

September 6, 2022

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Submitted electronically via <http://www.regulations.gov>

RE: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-P)

Dear Administrator Brooks-LaSure:

On behalf of the Society of Gynecologic Oncology (SGO), thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year (CY) 2023. The SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. Our 2,000 members, who include physicians, nurses, and other advanced practice providers, represent the entire oncology team dedicated to the treatment and care of patients with gynecologic cancers.

The SGO's purpose is to improve the care of women with gynecologic cancers by encouraging research and disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies, and collaborating with other organizations interested in women's health care, oncology, and related fields. Given these goals, the SGO appreciates CMS' continued efforts to expand access to high quality, comprehensive medical services, such as cancer screening and treatment, for Medicare beneficiaries. As such, we will provide comments on the following policies of importance to SGO members and their patients:

- Conversion Factor Update
- Evaluation and Management (E/M) Services
- Payment for Medicare Telehealth Services
- Strategies for Improving Global Surgical Package Valuation
- Medicare Potentially Underutilized Services
- Changes to the Quality Payment Program

Conversion Factor Update

For CY 2023, the conversion factor is set to decrease by approximately 4.5 percent due to the expiration of the 3 percent increase to payments authorized by the Protecting Medicare & American Farmers from Sequester Cuts Act (P.L. 117-71) at the end of 2022, coupled with a mandated 0 percent conversion factor increase and the required budget neutrality adjustments. The SGO recognizes that CMS does not have the statutory authority to mitigate these cuts; however, this reduction in the conversion factor in addition to the statutorily mandated 4 percent Medicare PAYGO cut also scheduled for January 1, 2023, could negatively impact Medicare beneficiary access to surgical care and the viability of physician practices. The SGO intends to work with Congress to develop a legislative solution to mitigate the decrease to the conversion factor.

Evaluation and Management (E/M) Services

Inpatient and Observation Codes

CMS is proposing to adopt most the revisions for CPT® codes used to report other E/M visits including inpatient and observation services. The changes include revisions to the code descriptors and documentation requirements, which will now allow physicians to select the visit level based on time or medical decision making (MDM), mirroring those changes previously made to the outpatient E/M services. Additionally, CMS proposed a new prolonged service code HCPCS GXXX1, which can be utilized when physicians choose to bill by time. The SGO urges CMS to finalize these changes to provide for consistency across E/M code families and reduce administrative burden on physicians.

The SGO recognizes and appreciates that CMS has proposed to adopt the Relative Value Scale Update Committee (RUC) recommended values for the revised code family. However, we are concerned that some of the values for the inpatient family are decreasing, and when finalized, will be valued less than the comparable outpatient service. For instance, CPT code 99205, the highest-level new outpatient service code, and CPT code 99223, the highest-level initial hospital care code, are valued at 5.39 RVUs and 5.19 RVUs respectively in the facility setting. Finalizing these values may disrupt the relativity of the MPFS, and the SGO urges CMS to monitor this and take any steps necessary to maintain relativity.

Split/Shared Services

In 2022, CMS finalized and then delayed a proposal which stated that the practitioner who billed the split/shared service should be based on substantive time spent with the patient, defined as more than 50 percent of the total time. CMS is proposing to delay the much-debated split/shared services policy for another year, until 2024. The SGO supports this delay and recommends the agency use this time to collaborate with providers to ensure that this policy does not negatively impact team-based care, which CMS promotes in its programs. High quality cancer care delivery typically involves a team, and once the policy is finalized, it should not undermine the delivery of collaborative care. The SGO welcomes the opportunity to work with the agency to finalize this policy in a way that will not lead to increased burden for providers and hospital teams.

Payment for Medicare Telehealth Services

Since the beginning of the COVID-19 public health emergency (PHE), SGO members have utilized telehealth to secure and improve access to services for all gynecologic cancer patients. Besides

improving access to care, telehealth has improved access to care while reducing disparities in health care access, increasing practice efficiency, reducing patient costs and no-shows, and improving patient satisfaction.¹ Because of this, we welcome the opportunity to work with CMS to ensure that physicians and other practitioners will be able to provide these services to patients after the conclusion of the PHE.

