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September 27, 2019

Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1715-P

P.O. Box 8016

Baltimore, MD 21244-8016

BY ELECTRONIC DELIVERY

**Re: Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1715-P)**

Dear Administrator Verma:

The Association of Community Cancer Centers (ACCC) appreciates this opportunity to comment on the proposed rule published by the Centers for Medicare & Medicaid Services (CMS) related to payment policies under the Physician Fee Schedule (PFS) and other revisions to Part B, the Quality Payment Program (QPP), and other programs for Calendar Year (CY) 2020 (the “Proposed Rule”).<sup>1</sup>

ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC represents more than 23,000 cancer care professionals from approximately 1,100 hospitals and more than 1,000 private practices nationwide. These include Cancer Program Members, Individual Members, and members from 34 state oncology societies – including the following undersigned state societies: The Arizona Clinical Oncology Society (TACOS), Indiana Oncology Society (IOS), Iowa Oncology Society (IOS), Minnesota Society of Clinical Oncology (MSCO), Virginia Association of Hematologists and Oncologists, West Virginia Oncology Society (WVOS). It is estimated that 65 percent of cancer patients nationwide are treated by a member of ACCC.

<sup>1</sup> 84 Fed. Reg. 40,482 (Aug. 14, 2019).

ACCC is pleased to respond to this request for comments. In our comments below, we recommend that CMS:

- Finalize its proposed revisions to the Transitional Care Management (TCM) and Chronic Care Management (CCM) services codes and payment;
- Continue the payment freeze for radiation therapy G-codes for CY 2020;
- Proceed with caution when proposing any bundled payments under the PFS including possible expansion of the use of the monthly enhanced oncology services (MEOS) outside the Oncology Care Model (OCM);
- Finalize its proposed changes to the evaluation and management (E/M) current procedural terminology (CPT) codes and documentation guidelines, including the proposed revisions to the add-on G-codes for these services;
- Propose simple, easy to implement rules governing notification of the options for infusion therapy services under the home infusion therapy benefit; and
- Withdraw the payment reduction for non-excepted off-campus provider based departments, which is supposed to be equivalent to the PFS rate for such services but is instead proposed to continue to be set at 40 percent of the OPPS rate for the same services for CY 2020.

We have addressed these issues further below.

## **I. TCM/CCM Services**

### **A. CMS should finalize its proposed revisions to TCM service codes and payment to encourage further utilization of TCM, reduce costs and improve patient outcomes.**

Following an analysis by Bindman and Cox that found that TCM services were associated with “reduced readmission rates, lower mortality, and decreased health care costs” and that these services are being underutilized, CMS is proposing changes to the rules governing billing for TCM services in an effort to increase their utilization.<sup>2</sup> These changes include expanding the list of active Healthcare Common Procedure Coding System (HCPCS) codes that can be billed with TCM services to include 14 additional codes on the grounds that these codes

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<sup>2</sup> 84 Fed. Reg. at 40,549.

“may complement TCM services rather than substantially overlap or duplicate services” and a slight increase in the work Relative Value Units (RVUs) for TCM services.<sup>3</sup> CMS also is seeking comment “on whether overlap of services exist, and if so, which services should be restricted from being billed concurrently with TCM” and “whether [its] policy should differ based on whether it is the same or a different practitioner reporting the services.”<sup>4</sup>

ACCC applauds CMS’s efforts to encourage the use of TCM services in the physician community. TCM services are essential to ensuring that a patient’s health continues to improve after their condition no longer requires the need for more involved inpatient services. Patients returning to the community, whether at home or another facility, need engaged health care professionals to help manage their care so they receive the services they need and are not readmitted for more intense services. ACCC believes that allowing TCM to be billed with more HCPCS codes than currently will expand use of these services and expand the number of patients who benefit from this transitional care. In addition, continuing to update the payment rates for these services will ensure that health care professionals are adequately compensated for this care. For these reasons, ACCC urges CMS to finalize the changes to TCM services and payment as proposed.

