries. Standards for payment in the Medicare program affect those beneficiaries with cancer and set a marker for other payers.

Revisions to Documentation Requirements and Revisions to Evaluation and Management Payments

We appreciate the attention that CMS has directed to the documentation requirements for E/M visits. For years, Medicare providers have urged refinement of documentation requirements and have noted that the standards related to patient history and physical exam may actually impede the quality of the office visit instead of strengthen it. In addition, the documentation

requirements do not serve to improve the patient record. CMS has suggested that changes in documentation requirements will have the effect of improving the interaction between patients and providers in evaluation and management visits.

Although we commend efforts to streamline documentation requirements, we do not support the decision to link changes in documentation to changes in payment for E/M codes. By creating a single rate of payment for E/M visits level 2 through 5, the proposed fee schedule for 2019 could reduce reimbursement to those providers who treat people with cancer. These changes in payment for E/M services will not only affect cancer care providers; the changes will also adversely affect cancer patients.

Cancer is a complex disease, requiring complex analysis and decision-making related to treatment options. These topics are a focus of E/M visits for cancer patients. In addition, cancer patients experience a wide range of side-effects of cancer and cancer treatment, and interventions to address these adverse effects are an additional focus of E/M visits for people with cancer. Because of the complexity of cancer, diagnosis of cancer, cancer treatment decision-making, and the management of cancer and cancer treatment adverse events, office visits for those with cancer are lengthy and require sophisticated medical decision-making. These visits are typically level 4 or 5 E/M visits. Providers supplying these E/M services will see reductions in payment as a result of the streamlining of payments for E/M services level 2 through 5.

Estimates of the impact of the E/M coding changes show that oncologists and hematologists will experience a significant reduction in reimbursement for E/M services. These estimates do not take into account the effects that might be experienced within a specialty. It seems possible – if not likely – that providers who have an especially complex cancer patient case mix might suffer even more substantial reductions in payment than are reflected in estimates of impact. And the effects on patients in those practices could be substantial, as well, as the result of disruptions in oncology practices.

The impact of these proposed E/M changes on people with cancer will be significant. We do not think that there will be immediate changes in the delivery of E/M services. However, we anticipate that, over time, additional visits will be necessary as cancer care practices experience pressures related to changes in E/M visit payments. If cancer patients require more E/M visits than at the present time in order to receive necessary care, they will experience both economic and time burdens. If the changes in E/M services payments affect the organization or structure of oncology practices, cancer patients will feel these effects and access to care may be adversely affected.

We also caution that the proposed E/M changes could have a long-term fiscal impact on the Medicare program. At the present time, evaluation and management visits are the frontline for management of cancer treatment and treatment side-effects. High quality care provided in physician offices can prevent emergency department visits and inpatient admissions, which are of great cost to the Medicare program. We are concerned that the changes in E/M payments will affect access to quality E/M services and have subsequent effects on utilization of emergency department and inpatient services.

G Codes: Visit Complexity Inherent to Evaluation and Management and Prolonged Evaluation and Management or Psychotherapy Service(s)

Cancer patient advocates have for some years proposed the establishment of a code for cancer care planning.¹ We have consistently recommended – by legislative action or through annual fee schedule updates -- a service that would permit the evaluation of cancer treatment options, choice of treatment, and planning of active cancer treatment and symptom management. This service, in our recommendation, should be provided at the beginning of active treatment, when there is a change in prognosis or treatment, and at the end of treatment in the form of a transitional care management plan. In our view, this planning service is necessary because the type of planning and care coordination that is necessary for cancer care requires visits of complex medical decision-making and also requires more time than is typically dedicated to an evaluation and management service, including a level 5 visit.

Our recommendation for a cancer care planning service is related to a fee schedule that included separate levels of payment for E/M codes 2 through 5. If payment for these codes is set at a single rate, the need to appropriately reimburse those visits that are complex and prolonged will be even more significant. Therefore, we support the effort to provide adjustments to payment to capture the resource costs associated with prolonged and complex E/M visits. This is consistent with our efforts to establish a cancer care planning visit, although more urgent in light of proposed payment reductions.

CMS proposes to make resource cost adjustments through the establishment of G codes for visit complexity and for prolonged visits. The agency has identified several specialties that would be permitted to use G codes, including hematology/oncology. Although we are pleased that the list of specialties includes hematology/oncology and acknowledges that these specialists will have a need to use the G codes, we urge that the agency clarify that the use of the proposed G codes will not be limited to those specifically identified in the proposed rule. There are other specialists, including radiation oncologists, surgical oncologists, and other specialists, who provide complex cancer care services and who should be permitted to use the proposed G codes.