Changes to the Medicare Telehealth Services List

CMS is proposing to add additional services to the Medicare telehealth list with a Category 3 designation, which are services added on a temporary basis through the end of CY 2023 and may be considered for permanent addition when the requirements for Category 1 or Category 2 services can be met. The SGO applauds this proposal and supports CMS' proposal to add the new HCPCS codes for prolonged services associated with certain types of E/M services — GXXX1, GXXX2 and GXXX3—to the telehealth list on a Category 1 basis to replace the existing prolonged service codes.

CMS is also proposing to allow all services that were added to the telehealth list on a temporary basis during the PHE, including those that have not been converted to Category 1, 2 or 3, to remain available through the 151-day period after the end of the PHE, as authorized by Congress, for certain telehealth flexibilities to remain in place. The SGO supports this and urges CMS to finalize this policy as proposed.

Reimbursing Telehealth Services at the Facility Rate

CMS has proposed to continue paying for telehealth services at the facility payment rate as the agency believes this reimbursement rate best reflects the direct and indirect practice expenses of telehealth services. The SGO disagrees with this assessment and urges CMS to reimburse telehealth services at the physician office rate. Respectfully, the agency must recognize that telehealth visits include both complex physician-patient discussions and significant infrastructure investments as well as clinical and office staff time and resources that are comparable to an in-person visit. For example, office staff will call patients to make sure they are set up with the proper technology, review medication lists and arrange for any necessary laboratory testing prior to virtual appointments. For these reasons, the SGO urges CMS to provide parity for telehealth services by reimbursing them at the physician office rate to accurately reflect the physician work and practice expense of these services once the PHE concludes.

SGO members in urban and rural locations feel this is a significant issue that raises equity concerns as telehealth allows our members to provide care to all their patients. Many visits for cancer treatment require face-to-face interaction and delivering virtual care when appropriate allows patients to miss less work and minimize traveling long distances. Without access to telehealth, patients in these areas are not getting the best care they deserve. SGO members who practice in rural and underserved communities have provided the following examples:

- Rural patients in Alabama who do not have reliable access to internet, or the necessary technological literacy will decline video visits due to a preference for phone or audio-only visits. For many patients, audio-only telehealth care is reasonable when discussing test results or next steps in treatment plans. If a patient requires physical (i.e., video) assessment, SGO members will typically recommend the patient come in for a follow-up in-person visit soon. Should there

¹ <https://www.sgo.org/resources/telehealth-and-your-practice-then-now-and-post-pandemic/>

be a more urgent issue, SGO members recommend that the patient go to the nearest emergency department.

- In an underserved, urban environment of West Philadelphia, one SGO member has many patients who are elderly and cannot drive themselves to appointments. Telehealth has allowed them to receive care rather than asking a family member to take off from work to drive them or pay the expense of a cab which many of them cannot afford or take public transportation which can take several hours out of their day.

Virtual Direct Supervision

Under CMS' current policy, virtual direct supervision is until December 31 of the year the PHE concludes. SGO members have been using the virtual direct supervision flexibility during the COVID-19 PHE and believe this policy should be extended permanently once the PHE concludes. Specifically, our members believe this flexibility helps ensure equitable access to patient care as it allows us to supervise more residents and/or advanced practice providers and see more patients. For example, there are some areas of the country that lack access to any gynecologic oncologists. An increasing number of hospital systems have a multi-site structure, and this telehealth flexibility allows gynecologic oncologists to oversee care from different sites within the hospital system, expanding their reach geographically and in terms of the number of patients who can be treated.

The SGO recognizes that CMS is also seeking information on the safety and effectiveness of care delivered under virtual supervision. While SGO does not have data to share at this time, we would like to offer a few anecdotal examples for the agency's review. Regarding safety, SGO members have used this flexibility to examine patient rashes and abdominal incisions that may be infected. Additionally, members have been able to look at patients' port-sites virtually, which has saved time and resources for the health system. For example, if a patient reports having redness at the port-site, physicians can review the port-site virtually and see if it is related to a band aid, for example, or something more significant. This saves an office or ER visit as well as health care resources. SGO members would be happy to meet with CMS to discuss this issue further as the agency works to finalize this policy.

Strategies for Improving Global Surgical Package Valuation

CMS is requesting comments on how to pay for services, including the surgery and pre- and post-surgery E/M care, in the global surgical packages. The SGO recognizes the agency's continued concern that E/M visits paid under a global surgical package are not performed. Currently, SGO does not have specific data to assist the agency in assessing global package valuation. However, our members do deliver these global services, which are particularly important to their work and the care they deliver to cancer patients. We welcome the opportunity to work with the agency and be part of the conversation as future policy options on this topic is developed.

