

CANCER LEADERSHIP COUNCIL

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

October 5, 2020

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

Submitted electronically at www.regulations.gov

Re: CMS-1734-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2021

Dear Administrator Verma:

The undersigned organizations representing cancer patients, health care professionals, and researchers are pleased to offer comments on the proposed rule updating the Medicare physician fee schedule and making other changes to Medicare Part B for CY 2021.

Before offering comments on specific provisions of the proposed rule, we would like to review the challenges that cancer patients, physicians, other cancer care professionals, and researchers have faced during the coronavirus pandemic. A reminder of these issues is important as context for some of our comments.

Cancer providers responded promptly and aggressively, consistent with the regulatory flexibilities granted by the Centers for Medicare & Medicaid Services pursuant to authority provided by Congress, to shift care where possible to telehealth and to implement safety measures to permit face-to-face care to be resumed where appropriate and without unreasonable delay. Cancer patients also adapted quickly to the challenges of the pandemic, embracing care through telehealth and employing personal mitigation strategies to permit them to return to health care institutions to receive care.

Although many disruptions in care have been addressed, the cancer care system has not returned to its pre-pandemic state, and there is lasting harm from the interruptions in care that have occurred during the pandemic. Dr. Ned Sharpless, Director of the National Cancer Institute, has detailed the interruptions in cancer research and care and the possibility that there will be additional cancer diagnoses and later stage diagnoses due to the pandemic. With pandemic-related disruptions in cancer screening, there is concern that more cancers will be

diagnosed at a later stage. Moreover, the pandemic threat remains with us, and providers and patients are poised to adapt as their local and personal situations shift.

The cancer care system may never be the same as it was pre-pandemic, with site of care perhaps evolving for certain services permanently. Our organizations are providing services to cancer patients to help them adapt to changes in cancer care and to receive quality care no matter the site of care and to accept more responsibility for their own care in telehealth settings. At the same time, we support the ability of the patient to choose a telehealth visit or to reject it in favor of in-person care, if the safety of care can be assured. Professional societies are assisting providers in adjusting to pandemic protocols as well as looking forward to providing care post-pandemic. Our organizations are looking for ways to turn the challenges of the pandemic into opportunities, but that is not a straightforward or simple process. In the meantime, practices are experiencing the financial ramifications of a lower volume of care provided during the pandemic, when considering both face-to-face and telehealth services.

At a time of continued uncertainty for patients and providers, we will emphasize throughout our comments the need for flexibility related to site of care and we will caution against abrupt reductions in reimbursement.

Telehealth

We have previously applauded the actions by Congress and subsequent actions by CMS to provide patients and providers flexibility related to telehealth services. In comments on the interim final rules released by CMS, we applauded the agency's actions to loosen telehealth restrictions and to make regulatory changes that permit payment for telehealth services furnished in any geographic location in the country and to permit receipt of services in the patient's home.

Audio-Only Communication

Through provisions of two interim final rules, CMS first established coverage and payment for audio-only services, which represented a significant change from previous Medicare coverage standards. The agency subsequently increased the reimbursement rate for audio-only services to equal the rate of in-person, established patient evaluation and management (E/M) services. These actions by the agency have been critically important to protecting access to care by cancer patients.

Our organizations – both patient and provider – have found that the demand for audio-only services during the public health emergency has been robust and beyond our initial expectations. Many patients do not have access to broadband or the technology necessary for audio/visual communication, and some practices have had to make quick adjustments to ensure that they have the capacity for audio/visual communication. Even as adjustments have been made during the public health emergency, there are still many patients and providers who depend on audio-only communication.

We are concerned that terminating coverage and reimbursement for audio-only services will have a particularly significant impact on cancer patients in minority populations, those who are low-income, and others who are medically underserved. The coronavirus pandemic is having an especially significant impact on those in minority populations, and we must be sure that policies designed to respond to the pandemic do not exacerbate disparities in access to care, including telehealth services.

We would also note that cancer is a disease of the elderly, and senior citizens may not have the access to technology to support audio/visual communication or may not be comfortable with the use of the technology they do have. Cancer patients, who may be immune-compromised during treatment and after, may remain especially dependent on telehealth services through the public health emergency.

