



## COMMUNITY ONCOLOGY ALLIANCE

Innovating and Advocating for Community Cancer Care

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September 10, 2018

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

The Honorable Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1693-P  
P.O. Box 8016  
Baltimore, MD 21244-8013

Re: *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program; CMS-1693-P (the "CY 2019 Medicare Physician Fee Schedule Proposed Rule")*

Dear Administrator Verma:

On behalf of the Board of Directors of the Community Oncology Alliance ("COA"), I am submitting this comment letter regarding the CY 2019 Medicare Physician Fee Schedule ("Physician Fee Schedule") Proposed Rule ("Proposed Rule").

COA is a non-profit organization that is dedicated to advocating for the complex care and access needs of patients with cancer and the community oncology practices that serve them, especially vulnerable seniors with cancer. COA is the only organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving cancer treatment. COA's mission is to ensure that patients with cancer receive the highest quality, affordable, and accessible cancer care in their own communities. For more than 15 years, COA has built a national grassroots network of community oncology practices to advocate for public policies to support their patients with cancer.

COA is deeply concerned about many provisions in the Proposed Rule, especially **the proposed payment cuts to Evaluation and Management ("E&M") services that jeopardize the progress made towards value-based cancer care. We feel strongly that the E&M cuts, coupled with the severe payment cuts to the administration of chemotherapy and modifier 25, which allows patients with cancer to reduce multiple visits to their oncologists, will have a very negative impact on the vulnerable patients we serve.**

Community oncologists truly appreciate the focus of the Centers for Medicare & Medicaid Services ("CMS") on reducing Medicare bureaucracy and documentation requirements so that physicians can spend more time on actual patient care; not data entry and paperwork. Those bureaucratic burdens are increasing and are having an escalating adverse impact on patient care. However, the associated payment reductions proposed by CMS **send the message that the agency is more interested in the quantity of patient care, not the quality of patient care.** Paying the same for a medical visit dealing with the case of a head cold with sniffles as a complex case of metastatic breast cancer **severely devalues the expertise, time, and resources of oncologists and the complexity of treating cancer. It also sends a demeaning message to seniors with cancer who rely on Medicare to provide the highest quality cancer care.**

COA and community oncology as a whole is committed to meaningful, patient-centered oncology payment reform. We have been on the forefront of national efforts to advance this, including leading a collaborative network of over 80% of the participants in the Oncology Care Model (“OCM”), which provides a forum to share best practices and ideas. COA routinely communicates with the CMS Innovation Center OCM team on suggestions designed to address problems and concerns with the OCM. While we are committed to making the OCM a success, we are also deeply involved in developing the “OCM 2.0” – an evolved version of the OCM 1.0 that, among other improvements, streamlines the model and incorporates value-based drug performance directly into the model. This is not just a Medicare model, as with the OCM 1.0, but a universal model of oncology payment. We are also very involved with both insurers and employers in field-testing new models of oncology payment reform and will be hosting another in our annual series of Payer Exchange Summits on Oncology Payment Reform in late October.

We want to underscore that with oncology payment reform, and the delivery of cancer care in general, COA is oriented to providing solutions – not just pointing out problems. As such, in this comment letter, while we strongly object to aspects of the Proposed Rule, we do advance recommendations and potential solutions.

Finally, it is critical for you, your leadership, and staff at CMS to understand the very precarious nature of independent community oncology. A variety of misguided public policy, including notably the CMS decision to continue to apply the sequester cut to Medicare Part B (“Part B”) drugs, has resulted in the documented closing of cancer treatment sites, especially in rural areas, and in pushing independent practices to sell out to hospitals. The result has been access problems and higher costs for seniors, Medicare, and taxpayers. While we appreciate CMS’ moves to moderate the runaway 340B drug discount program and to achieve greater site payment parity for delivering cancer care, CMS has to be much more attuned to the unintended consequences of its policy and regulatory decisions. That has to start with this Proposed Rule and other initiatives CMS is pursuing to address the increasing costs of cancer drugs and other prescription medications.