As CMS considers next steps, the SGO would like to share the following examples of the cancer care and services to prevent the recurrence of disease typically delivered in a global period. When treating patients with ovarian cancer, our members have important discussions with their patients regarding the role for chemotherapy to prevent recurrence, as well as the need for genetic testing to rule out a genetic predisposition for ovarian cancer -- all during the global period. Additionally, for patients undergoing a laparoscopic hysterectomy for endometrial cancer, during the post operative period, our

members discuss with patients the importance of maintaining screening for colon cancer and/or breast cancer as part of their cancer survivorship. Additionally, our members discuss weight management to decrease mortality risk as an increasing proportion of endometrial cancer is due to obesity in the US. Further, whether they have endometrial, cervical, or ovarian cancer, SGO patients are part of a population that requires adjuvant therapy (i.e., chemotherapy, radiation therapy, targeted therapy, immunotherapy, hormonal therapy) after surgery to prevent cancer recurrence and maximize survivorship. These conversations are held in the critical weeks immediately after pathologic diagnosis, requiring significant time from the physician and their team to provide in-depth patient education.

Our members have noted that often during the surgical post-operative period they manage co-morbidities that have require special considerations related to surgery such as the management of blood thinners used to prevent blood clots. This is often an acute diagnosis and not managed post-operatively by the primary care physician.

In the proposed rule and consistent with the goals of this administration, CMS aims to improve access to cancer screening and prevention. We hope these examples provide clarity around the work that takes place during the global periods for cancer care. Any changes contemplated by the agency should consider these services and ensure the services are valued appropriately. Again, SGO welcomes the opportunity to engage with the agency on this issue as your thinking evolves.

Medicare Potentially Underutilized Services

The agency has requested comments on how to increase the utilization for certain services Medicare considers to be high value, including preventive, annual wellness visits, cancer screening, and complex/chronic care management services, among others. As part of post-surgical care, SGO members develop survivorship care plans for patients, which includes counseling patients about future cancer screenings based on their current diagnosis. This applies across gynecologic cancer diagnoses. For example, Lynch syndrome screening is performed for those with endometrial cancer and a number of germline and somatic genetic tests are performed in those with ovarian cancer. Gynecologic oncologists take the role of primary screener and coordinate many of these post-surgical activities. However, these visits and services are often left unpaid even though they are billable services.

Published literature notes that post-cancer diagnosis and utilization of cancer screening shows long-term cancer survivors are not more likely to receive follow-up screening for second cancers.² Our members make a practice of prioritizing these screenings but do believe they could be better utilizing some of these codes. However, they report that they do not use the care coordination services due to a lack of understanding and awareness of these codes. We recommend that CMS educate both physicians and coders about these services and the associated requirements. The SGO is pleased to be a resource to the agency as steps are taken to increase the utilization of these services.

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506256/>

Changes to the Quality Payment Program

Transforming the Merit-Based Incentive Payment System (MIPS) Value Pathway Strategy

CMS outlined its plans to transition to the MIPS Value Pathways (MVPs) to improve value, reduce burden, inform patient choice in selecting clinicians, and reduce barriers to participation in Alternative Payment Models (APMs). The SGO is hopeful this transition will decrease the burden of MIPS participation and make reporting more meaningful for participating providers. Additionally, the agency intends for MVPs to be the only MIPS participation method in the future but has not yet outlined a timeline for this transition. As the agency contemplates this further, the SGO urges the agency to work closely with physician specialty societies, like the SGO. For this transition to be successful, all physicians must have meaningful options to participate.

MVP Development and Reporting Requirements

The SGO urges CMS to finalize its proposal to allow MVPs to be evaluated more than once a year. Under the policy outlined in the rule, CMS would modify the MVP development process to allow the agency to evaluate a submitted candidate MVP on an ongoing basis through the MVP development process and then post a draft version of the submitted candidate MVP on the Quality Payment Program (QPP) website to solicit feedback for a 30-day period. CMS would then review the feedback submitted and determine if any changes should be made to the MVP before including it in proposed rulemaking. Under this rolling approach, the SGO agrees that holding public facing webinars on potential revisions is an appropriate way to engage stakeholders in this process.

