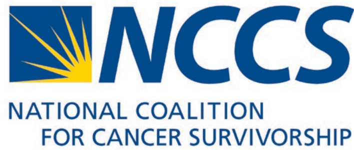

September 9, 2024

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

Submitted electronically at www.regulations.gov

Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure:

The National Coalition for Cancer Survivorship (NCCS) appreciates the opportunity to comment on the CY 2025 Payment Policies under the Physician Fee Schedule. NCCS represents survivors of all forms of cancer in public policy efforts to ensure patient access to quality cancer care. We applaud the efforts of the Centers for Medicare & Medicaid Services (CMS) over many years to undertake payment and delivery experiments to improve cancer care quality and to utilize the Medicare physician fee schedule (PFS) in constructive ways to improve access to high-value care.

In our comments, we will focus on the codes put in place in CY 2024 to reimburse principal illness navigation (PIN), community health integration (CHI), and social determinants of health (SDOH) assessment. NCCS commends CMS for issuing a broad request for information (RFI) on these codes and to ask for potential refinements in the codes for future rulemaking.

Implementation of PIN and CHI Codes in CY 2024

We are aware of a survey that suggests significant interest in the new codes, with a majority of those surveyed saying they are already using the codes or are making plans to do so. Separately, we have stayed in close touch regarding the new codes for services addressing health-related social needs with oncologists who are Medicare providers, nonprofit organizations interested in providing navigation services, and our colleagues in the cancer advocacy community. They have identified substantial challenges associated with use of the codes and a somewhat slow movement toward implementation as they assess challenges and make plans to overcome them.

Among the issues that we have heard are the significant commitment required to modify billing systems to accommodate the codes, the difficulties of meeting the documentation requirements for the codes because of the limits of certain electronic health records (EHR) systems, and the process for engaging with auxiliary personnel (perhaps from community-based organizations) to provide navigation services. The first two issues are identified as the more vexing ones.

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All parties who are involved in the implementation of these codes identify the cost-sharing that patients will be required to shoulder as a serious obstacle to implementation and utilization of the codes. Medicare providers who are currently providing navigation services (supported by evaluation and management code reimbursement, supplemented in many cases by philanthropic funds) say that introducing new cost-sharing for PIN services, for example, represents a serious NEW burden for patients that could discourage them from consenting to the services. Nonprofit cancer organizations that have for many years provided counseling, supportive care, navigation, and other services to cancer patients without cost to the patient are reluctant to serve as auxiliary staff to provide those same services under contract with a medical practice if those services will be accompanied by cost-sharing.

We understand the limits that CMS faces in addressing Medicare cost-sharing requirements. We will work with our peers in the advocacy community in discussing with Congress the potential of addressing this problem with a legislative solution.

Although we take the obstacles identified above (and especially the cost-sharing issues) seriously, we are not persuaded that they represent unsurmountable obstacles to utilization of these codes. We appreciate that CMS is taking a long view to implementation and utilization of these codes. New Medicare PFS codes always have a long lead-time for implementation, and the navigation and SDOH codes may be especially challenging.

We commend CMS for the awareness and education efforts it has undertaken in connection with these codes. We know that professional societies and others are collaborating with CMS in these efforts and undertaking their own parallel efforts.

Navigation Services Provided by Practices Prior to PIN Code Establishment

NCCS has been a strong supporter of Medicare payment and delivery experiments, including the Oncology Care Model (OCM). We were pleased to be included, along with many other patient groups, in discussions with CMS regarding the design and implementation of the OCM, discussions which permitted us to share our advice about strategies for ensuring patient-centered care delivery in the OCM. We also found that many practices were open to consultation with patients and patient advocacy organizations regarding the OCM and its patient-centered care goals.

We understand that the OCM ended after a five-year trial and that the Enhancing Oncology Model (EOM) is the successor model; we also understand that some consider the OCM to be of mixed success, in part because of the limited impact in reducing Medicare expenditures. However, we observed some important steps by many practices in meeting the “practice transformation” goals of the OCM, including to provide navigation services to patients. In the course of our recent conversations with oncology practices related to the PIN and CHI codes, we have found that many of them have continued to provide navigation services as they did during the term of their OCM participation, even though the OCM has concluded and the payments for practice transformation of course ended with the model.

NCCS has had conversations over time with practices that were OCM participants and some that were not, in our efforts to understand the state of navigation in oncology practices. Oncologists tell us that they are providing navigation services to their patients and that they developed their navigation model through practice transformation in the OCM. They have reformed and refined their model of cancer care delivery to assess patients' needs, navigate them to quality care, address financial toxicities of care, and ensure coordination of care. Some tell us that they are making referrals to address social determinants of health (SDOH) needs, in some cases relying on philanthropic funds to meet transportation, food, and other essential needs.

The practices we describe above are using a model of navigation that relies on practice resources and does not engage auxiliary personnel as navigators. According to the conversations we have had with oncologists, some would like to retain their current navigation systems instead of moving toward a system that assigns a navigator to each patient. They do not doubt the value of that approach but believe their approach is responsive to patient needs, too.

In the Medicare PFS proposed rule, CMS asks if there may be "additional opportunities to create codes that describe reasonable and necessary services" for the diagnosis or treatment of illness or injury. We urge CMS to consider codes in this family of codes that would reimburse for navigation services that oncologists have provided for some time, often prompted to develop this navigation system by the OCM. Over the five-year period of the OCM, CMS conducted evaluations of the model including on-site visits to practices. We trust that the OCM evaluations yielded significant insights into the time and workflow required to provide navigation services, and that those insights can inform the documentation requirements for a navigation code that does not rely on auxiliary personnel and the rate of reimbursement for the service.

Medicare PFS Codes for Survivorship Care

CMS has signaled that PIN codes will be appropriate for survivorship care in limited cases, where the survivor may be at risk of serious illness. We understand that this might include survivors who are diagnosed with late and long-term effects of cancer and cancer treatment that may cause them serious illness. We refer again to the question CMS posed in the proposed rule about additional opportunities to create codes that describe reasonable and necessary services for treatment of illness or injury. New codes should be created for the care of cancer survivors, who in most cases have illness or injury related to their cancer or cancer treatment. At the termination of active treatment, cancer survivors should be given a plan for surveillance for late and long-term effects and second cancers and for follow-up care for illness or injury related to their cancer diagnosis.

Cancer survivors require this follow-up care from the termination of active treatment and potentially for the remainder of their lives. We recommend that two codes be created for cancer survivorship care. One code would provide for the development of a summary of the active treatment the patient received and a plan for surveillance and follow-up care and should be billed in the first month after transition from active treatment (and perhaps the second). A second code would reimburse for cancer survivorship navigation services in the months after the survivorship plan is developed and provided to the patient.

NCCS has in the past urged an alternative payment model for survivorship care that would be structured as an episode of care model. Considering the work that CMS has dedicated to

development of codes for navigation and SDOH assessment and services and its willingness to consider additional codes, we urge consideration of PFS codes for survivorship care.

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NCCS appreciates the opportunity to comment on the CY 2025 Medicare PFS proposed rule and to offer recommendations for improving the payment for quality cancer care.

Sincerely,

Shelley Fuld Nasso, MPP
Chief Executive Officer