We encourage CMS leadership and staff to actually visit independent community oncology practices to understand the complexity of delivering modern-day cancer care in the context of the overall shifting cancer delivery landscape. Our member practices would be glad to host you for such a visit to see firsthand the high-quality cancer care that community oncology provides to patients across the United States.

### **Comments on the Proposed Rule**

COA will be providing specific comments and recommendations on the following topic areas in the Proposed Rule:

- E&M Payment Changes
- Reimbursement Changes When a Procedure and an E&M Service Are Performed on the Same Day
- Relative Value Unit (“RVU”) Proposals; Changes to Practice Expense (“PE”) Inputs
- Payment Provisions for Part B Drugs
- Site Neutral Payments for Cancer Care Services
- Appropriate Use Criteria (“AUC”) for Advanced Diagnostic Imaging Services
- Telehealth Services
- Modernizing Medicare Physician Payment by Recognizing Communication Technology Based Services
- Quality Payment Program Updates
  - Changes to the Merit-Based Incentives Payment System (“MIPS”)
  - Medicare Advantage Qualifying Payment Arrangement Incentive (“MAQI”) Demonstration

## *E&M Payment Changes*

COA is staunchly opposed to any proposals that would put at risk value-based, patient-centered cancer care. CMS is proposing to create a single payment rate for E&M visit complexity levels 2-5, for both new and established patients, which in practice means paying a physician the same amount for evaluating a case of sniffles and a complex brain cancer. Although CMS is proposing to streamline the associated documentation and reporting of patient encounters, the change would severely undervalue the thorough and critical evaluation and management of seniors with cancer, especially life-threatening complex cases.

COA appreciates CMS' interest in reducing administrative burdens on providers. However, the proposed changes to E&M coding and payment represent a step in the wrong direction for two reasons. First, simply changing the reimbursement, by itself, does not lessen the documentation requirements. Physicians document based on three components, as stated in the American Medical Association ("AMA") CPT Codebook: history, physical exam, and decision making. Cancer patients typically require more intensive documentation for all three categories to assure high quality and coordinated care with other provider teams. The need to collect and analyze robust information to aid in sound medical decision-making will not go away, simply because the coding requirements have been streamlined. Second, CMS' rationale for the proposed change appears to be driven by the faulty notion that documentation and reporting activities represent the bulk of effort associated with cancer patient visits. The reality is that community oncologists provide complex, specialized medical care and the "administrative" portion of what we do associated with a patient visit is just the tip of the iceberg. The large majority of what community oncologists do with each patient is the actual evaluation and management of their cancer by relying on our experience, medical decision making, and diagnostic tools. Physicians should be incentivized to spend more time, not less, with their patients, coordinating care, discussing therapy options, and answering questions.

Fundamentally, the proposed change to the E&M payment codes is about devaluing what physicians do – and what patients with cancer demand from their oncologists. It is also just another in a string of Medicare reimbursement cuts that have compounded to result in independent community oncology treatment sites closing or consolidation into the more expensive hospital setting.

The proposed E&M changes impact physicians differently, based on their distribution of patients by acuity level. Providers who see more complex patients, equivalent to level 4 and 5 E&M visits, would be impacted more than those who typically see levels 2 and 3. To illustrate this variability, COA commissioned Avalere Health to analyze E&M code utilization between specialties in Medicare claims. The results show that a majority (65%) of E&M services provided by oncologists are for level 4 and level 5 codes, compared to 42% for other specialties and 54% for general practice, such as primary care, internists, and geriatric medicine.<sup>1</sup> Furthermore, Avalere found that 20% of Medicare spending on E&M codes among community oncologists is associated with level 5 codes, while only 7% among general practice.<sup>2</sup>

Under the proposed blended E&M rate, providers would see a reduction for established patients from \$109 to \$93 (15% payment decrease) for complex level 4 visits and from \$148 to \$93 (36% payment decrease) for level 5 codes.<sup>3</sup> The cuts are even more significant for new patients – \$167 to \$135 (19% payment decrease) for level 4 and from \$211 to \$135 (37% payment decrease) for level 5.<sup>4</sup> These payment cuts would disproportionately hurt community oncologists, for whom new patients accounted for 11% of E&M codes, compared to 5% among general practitioners.<sup>5</sup> COA estimates that the total impact of the proposed changes to E&M services billed by community oncology would be an

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<sup>1</sup> Avalere Health analysis of 2016 Physician/Supplier Procedure Summary (PSPS) file

<sup>2</sup> Ibid.