**B. CMS should finalize its proposed revisions to the CCM service codes to ensure that health care professionals are appropriately compensated for their services.**

CMS is proposing to adopt two new G-codes codes for non-complex CCM services to be used in lieu of the existing CPT code for these services, CPT code 99490, which, CMS notes, assumed that most non-complex CCM would require only about 20 minutes of clinical staff time.<sup>5</sup> The propose new codes include GCCC1 for the initial 20 minutes of chronic care management services and GCCC2 for each additional 20 minutes to be use until the CPT Editorial Panel can develop codes on non-complex CCM that would allow for these additional time increments.<sup>6</sup>

CMS is also proposing two new G-codes for complex CCM services to be used in lieu of CPT codes 99487 and 99489 “and that would not include the service component of substantial care plan revision” because CMS “believe[s] it is not necessary to explicitly include substantial care plan revision because patients requiring moderate to high complexity medical decision making implicitly need and receive substantial care plan revision.”<sup>7</sup> These codes include GCCC3 for complex care management services (which cannot be reported separately in a given month for less than 60 minutes of services) and GCCC4 for each 30 additional minutes of complex care management services.<sup>8</sup> CMS also is proposing to update its guidance on what could be included in a comprehensive care plan that is required for the billing of these codes by providing an updated list of possible (though not necessarily required) elements of these plans.<sup>9</sup>

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<sup>3</sup> *Id.* at 40,549-50.

<sup>4</sup> *Id.* at 40,550.

<sup>5</sup> *Id.* at 40,551.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.* at 40,552.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* at 40,552-53.

ACCC supports CMS's proposed revisions to billing of CCM services. Providing more options for billing non-complex CCM services will allow health care professionals to better account for the diversity of patients and situations in which these services may be provided and ensure that these health care professionals are actually able to bill for the full scope of the non-complex CCM services they provide. ACCC also appreciates CMS's efforts to clarify billing for complex CCM codes by proposing two new G-codes for these services that make clear that billing for these services does not independently require substantial care plan revision and clarifying the requirements for a comprehensive care plan. These revisions will help ensure that health care professionals are being appropriately compensated for the services they provide both in terms of allowing them to bill for enough time for these services and in terms of ensuring there is clarity as to when these codes can be billed.

## **II. CMS should continue the payment freeze for radiation therapy services in CY 2020.**

As noted by CMS, effective for 2015, the CPT Editorial Panel adopted an updated radiation therapy code set. CMS delayed implementation of this code set for that same year and adopted a number of G-codes so that billing could continue as if there had been no revisions.<sup>10</sup> Congress then adopted a payment freeze for these G-codes which Congress ultimately continued through CY 2019.<sup>11</sup> CMS is proposing to extend this payment freeze through 2020 for purposes of continued payment stability.<sup>12</sup>

ACCC appreciates CMS's proposal to stabilize payment for radiation therapy services. CMS has used G-codes for a number of years now to continue the previously existing system of billing for radiation therapy services until such time as billing for radiation therapy services can be appropriately reevaluated. Congress has reinforced this position by implementing the payment freeze for these codes. Until CMS is able to complete a comprehensive evaluation of how to best update payment for radiation therapy codes, it should continue to pay for the G-codes as it has done in recent years so that radiation therapy services can continue to be adequately reimbursed. ACCC appreciates CMS's careful consideration of this issue and its efforts to ensure that it does not implement more involved changes to radiation therapy code billing until such time as it can determine how best to value these services.

## **III. CMS should proceed with caution when proposing new bundled payments under the PFS but there may be some opportunity to expand the MEOS provisions outside the OCM.**

As part of the Proposed Rule, CMS issued a comment solicitation on whether there are opportunities to adopt bundled payments under the PFS, noting that it is:

[S]eeking public comments on opportunities to expand the concept of bundling to recognize efficiencies among physicians' services paid under the PFS and better

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<sup>10</sup> *Id.* at 40,604.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

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. We believe that the statute, while requiring CMS to pay for physicians’ services based on the relative resources involved in furnishing the service, allows considerable flexibility for developing payments under the PFS.<sup>13</sup>

CMS describes bundled payments as “circumstances where a set of services is grouped together for purposes of ratesetting and payment” and lists the OCM as one example of such services.<sup>14</sup>

ACCC has some concerns about expanded bundled payments under the PFS particularly to the extent that bundled payments may negatively impact patient access to services or treatment. CMS should proceed with caution with any bundled payment systems it ultimately proposes to make sure that each such model is thoroughly vetted to minimize any negative impact such patient access. In addition, CMS should ensure that if it does proceed with any bundled payment models under the PFS that appropriate monitoring mechanisms and safeguards are adopted to identify patients who may not be receiving full access to services and take corrective action as necessary to address any gaps.

