# CANCER LEADERSHIP COUNCIL

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

September 13, 2021

The Honorable Chiquita Brooks-LaSure
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-1751-P, Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

The undersigned cancer patient, health care professional, and research organizations appreciate the opportunity to comment on the proposed rule to update the Medicare physician fee schedule for CY 2022 and to make other changes in Part B payment policies. We urge the Centers for Medicare & Medicaid Services (CMS) to exercise caution in making changes to payment policies during the COVID-19 pandemic if those changes may adversely affect access to quality cancer care. The pandemic has created significant barriers to care for cancer patients. Despite innovation and determination to address those barriers, access to care remains a challenge for many.

In the early days of the pandemic, cancer care, screening, and research were delayed for the protection of cancer patients and health care professionals. However, those delays created their own risks for patients. Health care institutions, practices, and professionals implemented a range of safety protocols to permit patients to resume care that could only be provided in person, and providers and patients embraced the use of telehealth for safe and effective care where that was possible. Researchers adapted as well, with new strategies for resumption and completion of clinical trials. Credit should be shared all around for the adaptations in care patterns that permitted much cancer screening, care, and research to be resumed. Regrettably, damage was already done. Delays in screening have meant cancer diagnosed at a later date. Delays in care may affect outcomes. Clinical trials have been slowed, even if most have been resumed.[1]

[1] Sharpless NE. COVID-19 and Cancer. Science; 19 June 2020. Wehrwein P. US Cancer Diagnoses Fell by 50% in 2020 Amid the Pandemic, Say NCI Director Sharpless. Modern Healthcare Executive. February 2021.

Some cancer patients and survivors are at heightened risk of contracting COVID-19 and suffering poor outcomes if infected, as a result of their immunocompromised status. Although COVID-19 vaccines have resulted in important protections for those Americans willing to be immunized, some cancer patients do not enjoy the full protection of vaccines. Cancer patients and survivors who are immunocompromised may not have a strong response to COVID-19 vaccines and therefore may not enjoy strong protection from vaccination. The Centers for Disease Control and Prevention has advised that those who are immunocompromised should be counseled that their response to COVID-19 vaccines may be reduced and that they should follow prevention measures to reduce their risk of COVID-19 exposure, including masking, keeping a safe distance, and avoiding crowds and poorly ventilated spaces.[2] In short, those cancer patients and survivors who are immunocompromised may remain at significant risk of COVID-19 infection and poor outcomes if they do suffer infection. Even if vaccinated, these individuals must exercise great caution to avoid infection. As the Delta variant sweeps across the country, the risks for some cancer patients have increased.

For cancer patients, health care professionals and researchers, and the families and friends of the immunocompromised, the COVID-19 pandemic remains a crisis. For cancer patients and survivors, the challenges of living with cancer and receiving quality care have only intensified. For cancer care professionals, providing quality care during the pandemic remains a daily trial, accompanied by serious economic, clinical, and personal difficulties. It is important that changes in Medicare reimbursement not create any additional obstacles to access to quality cancer care.

We understand that payment reforms to ensure fair reimbursement for quality care for all Medicare beneficiaries cannot come to a standstill during the pandemic, which may last longer than we had hoped. However, reforms must be responsive to the pandemic times in which cancer patients are being diagnosed, receiving treatment, returning to work, and managing their long-term survivorship care.

***Clinical Labor Pricing***

The proposed fee schedule would update clinical labor prices. This update addresses the concern that current wage rates do not reflect current labor rate information. We understand the need to make these updates, but we are concerned about the impact of the clinical labor pricing update on hematology/oncology and radiation oncology and radiation therapy centers. Under the budget neutrality requirements of the Medicare statute, adjustments in the practice expense methodology to account for the updates to the clinical labor price inputs will create a shift in payment that disproportionately affects physician services with high-cost supplies and equipment. Those adjustments fall particularly hard on specialists who diagnose and treat cancer patients.

[2] Interim Public Health Recommendations for Fully Vaccinated People, accessed on September 9, 2021, at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html.

As we have detailed above, the pandemic has roiled cancer care. Any adjustments that threaten the viability of cancer practices – hematology/oncology and radiation oncology practices – are a threat to cancer patients' access to care. This is particularly problematic given that cancer patients are presenting with more complex and advanced stage disease, requiring more expensive treatment, as a result of delays in diagnosis due to the public health emergency. We are concerned that updating the clinical labor pricing as outlined by CMS, especially when combined with changes to the Conversion Factor, will reduce reimbursement for life-saving cancer treatments to a level that many practices will find themselves in the position of being unable to cover the cost of care, potentially limiting access and even leading to clinic closure.

We strongly recommend that CMS consider action to hold harmless those specialties that are disproportionately affected by the clinical labor pricing update. Such action is necessary to prevent additional disruptions in cancer care during the COVID-19 pandemic.

***Telehealth***

The ability to receive telehealth services has been critical to tempering the disruptions in cancer care that we have detailed above. We applaud the agency for the proposal to allow certain services that have been added to the telehealth list to remain on the list to the end of December 2023. In the Fact Sheet describing the proposed rule, the agency suggests that this action will provide a "glide path" to evaluate whether these services should be permanently added to the telehealth services list. We will be aggressively engaged in advocacy to ensure the continued availability of telehealth services after the public health emergency. Permanent listing of services is only one action we will press. We realize that there are other regulatory issues and professional licensing issues that must be addressed to ensure that telehealth services are a part of quality cancer care. Some of those matters are beyond the scope of the physician fee schedule update, and we will pursue their resolution through every avenue.

The agency has proposed standards for mental health telehealth services, including the ability of patients to receive services by audio only if that is their preference. We urge the agency to consider making audio-only telehealth available to beneficiaries for other than mental health services. Cancer patients and professionals report that phone-only telehealth can be effective and of high quality and may be the only telehealth option for some beneficiaries. We believe that phone-only services can be an important part of the cancer care experience after the public health emergency and that these services can help address disparities in care.

***Phase-Out of Beneficiary Cost-Sharing for Colorectal Cancer Screening***

We are pleased that CMS plans to implement Section 122 of the Consolidated Appropriations Act (CAA), which eliminates over a number of years the coinsurance that a beneficiary has been required to pay when a colorectal screening test becomes a diagnostic test because of removal of a polyp. Many of the undersigned organizations were active in the legislative effort to address this beneficiary cost-sharing issue and we are pleased to see the law implemented.

We appreciate the opportunity to comment.

Sincerely,

**Cancer Leadership Council**

Academy of Oncology Nurse & Patient Navigators
American Society for Radiation Oncology
Association for Clinical Oncology
Association of Oncology Social Work
Cancer*Care*
Cancer Support Community
Children's Cancer Cause
Fight Colorectal Cancer
LUNGevity Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer Research Alliance
Prevent Cancer Foundation
Susan G. Komen