Society of Gynecologic Oncology

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September 11, 2023

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

RE: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1784-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) 2024. SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. Our 2,800 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.

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, 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
- Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology
- Valuation of Specific Services
- Complex Patient Care Add-on Code
- Request for Comment on Valuing Evaluation and Management Services
- Creation of New Services and Payment for Caregiving Training Services
- Payment for Medicare Telehealth Services
- Payment for Dental Services
- Transforming the Quality Payment Program

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Conversion Factor Update

For CY 2024, the conversion factor is set to decrease by 3.36 percent because of a statutory 0 percent update, negative 2.17 percent relative value unit budget neutrality adjustment, and expiration of additional funds Congress added to the conversion factor for 2023. SGO recognizes that CMS does not have the statutory authority to mitigate these cuts; however, we note that the conversion factor was $31.0010 in 1992 and yet, thirty years later, the conversion factor has only increased by $2.00 as proposed for 2024. Had it been adjusted for inflation; the current conversion factor would be approximately $67.00.[1]

We find the lack of updates to the conversion factor egregious at a time when our members and other physicians work tirelessly to care for Medicare patients. Additionally, we believe that the MPFS should, at the very least, receive the same type of inflationary adjustments as other Medicare payment systems including the Inpatient Prospective Payment System and the Outpatient Prospective Payment System. Each year we watch as inflationary updates are applied in these payment systems, while the physicians who provide office-based services see no Medicare payment increases, and in fact are always slated for decreases in payment. Every year our members also face uncertainty as the Medicare payment system remains in flux, and lawmakers scramble to avert or mitigate cuts to the MPFS at the end of the year. This uncertainty leads to anxiety and even burnout, which may lead to physicians leaving the profession entirely.

SGO recognizes that conversion factor updates and budget neutrality requirements cannot be amended without Congressional intervention; however, we encourage the agency to work with Congress on physician payment reform to develop the means to regularly update the conversion factor. We also intend to meet with members of Congress to encourage them to develop or support a legislative solution to mitigate decreases in the conversion factor and to improve physician payment in the Medicare program.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology

SGO is encouraged that the American Medical Association (AMA) has undertaken the enormous task of updating the Physician Practice Information Survey (PPIS). As such, we believe the agency should wait for the results of the PPIS before implementing any changes or updates to practice expense (PE) inputs. We understand the practice expense data is an important component of the MPFS, encompassing approximately 45% of total payment for a service. As such, practice expense data needs to be complete and updated for each procedure priced under the MPFS.

Understanding the redistributive effects that new PE data will have on the MPFS, we suggest that if CMS accepts the results of the PPIS, that this data be phased in over a four-year period. The phase-in will allow physicians and their practices to adjust to the changes without a large redistribution in RVUs, and payment.

[1] US. Bureau of Labor Statistics, CPI Inflation Calculator. https://www.bls.gov/data/inflation_calculator.htm

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We also believe that PE data should be updated on a regular basis and suggest conducting updates every five years to account for the inevitable changes in technology, practice patterns, clinical labor rates, and other factors that influence these inputs. Updating the data more regularly will provide greater stability within the payment system.

Valuation of Specific Services

Pelvic Exam

Recently, the AMA CPT® Editorial Panel approved a new code to capture the additional practice expense needed during the performance of a pelvic examination. The new CPT® code 9X036 (pelvic exam) may be reported with evaluation and management (E/M) codes in the office setting. SGO thanks the agency for accepting this code for payment under the MPFS, and we support the finalization of the PE values as proposed.

Hyperthermic Intraperitoneal Chemotherapy (HIPEC)

Last year, the AMA CPT® Editorial Panel created two time-based, add-on codes to report the services associated with providing HIPEC. During the subsequent AMA Relative Value Update Committee (the RUC) survey for this service, the accuracy of the survey data was called into question. As such, a resurvey was recommended and undertaken. In the interim, the HIPEC procedure will be priced at the carrier level, which we support while a new survey is completed. We thank the agency for its flexibility during the resurvey process.