We urge CMS to establish policies for coverage and reimbursement of audio-only services beyond the public health emergency. Access to such services will be critical for cancer patients who are navigating the public health emergency and beyond, taking advantage of telehealth services to protect themselves, their families, and their health care teams. Access to audio-only services is also important to prevent the exacerbation of health care disparities during the public health emergency and beyond.

Additions to the Medicare Telehealth Services List for CY 2021

In the proposed rule, CMS has exercised its authority to add services to the list of covered Medicare telehealth services. In the proposal, the agency has identified services to be added on a Category one, or permanent basis, because they are similar to services on the existing telehealth list. CMS also proposes services to be added on a Category 2 (permanent) basis because there is demonstrated clinical benefit to those services. The agency has also proposed services as Category 3 services, for coverage through the end of the year in which the public health emergency ends.

We support the effort of CMS to solicit stakeholder input regarding additional permanent and temporary services for the Medicare telehealth list. For these additions to the list to have lasting benefit for Medicare beneficiaries, the telehealth policies that were established in the interim final rules related to the public health emergency must be made permanent policies. If those policies are made permanent, the additions to the list may represent important long-term benefits for Medicare beneficiaries with cancer.

The efforts of health care providers and patients to offer and utilize telehealth services have been impressive, and we believe that every effort has been made to ensure that the care offered by telehealth is of high quality. Nonetheless, we urge CMS to make strong efforts to evaluate the quality of care offered through telehealth and outcomes that result from care that includes telehealth services. We urge that health care professionals and patients be fully integrated into telehealth quality assessment and improvement efforts launched by CMS.

Budget Neutrality

The final Medicare physician fee schedule for calendar year 2020 included several updates to evaluation and management (E/M) services; those updates will go into effect on January 1, 2021. The E/M updates contributed to changes in work relative value units, or RVUs. In turn, the RVU changes have triggered a reduction in the physician conversion factor (CF) from \$36.0896 in 2020 to \$32.2605 in 2021, to meet budget neutrality requirements. The budget neutrality requirement results in a conversion factor reduction of 10.6%. These changes will result in reductions in reimbursement for several cancer care services.

Cancer organizations, including provider and patient organizations, support the updates to E/M services. However, we are concerned about the impact of the conversion factor reduction on cancer care reimbursement and the potential impact on patient access to care. Our concerns are related in large part to the fact that reimbursement reductions will come during the coronavirus pandemic. As we have explained above, providers have experienced significant changes in the volume of services they are providing and costs associated with responding to the pandemic (including technology for quality telehealth services and personal protective equipment and other steps to ensure safe care provided in-person). January 1, 2021, is not an opportune time to force providers to deal with reimbursement reductions.

We urge CMS to exercise its public health emergency powers to waive the fee schedule budget neutrality requirement for the duration of the emergency. An exercise of public health emergency power in this manner would be in the best interest of Medicare beneficiaries and the providers who care for them.

Molecular Pathology Interpretation (NCPCS code G0452)

We would like to shift our attention from broad policy to a specific code. We address this specific issue because it relates to appropriate reimbursement and patient access to molecular tests. In the proposed rule, the agency has recommended increasing the work value for molecular interpretation code G0452 in a manner consistent with the proposal of the RVS Update Committee (RUC). The increased valuation for this code will provide more appropriate reimbursement for the interpretive work related to certain molecular tests. We believe this change will also enhance patient access to these tests, important for cancer diagnosis. We support the proposed valuation for G0452.

We appreciate the opportunity to comment on telehealth services, including audio-only services, the waiver of the fee schedule budget neutrality requirement for the length of the public health emergency, and the molecular pathology interpretation code valuation.

Sincerely,

Cancer Leadership Council

American Society for Radiation Oncology
Cancer*Care*
Cancer Support Community
Children's Cancer Cause
Fight Colorectal Cancer
Hematology/Oncology Pharmacy Association
International Myeloma Foundation
LUNGeivity Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Prevent Cancer Foundation
Susan G. Komen