<sup>3</sup> CY2019 Medicare Physician Fee Schedule Proposed Rule

<sup>4</sup> Ibid.

<sup>5</sup> Avalere Health analysis of 2016 Physician/Supplier Procedure Summary (PSPS) file

almost 11% reduction, or approximately an \$84 million reimbursement cut across all community oncologists billing in the physician office setting (POS).<sup>6</sup>

To soften the impact of the proposed cuts to E&M reimbursement, CMS has developed add-on codes to reflect resources that are needed beyond what is accounted for in the single payment rates. The new add-on “G” codes would pay extra per visit based on 30 minutes of additional visit length (GPRO1) and patient complexity (GCG0X) but may still not fully offset the potential payment cuts for certain specialties. This is in part because it is unclear in the Proposed Rule how and when these add-on codes can be appropriately used. For example, when exactly would the clock begin for the additional 30 minutes – after the initial service or from the minute a physician begins seeing a patient? We are concerned that use of a time-based G code would place excessive importance on the length of a visit, rather than the quality and depth of medical decision-making. Providers should be able to focus on providing their patients attentive care without having to worry about starting and stopping the clock to receive payment. This proposal appears to be another example of valuing quantity of care over quality of care.

Last, but not least, the potential implementation of this new proposed reimbursement structure presents significant operational challenges for practices and providers, not to mention their data system vendors and Medicare carriers. Upon the final rule’s release, the CPT Codebook and all providers’ practice management software would immediately require updating to reflect the new condensed E&M blended rate and G-codes. Implementing these changes in the short time before CMS’s proposed effective date would create a significant burden for providers.

**Recommendation:** COA urges CMS not to finalize the changes to E&M coding and reimbursement, because they could seriously negatively impact the quality of care for Medicare seniors with cancer. Patients should not be subjects of policy experiments that could literally jeopardize lives. If CMS is intent on moving forward with the condensed E&M codes and new G-codes, we urge the agency to consider excluding oncology due to the highly sensitive nature of the disease of cancer and the life-or-death implications. Oncologists should not be penalized for spending more time with patients or taking on difficult cancer cases. CMS should also avoid implementing policies that would incentivize more frequent, shorter patient visits in lieu of comprehensive evaluation and management visits, because it would likely result in avoidable inconvenience for Medicare beneficiaries, higher out-of-pocket costs, and an alarming shift back to paying for volume instead of value.

If CMS ignores requests from physicians not to implement the proposed changes, but instead proceeds with blending the E&M 2-5 payment rates, the agency must take several steps to protect cancer care. First, CMS must label these new blended rates as payment for “reporting and documentation” that streamlines reporting and documentation for levels 2-5. Next, CMS must clearly define the appropriate use of the patient complexity (GCG0X) G-code such that the “evaluation and management” – the actual task of medical decision-making – is acknowledged and adequately reimbursed by allowing these codes to be used with 2-5 level visits in oncology and hematology. This would include clear instructions that the complexity code can be used for all visits, for both new and established patients, that would otherwise be levels 2-5. We also recommend that the prolonged code (GPRO1) be allowed to be used in addition to the complexity code for any new or established patient visit with additional time beyond 16 minutes, instead of the proposed 30 minutes. We also request that CMS ensures that any reporting and documentation associated with these G-codes do not supplant those that the agency is trying to phase out.

### ***Reimbursement Changes When a Procedure and an E&M Service Are Performed on the Same Day***

Another provision related to E&M visits that is very troubling is CMS’ proposal to apply a payment adjustment when an E&M visit is reported the same day as a procedure (such as the administration of chemotherapy) or other oncology services. Under the proposal, when an E&M code is reported on the same date as another procedure, Medicare would

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<sup>6</sup> Avalere Health analysis of analysis of the 2016 Physician/Supplier Procedure Summary (PSPS) dataset and the 2018-2019 PFS RVU files

reduce payment by 50% for the least expensive service provided. Community oncologists typically use modifier 25 to account for providing multiple services to a patient on the same day. This often occurs when patients come in for chemotherapy administration and alert their oncologist to other health issues that warrant a discussion, often detailed in nature.