Complex Patient Care Add-on Code

With this rule, CMS has alerted stakeholders that the agency will begin making payment for G2211, which is used to describe services associated with office/outpatient evaluation and management (E/M) services that are complex in nature and are related to a patient's single, serious, or complex condition. The code may be used with any level of E/M office/outpatient visit and cannot be billed when modifier 25 is used. We appreciate that the agency has limited the application of this code and revised utilization assumptions; however, SGO has been and continues to be opposed to implementation and payment for G2211.

We believe that higher level E/M service codes, revised and revalued during the years long revision of the entire E/M code set, appropriately captures the resources associated with complex and serious conditions. Even if SGO were to support the payment for G2211, services associated with this code remain ill-defined, and questions remain as to the medical record documentation required to bill for it.

In addition, the creation and subsequent payment of this code continues to drive a wedge between medical specialties, pitting specialty against specialty, in a budget neutral system with a limited amount of money to pay for physicians services. We believe that these battles for RVUs could be mitigated with statutory changes to the MPFS and how payment updates are made within that system. We do not believe that creators of the MPFS had envisioned this type of discord when it created the relative value payment system such that specialties argue to maintain the relative values of their services to the detriment of other services. Medicare beneficiaries require the full range of care represented by services on the MPFS; however, adding services and payment, particularly for services with a significant

enough volume to affect the conversion factor, is difficult to do when all physicians recognize that their Medicare reimbursements have not come close to keeping pace with inflation.

Again, SGO realizes that the agency does not have the statutory authority to address budget neutrality on its own and recommends that CMS work with Congress to create solutions in the best interest of providers and patients.

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

As we have stated in previous MPFS comment letters, we supported the work of the AMA CPT® Editorial Panel to revise the entire E/M code set, with those revised services then valued by the AMA RUC. In this proposed rule, CMS has asked for comments as to whether the AMA RUC is the entity best positioned to provide recommendations to CMS on the relative values and practice inputs for all MPFS services, not just E/M services. SGO supports the work of the AMA RUC as we believe that it is the entity best suited for valuing physician services. While we are not members of the AMA RUC Advisory Committee, we do participate in the process by fielding RUC surveys to our members for services related to the practice of surgical gynecologic oncology in partnership with the American College of Obstetricians and Gynecologists. SGO plays a significant role in valuing new or revised services within our specialty, including two procedures that are included in this year's proposed rule (HIPEC and pelvic exam). We believe that the processes used by the RUC provide an avenue for physician input that helps to maintain an appropriate resource-based payment system. We will continue to participate in the RUC process and associated activities as needed.

Creation of New Services and Payment for Caregiving Training Services

As a part of the Biden Administration's efforts to develop policies and regulations that address healthcare equity and to create fair access to government funded healthcare services and programs, the agency has created several new codes to describe services that will benefit Medicare beneficiaries as they move through the care continuum.

These new services include the following:

- GXXX1 and GXXX2: community health integration services
- GXXX3 and GXXX4: principal illness navigation
- GXXX5: administration of a social determinants of health (SDOH) health risk assessment.
- 9X015, 9X016, and 9X017: caregiver training to improve functional performance

Additionally, CMS has proposed to provide payment for group caregiver training services. The codes associated with these services (CPT codes 96202 and 96203) were previously not payable under Medicare, and we support payment for these services under the MPFS.

We believe that before GXXX5 is finalized there needs to be clarity as to the billing parameters for the service. Code GXXX5 describes the administration of a SDOH assessment not more than once every six months. It is unclear if this is service may be billed once every six months per patient or if the service is billable only once every six months per physician performing the assessment. That is, can a surgical gynecologic oncologist perform the SDOH assessment, and then one month later, the patient's primary care physician can also perform the assessment? We believe that it is possible that both physicians may

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want to perform the assessment based on the needs of the patient and the care plan set forth by both doctors. We seek clarity as to how the agency intended this code to be used and that the frequency be better defined.