Advancing Cancer Care MVP

The SGO supports the inclusion of the Advancing Cancer Care MVP to the MIPS program for payment year 2023. Besides simplifying the MIPS program, the SGO strongly believes that all providers should have measures and MVPs that reflect the patient care they provide. Our members believe the improvement activities outlined in the MVP are particularly relevant to our patient population. Specifically, we are pleased to see the financial navigation program included in the list as this activity is important to ensure that patients are informed about the costs of their care and their payment options. Regarding the MVP's quality measures, SGO members believe they are heavily skewed towards medical oncology, as opposed to surgical oncology. We recommend that CMS work to incorporate quality measures that are more aligned with the clinical care associated with surgical oncology. We encourage CMS to support and incentivize the development of specialty and subspecialty specific measures to make participation more meaningful for providers, Medicare beneficiaries, and the agency.

Complex Patient Bonus

The SGO supports CMS' proposal to ensure that facility-based clinicians are eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category, beginning with the 2023 performance year. Many SGO members meet CMS' definition of facility-based and rely on those scores rather than reporting individually; they should not be disqualified from receiving this bonus, if they would otherwise qualify, because of their performance pathway.

MIPS Performance Category Scoring

The SGO applauds CMS for prioritizing health equity in the QPP. We understand that CMS is proposing the addition of two new measures in the APM Performance Pathway (APP) measure set: MUC21-136: Screening for Social Drivers of Health and MUC21-134: Screen Positive Rate for Social Drivers of Health, and strongly support their inclusion. Social determinants of health (SDOH) play a significant role in the cancers, including endometrial and cervical, treated by our members, and determining how to accurately account for these SDOH is imperative to accurately assess the care delivered and patient outcomes. We welcome the opportunity to work with CMS to implement these measures and explore new measures.

CMS also seeks feedback on questions to better understand the type and structure of health equity measures that would be appropriate for implementation in MIPS. The SGO has prepared the following responses:

- How would a measure best capture health equity need under MIPS in the future?
 - The SGO urges CMS to incorporate the SDOH ICD-10 codes into future measures, which should also be appropriately risk adjusted, to accurately reflect the health equity of the patients undergoing treatment.
- How would a measure's quality action provide actionable information and link to improvement in the quality of care provided to populations with health inequities? Would a measure be meaningful to clinicians in small practices or Federally Qualified Health Centers (FQHCs) that may have limited or no access to referral services?
 - SGO members believe health equity measures would be very meaningful to clinicians in small practices and FQHCs. Further, this would produce actionable data that can be used to further identify sites of need.
- Would there be any concerns if a future health equity-related measure did not specify requirements for use of consistent tool(s) for data collection under such a measure? Should such a future measure support flexibility in choice of tools while requiring standardized coding of responses to support interoperability?
 - Yes, standardized coding and a simplified set of tools would help ensure the most consistent data and interoperability.

APM Incentive

Payment Year 2024 is the final year for which the statute authorizes an APM Incentive Payment. After performance year 2022/payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become QPs for a year. In performance year 2023/payment year 2025, the statute does not provide for any type of incentive for eligible clinicians who become QPs. CMS is concerned that the statutory incentive structure beginning in the 2023 performance year/2025 payment year could lead to a drop in Advanced APM participation.

Therefore, CMS seeks public comment to inform future rulemaking on the APM incentive beginning with the 2024 performance period/2026 payment year. Specifically, the agency requests information on the primary considerations as providers choose whether to participate in an Advanced APM or be subject to MIPS reporting requirements and payment adjustments. For SGO members in a private practice that are successful MIPS reporters, they believe it would be exceedingly difficult to consider moving to

participate in an advanced APM. Our members reviewed the incentives considered by the agency and believe these incentives are insufficient to incentivize providers to participate in an advanced APM. Additionally, we believe that any APM requiring participants to take on downside financial risk may be considered too risky for participation, particularly for smaller practices who will be hesitant to participate due to the risk of losing money if they do not reach certain requirements. As the agency considers future rulemaking, the SGO welcomes the opportunity to discuss this issue further.

The SGO thanks CMS for the opportunity to provide these comments. We appreciate CMS' efforts to expand access to high quality, comprehensive health care for Medicare beneficiaries. Should you have any questions or require further information, please contact Pierre Desy, SGO Chief Executive Officer (CEO), at Pierre.Desy@SGO.org.

Sincerely,



Pierre M. Désy, MPH, CAE
CEO
Society of Gynecologic Oncology & Foundation for Women's Cancer