We are extremely concerned that CMS is considering a 50% cut to same-day services billed with modifier 25. For community oncologists, 36% of drug infusion claims in 2017 were submitted on the same day as an E&M service provided to a patient.<sup>7</sup> This would mean that more than one-third of drug infusion billings could be subject to the 50% payment cut under the proposed changes. The logic of believing that there are some “economies of clinical scale” to justify this arbitrary 50% payment cut is totally faulty. Once again, this proposed payment cut is another significant devaluing of the complex processes involved in treating seniors with cancer. What CMS is doing is putting oncologists in the terrible position of either accepting this devastating payment cut, which will threaten the viability of more independent community oncology practices, or requiring their patients to come back on another day for treatment. And this is all because the agency seemingly does not understand the realities – and complexities – of providing cancer care.

**Recommendation:** We strongly urge CMS not to finalize this draft provision because it might have unintended consequences for practitioners and Medicare beneficiaries. Senior patients with cancer are often frail, and their care teams should not be penalized for trying to provide as many necessary services on the same day to minimize the need for multiple visits. At the very least, if CMS proceeds with this payment cut, oncology must be exempted.

### ***RVU Proposals: Changes to PE Inputs***

COA recognizes that the process of developing appropriate adjustments to RVUs each year is very complex and takes into account various factors, including recommendations by the AMA/Specialty Society Relative Value Scale Update Committee (“RUC”), the Medicare Payment Advisory Commission (“MedPAC”), and others. We also understand that CMS worked with a contractor to update the PFS direct practice PE inputs for supply and equipment pricing for CY 2019. As a result, CMS’ estimates of the overall impact of the potential adjustments for 2019 would translate into a 4% reduction in reimbursement for hematology/oncology and a 2% cut for radiation/oncology. COA is very concerned about these reductions, which we deem inaccurate – they are too low – and inappropriate given the rate of inflation and the ongoing 2% sequestration cut that CMS wrongfully continues to apply to Part B drug payments.

Moreover, certain services appear to be subject to significantly larger payment decreases – for example, COA estimates that the payment cut to infusion services, such as the administration of chemotherapy, will be 11%, and possibly higher in cases. We have done extensive modeling of the infusion codes based on actual utilization data by code. The attachment to this letter displays an actual example provided by a practice that represents the average reimbursement cut to both E&M and infusions.

Furthermore, we have found a troubling misalignment in CMS’ calculations. COA analyzed how various inputs for oncology codes changed from CY 2018 to CY 2019 in the Proposed Rule to determine if they contribute to increases or decreases in payments. For a list of drug infusion procedures, we found that changes to the supply and equipment inputs are not driving the estimated cuts. In fact, the updated inputs for supplies and equipment for the codes we studied in most cases were actually increasing.

Instead, it appears that changes to the indirect practice cost index (“IPCI”) are responsible for the proposed payment cuts because CMS created a unique new E&M specialty in order to create a single valuation for the level 2-5 E&M visits. As a result, between CY2018 and CY2019 the IPCIs for 6 specialties are proposed to decrease by more than 20%, including medical oncology (*a 26.7% decrease*) and hematology/oncology (a 20.1% decrease). In contrast, from

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<sup>7</sup> Avalere Health analysis of 2017 5% sample of Medicare claims submitted by physicians

CY2017 to CY2018 the IPCIs for medical oncology and hematology/oncology *increased by 2.7% and 2.9%*, respectively. The stunning 26.7% IPCI decrease, when the previous year the IPCI increased by 2.7% for medical oncology, shows a fundamental flaw in CMS' methodology.

COA requests more clarity from CMS on the process, methodology, and rationale behind these changes to the IPCI. It appears that the decision to create a single practice expense value for all E&M visits under the IPCI calculations compounds the negative effect of the blended payment for E&M visits by also translating in reductions to the RVUs for hematology/oncology.