SGO believes that all the services described above represent important pieces of the care continuum, particularly as it pertains to cancer patients, and we support the administration's goal of eradicating cancer while helping patients overcome their disease. However, we urge caution as these services are implemented into a payment system that is already stretched to its limit. In a budget neutral system, the creation and payment for new services creates pressure on the system and may cause unfair reimbursement fluctuations.

Payment for Telehealth Services Under the MPFS

SGO members continue to use telehealth to secure and improve access to services for all gynecologic cancer patients. Besides improving access to care, telehealth services also reduce disparities in health care access, increasing practice efficiency, reducing patient costs and no-shows, and improving patient satisfaction.[2] Because of this, we welcome the opportunity to work with CMS to ensure that physicians and other practitioners can provide telehealth services without disruption.

Many of the telehealth provisions discussed in the proposed rule for CY 2024 are the same as the policies that the agency sought comment on for the CY 2023 proposed rule. SGO has not changed its position on the use of telehealth and payment for telehealth services under the MPFS and continues to support the provisions that the agency has proposed in this rule. We thank the agency for continuing payment flexibilities for the provision of telehealth services through the end of 2024 which includes the following provisions:

- *Telehealth Payment Flexibilities:* We support the extension, through December 31, 2024, of certain telehealth flexibilities including the waiver of the originating site requirement, waiver of geographic site restrictions, and payment and coverage for audio-only services.
- *Direct Supervision:* In addition to the telehealth flexibilities previously mentioned, CMS will also allow the use of virtual direct supervision through the end of December 2024. SGO appreciates this continued flexibility, and we continue to support the use of this option. Our comment letter on the 2023 MPFS rule provides additional information and specific use cases to support the use of virtual direct supervision beyond December 2024.
- *Payment Parity:* We support the provision that allows for payment at the non-facility rate for telehealth services provided to a Medicare beneficiary in their home when the service is billed with POS 10. This flexibility is an important component of the provision of telehealth services. The setting under which a telehealth service is provided should have no bearing on the reimbursement level, as the costs and resources required are the same. We recognize that payment parity for services beyond those for mental health will not be continue beyond December 31, 2024, unless and until Congress provides a further waiver of the originating site requirement.

[2] https://www.sgo.org/resources/telehealth-and-your-practice-then-now-and-post-pandemic/

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Our MPFS comment letter on 2023 proposed rule reiterates our position and provides clinical examples of how our members use telehealth to care their patients.

Payment for Dental Services Inextricably Linked to Covered Medical Services

The agency first provided payment for dental services under certain clinical scenarios, when said dental treatment is related to the success of a treatment in CY 2023. With this rule, CMS has proposed to cover dental services for additional clinical scenarios, including the provision of chemotherapy. SGO supports coverage of dental services when inextricably linked to other covered medical services as we believe that oral health is an integral part of the success of the care we provide to our patients.

Changes to the Quality Payment Program (QPP)

SGO was pleased that the agency requested comments on how to modify policies under the QPP to foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries. CMS must ensure that QPP requirements support the delivery of value-based care and improved quality, and do not create new "check the box" exercises or administrative burden.

Our members are interested in the significant opportunities alternative payment models (APMs) may provide physicians to improve the quality and outcomes of their patients' care using clinical interventions that are currently not reimbursed under the Medicare program, while potentially lowering the overall cost of treatment of gynecologic cancers. However, it is critical that physicians, including SGO members, participate in designing APMs to ensure that alternative ways of delivering services are appropriate, not overly burdensome, and support the needs of our patients.

Value-based care programs aim to reduce healthcare costs and improve patient outcomes, hinging on robust physician participation; however, financial risk and administrative burden pose challenges to physician participation, particularly at a time that Medicare reimbursement has not kept pace with inflation. Physician practices vary by size, specialty, and location; therefore, it is important that APMs are developed in a way to support different practice types and the patient populations they serve. Nonetheless, significant financial investments deter many specialties and health systems from APM adoption. Therefore, SGO recommends that physician participation in APMs should remain voluntary as CMS continues to develop and evaluate new models suitable for a wide range of practices of different sizes and specialties.