That said, ACCC also believes that there are some circumstances where aspects of bundled payment models may be beneficial and may help encourage increased coordination of care of patients with certain illnesses or disease states. For example, the Monthly Enhanced Oncology Services (MEOS) payment that is part of the OCM is designed to help health care providers participating in the model to better manage and coordinate oncology care services.<sup>15</sup> Expanding the availability of MEOS to other providers and other types of services would help to serve CMS’s goal of achieving better care for patients and better health for communities.

#### **IV. E/M Proposals**

##### **A. CMS should finalize its proposals to update the E/M codes and documentation guidelines to align with changes adopted by the American Medical Association (AMA).**

Last year, CMS proposed and finalized “a number of coding, payment, and documentation changes under the PFS for office/outpatient E/M visits (CPT codes 99201–99215) to reduce administrative burden, improve payment accuracy, and update this code set to better reflect the current practice of medicine” that would have taken effect for CY 2021.<sup>16</sup> Since those changes were finalized, the Joint AMA CPT Working Group has updated and streamlined the existing E/M code descriptions and suggested alternative documentation guidelines, which were approved by the CPT Editorial Panel in February 2019, to take effect January 1, 2021.<sup>17</sup> CMS is now proposing to withdraw its changes to E/M billing and documentation finalized last year and replace them with the AMA’s, which would mean that:

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<sup>13</sup> *Id.* at 40,670.

<sup>14</sup> *Id.*

<sup>15</sup> CMS, Oncology Care Model, <https://innovation.cms.gov/initiatives/oncology-care/>, (last updated Sept. 11, 2019).

<sup>16</sup> 84 Fed. Reg. at 40,672.

<sup>17</sup> *Id.* at 40,673.

- E/M billing for new patients would occur across four different levels (99202 to 99205).
- E/M billing for existing patients would occur across five different levels (99211 to 99215).
- CMS would adopt the AMA’s guidelines for documentation of these codes.<sup>18</sup>

ACCC supports these proposals and appreciates CMS’s continued responsiveness to stakeholder feedback about billing and documenting E/M services. As noted in our comments on the Proposed Rule for CY 2019, ACCC believes that the changes to payment for E/M services finalized last year would have dramatically reduced reimbursement for E/M services to physicians because there would have been a single payment rate across four levels of E/M services and other reductions in payment intended to take advantage of supposed efficiencies from providing certain procedures on the same day as an E/M visit. ACCC believes that the AMA’s approach would more adequately compensate physicians by maintaining diverse levels of reimbursement for E/M services at potentially more appropriate reimbursement rates. ACCC therefore urges CMS to finalize the proposed updates to E/M coding, reimbursement, and documentation guidelines.

**B. CMS should finalize its revisions to the add-on G-codes for E/M services.**

CMS also is proposing to modify the add-on G-codes that it adopted as part of last year’s final rule. Specifically, CMS is proposing to delete HCPCS add-on G-code GCG0X, for non-procedural specialized care, and to update GPC1X, an add-on code for complex E/M services.<sup>19</sup> These codes are intended to capture the “additional resource costs inherent in furnishing some kinds of office/outpatient E/M visits” so that visits or care provided to certain patients that may be more resource intensive is not underreimbursed.<sup>20</sup> ACCC supports the update to these codes and appreciates CMS’s efforts to ensure that the range of E/M visits that could occur are appropriately compensated.

**V. CMS should propose simple, easy to implement policies governing provider notification of patients of the options available for furnishing infusion therapy.**

As noted by CMS in the Proposed Rule, the 21<sup>st</sup> Century Cures Act “created a separate Medicare Part B benefit . . . to cover home infusion therapy-associated professional services for certain drugs and biologicals administered intravenously or subcutaneously through a pump that is an item of durable medical equipment in the beneficiary’s home, effective for January 1, 2021.”<sup>21</sup> In addition, as noted by CMS, the 21<sup>st</sup> Century Cures Act “requires that prior to the furnishing of home infusion therapy to an individual, the physician who establishes the plan . . .