We also recommend that CMS clarify whether there are any limits on the use of the G codes, including limits on the frequency with which the G codes may be used. When we previously analyzed the need for a special code for cancer care planning and coordination, we anticipated that this code might reasonably be utilized frequently over the cancer care continuum. We

¹ The 1999 report of the Institute of Medicine, *Ensuring Quality Cancer Care*, identified “an agreed-upon care plan that outlines goals of care” as a core element of quality cancer care for each individual with cancer. National Cancer Policy Board, Institute of Medicine. *Ensuring Quality Cancer Care*. 1999. An expert panel convened in 2012 reiterated the importance of cancer care planning as an element of high-quality cancer care. Institute of Medicine. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*. 2013. The Oncology Care Model, an innovative, multi-payer model administered by the Centers for Medicare & Medicaid Services, requires participating practices to provide enhanced services to patients, including a care plan that contains the elements identified in the report, *Delivering High-Quality Cancer Care*. Legislation pending in the 115th Congress, the Cancer Care Planning and Communications Act of 2018 (HR 5160), would establish a Medicare service for cancer care planning and coordination.

think that there will be an urgent and reasonable need to use the G codes for almost all cancer care E/M visits, in light of the changes in payment. We urge CMS to clarify that aggressive utilization of the G codes is permissible.

We understand that providers will need to supply proper documentation in order to utilize the G codes. Although we understand that there must be a reasonable basis for use of the proposed G codes and that this must be established through documentation, we note that this documentation requirement is at odds with the overall effort to reduce the documentation burden for Medicare providers.

Proposed Update to Direct Practice Expense Inputs for Supply and Equipment Pricing

CMS is proposing to update the Direct Practice Expense (PE) inputs for supply and equipment pricing. In order to pursue the update, CMS contracted with the StrategyGen Co. to perform a Direct Practice Input Market Research Report. To address significant changes in payment, CMS recommends that the new direct PE inputs be phased in over a four-year period. The CLC appreciates CMS efforts to acquire current pricing information in order to accurately value services. However, we are concerned that the decision to contract with StrategyGen was done without stakeholders' expertise on these issues, and subsequently the analysis contains some significant shortcomings. In particular, some of the equipment prices for medical devices instrumental in the delivery of radiation therapy for cancer appear inaccurate and in need of correction. CMS estimates that these significant reductions in pricing of certain expensive equipment would result in precipitous drops in reimbursement for relevant cancer care services. We are concerned that these changes could needlessly put at risk cancer patient access to these services in community-based clinics. The CLC encourages CMS to work closely with the radiation oncology specialty society and radiation therapy equipment manufacturers to ensure accurate pricing, particularly for effective cancer treatment technology involving stereotactic body radiation therapy and brachytherapy, where radiation oncologists report that proposed prices appear to be considerably lower than market.

A Working Group to Provide Advice on E/M Codes

The American Medical Association, with support from other medical professional societies, has recommended that CMS withhold the E/M changes proposed for 2019 and instead consult a working group of Medicare providers for advice on defining and valuing codes. We endorse this proposal. The CLC urges CMS to work with medical professional societies on proposals for reform of E/M codes and payments.

The CLC will at the same time urge the medical professional societies to seek consultation with cancer patient advocates as part of the working group process. Cancer patient representatives -- with deep experience in the health care system, often over an extended period of time -- can offer advice about how to ensure that E/M visits are productive and patient-centered. Cancer patient advocates can also advise about how documentation requirements influence the nature and quality of E/M visits.

By participating in the working group deliberations of AMA and other provider groups, the CLC can be a party to helping CMS achieve the goal of patient-centeredness that is echoed throughout the physician fee schedule proposed rule.

We urge CMS to delay any changes in E/M codes until the agency can consult patients and providers and then propose E/M code changes that will honor the goal of improving interactions between patients and providers. We look forward to working with CMS in this important effort.

Sincerely,

Cancer Leadership Council

Academy of Oncology Nurse & Patient Navigators
American Society for Radiation Oncology
CancerCare
Cancer Support Community
The Children's Cause for Cancer Advocacy
College of American Pathologists
Fight Colorectal Cancer
Hematology/Oncology Pharmacy Association
The Leukemia & Lymphoma Society
LIVESTRONG
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer Research Fund Alliance
Prevent Cancer Foundation