When developing APMs, CMS should take advantage of opportunities to lessen administrative burden on physicians, including the use of certified electronic health records (EHRs) by waiving unnecessary requirements in existing payment systems. SGO members recommend that CMS work to enhance healthcare IT support and interoperability by prioritizing the development of comprehensive "packages" that seamlessly integrate with popular EHRs like Epic and Cerner. By partnering with these EHR providers, health systems can simplify the process of tracking quality measures and exchanging vital information. Leveraging existing solutions like Care Everywhere can further facilitate seamless data sharing across different health systems. Additionally, to ensure robust quality measurement, SGO suggests aligning with established organizations such as the American College of Surgeons' Commission on Cancer and Agency for Healthcare Research and Quality. By utilizing their pre-vetted quality measures, health systems can streamline their own processes and avoid duplicating efforts. This not

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only saves time but also enhances the credibility of the metrics being utilized. Creating targeted IT solutions, partnering with EHR providers, and embracing well-vetted quality measures can contribute to a more efficient healthcare system that benefits both providers and patients.

To address measurement challenges and improve physician participation, SGO members propose refining attribution and risk adjustment methods. Specifically, when a patient receives surgery for their cancer at one site and chemotherapy for their cancer at another site, the question of attribution arises. Attribution methodology must account for patients receiving care at one or more sites during an episode of care. The challenge here is whether to attribute the patient's care to a single physician or different physicians based on different phases of treatment. Therefore, CMS should consider establishing different categories of care (i.e., surgery phase, adjuvant treatment phase, maintenance treatment phase, surveillance, end of life care). This, for example, would attribute the surgery phase to the surgeon and the subsequent phases to the oncologist or other relevant specialists. Importantly, this recognizes that different physicians contribute expertise and care at different stages of the patient's treatment journey. Additionally, risk adjustment is a significant concern for physicians who treat high-risk patients, based on the disease they have, the SDOH affecting their care, or a combination of both. We urge CMS to ensure that risk adjustment methodologies account for all these factors to ensure that the physicians treating these patients are not penalized for doing so.

Additionally, while CMS' cost performance category now comprises 30 percent of the physician's Merit-Based Incentive Payment System (MIPS) score, SGO members do not feel that these cost measures accurately reflect a physician's performance and potentially penalize participating physicians. To accurately measure quality and value, physicians must be able to report on measures and metrics relevant to their practice. CMS is moving in the correct direction with the establishment of the MIPS Value Pathways (MVPs), yet there is still a long way to go until all physicians, including gynecologic oncologists, can meaningfully report measures within this system.

Specifically, SGO believes that CMS has a unique opportunity to address health equity concerns within the QPP. One way to achieve this is by implementing risk adjustment mechanisms that consider the higher costs associated with treating patients with specific characteristics, such as Medicaid or dual eligible patients. Instead of penalizing healthcare providers for treating sicker or more complex patients, there should be recognition and credit for the care they provide. This emphasizes the significance of quality over cost as a performance metric. As an example, cervical and uterine cancer disproportionately affects vulnerable populations due to barriers to access to screening and care. This recommended approach aligns with CMS' overarching goal of improving both quality of care and equitable patient outcomes within the QPP.

Lastly, CMS' highest priority should be expanding the availability of APMs in which specialists can successfully participate. The agency should commit to implementing condition-specific APMs that have been developed by physicians and medical specialty societies. Additionally, they should collaborate with societies like SGO, providing them with technical assistance during the APM design process. These changes could accelerate the adoption of APMs and provide specialties with needed support, including access to Medicare claims data. SGO recognizes that there are barriers to APM development for small patient populations, like those populations with gynecologic cancers. For specialists, like gynecologic

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oncologists, CMS must determine how to develop APMs for those physicians who treat diseases that are rare but still represent significant public health burden to the U.S. population. SGO welcomes the opportunity to work with CMS to develop APMs specific to gynecologic cancers, such as endometrial cancer.

In closing, 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 Kay Moyer, Director of Regulatory Affairs, CRD Associates, kmoyer@dc-crd.com.

Sincerely,

Angeles Alvarez Secord, MD, MHSc
President, 2023-2024