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<sup>18</sup> *Id.*

<sup>19</sup> *Id.* at 40,676-78.

<sup>20</sup> *Id.* at 50,677.

<sup>21</sup> 84 Fed. Reg. at 40,716. *See also* 21<sup>st</sup> Century Cures Act, Pub. L. 114-255, § 5012 (codified at SSA § 1861(s)(2)(GG)(iii)).

for the individual shall provide notification (in a form, manner, and frequency determined appropriate by the Secretary) of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy . . . ."<sup>22</sup> CMS is soliciting feedback "regarding the appropriate form, manner and frequency that any physician must use to provide notification of the treatment options available to their patient for the furnishing of infusion therapy under Medicare Part B . . ." noting that verbal or written notification could be among the options.<sup>23</sup>

ACCC appreciates CMS's ongoing efforts to implement the home infusion therapy provisions of the 21<sup>st</sup> Century Cures Act, including the requirement to provide notice to beneficiaries regarding their options for receiving infusion therapy. In doing so, however, ACCC encourages CMS to consider the burden that each notification requirement could impose on physicians of infusion therapy services and ensure that whatever notice requirements CMS ultimately propose are simple and easy to implement in practice. Doing so will further help ensure that patients are effectively notified in practice by making sure that physicians can easily put these requirements into effect.

**VI. CMS should withdraw the 60 percent reduction in payment for non-expected off-campus provider based departments for CY 2020 that it finalized as part of last year's PFS final rule.**

In last year's PFS final rule, CMS finalized a proposal to maintain reimbursement to a "PFS-equivalent amount" of 40 percent of the OPPS rate for certain services furnished at non-expected off-campus provider based departments.<sup>24</sup> This payment rate also applies to clinic visits in expected provider based departments, where it was to be phased in over two years with the full reduction implemented for CY 2020.<sup>25</sup> When CMS first implemented this adjustment, it based this payment adjustment on a comparison of OPPS and PFS rates for clinic visits while at the same time acknowledging that such visits "are not entirely comparable" because of the "more extensive packaging that occurs under the OPPS for services provided along with clinic visits" compare to the PFS.<sup>26</sup> CMS also noted for CY 2017 that the PFS payment rate for the 25 most frequently billed services at off-campus provider-based departments ranged from 0 to 137.8 percent of the OPPS rate.<sup>27</sup>

The wide range in variability in payment for services under the PFS compared to the OPPS suggests that a uniform reduction in payment of 60 percent is not supported by the data on payment for these services as a reduction that would make payment equivalent to the PFS rate. Without a more sufficient rationale, CMS should not continue to apply this payment reduction until it can develop a solid rationale to support it as an appropriate basis of payment. For these reasons, ACCC urges CMS to withdraw this payment reduction for CY 2020.

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<sup>22</sup> 84 Fed. Reg. at 40,716. *See also* 21<sup>st</sup> Century Cures Act, Pub. L. 114-255, § 5012 (codified at SSA § 1834(u)(6)).

<sup>23</sup> 84 Fed. Reg. at 40,716.

<sup>24</sup> 83 Fed. Reg. at 59,452, 59,522 (Nov. 23, 2018).

<sup>25</sup> 83 Fed. Reg. at 58,818, 59,014 (Nov. 21, 2018).

<sup>26</sup> 81 Fed. Reg. 79,562, 79,723 (Nov. 14, 2016).

<sup>27</sup> *Id.* at 79,724.

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ACCC greatly appreciates the opportunity to comment on the PFS Proposed Rule. ACCC reiterates its commitment to promoting access to effective cancer treatments for all Medicare beneficiaries who need them. If you have any questions about our comment letter or would like to discuss our comment in further detail, please contact Christian Downs at 301/984-9496 or [cdowns@acc-cancer.org](mailto:cdowns@acc-cancer.org).

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Ali McBride', with a stylized, flowing script.

Ali McBride, PharmD, MS, BCOP  
ACCC President