COA is very concerned that the proposed cuts to Medicare payments for CY 2019, both separately and in aggregate, may seriously threaten the economic viability of community oncology practices resulting in a very negative impact on patient access, particularly for small practices in rural areas, and increased costs to seniors and Medicare. If finalized, the cuts to oncology RVUs and E&M reimbursement could force some practices to limit the number of Medicare patients they treat, leave care altogether, or sell out to the hospital. For patients in areas with no local oncologist, it was estimated that patients travel on average 58 minutes, with many traveling an hour and a half or more each way to receive chemotherapy, adding significant cost and burden to them and their caretakers.<sup>8</sup>

**Recommendation:** COA urges the agency to avoid changing the E&M valuations in such a way that modifies PE RVUs for other unrelated codes and compounds potential negative effects of other coding and payment changes. **CMS must carve out medical oncology in such a manner that the IPCI change reflects reality and is not hostage to a methodology flaw.**

### *Payment Provisions for Part B Drugs*

According to statute (the Medicare Modernization Act of 2003), the Medicare program is supposed to pay for the majority of Part B physician administered drugs at a rate of Average Sales Price (ASP) plus 6%. Of course, we again note that CMS continues to illegally and unconstitutionally apply the sequester cut to Part B drug payments such that reimbursement is now actually ASP plus 4.3%. However, certain drugs – including new drugs before an ASP is available – are currently paid according to statute at Wholesale Acquisition Cost (WAC) plus 6%, which is now actually WAC plus 4.3% with CMS wrongfully applying the sequester cut. For CY2019, CMS proposes to reduce the add-on payment for these products from WAC plus 6% to WAC plus 3%. We note that this is, once again, disingenuous of CMS, because the true payment rate will end up as WAC plus 1.35% after factoring in the ongoing sequester cut.

COA notes that the Proposed Rule cites MedPAC analysis from 2017, which recommends that the Medicare program reduce payments of new Part B products from WAC plus 6% to WAC plus 3%. However, MedPAC's own analysis of eight new high-expenditure Part B products over eight years found that the differences between WAC and ASP payment rates for the new, high-expenditure products were modest (with one product showing no difference between initial WAC and ASP over the study period).

We question the basis and logic for this proposed reimbursement change. Our primary concern is actually not about reimbursement, but rather that CMS is inadvertently fueling higher drug prices rather than reducing them. This is just another example of a policy that is not well thought out and could have major unintended consequences. If CMS believes that providers are motivated and choose drugs based on reimbursement – something we add has no basis in fact and has not been proven; to the contrary, the opposite has been proven – then a reduction in new drug reimbursement will motivate pharmaceutical companies to increase prices (namely, WAC) for new products. Ironically, the MedPAC Commissioners have raised this very concern in meetings while discussing this policy. We specifically note that biosimilar manufacturers will face a pricing dilemma that may well fuel the launch prices of biosimilars.

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<sup>8</sup> <https://www.asco.org/research-progress/reports-studies/state-cancer-care>

**Recommendation:** This proposed pricing change simply needs to be scrapped. It would have disastrous consequences in fueling the prices of Part B drugs. WAC becomes ASP after a new product is on the market for 6 months, with any rebates and discounts accounted for in ASP. Fueling higher WAC-based launch prices will translate into higher ASPs.

### *Site Neutral Payments for Cancer Care Services*

In CY2017, CMS finalized the PFS as the applicable payment system for specific items and services furnished by certain off-campus hospital outpatient provider-based departments and set payment for these services as 40% of the payment that would have been paid under the hospital outpatient fee schedule (“OPPS”). For CY2019, CMS is proposing to maintain this 40% Relativity Adjuster for non-expected departments paid under the PFS. Furthermore, CMS proposes that this adjustment be maintained for future years until updated data or other considerations indicate that an alternative adjuster or change is warranted.

It has been long recognized that hospital outpatient departments are reimbursed at incrementally higher rates for the same services as those provided in the physician office setting. With hospitals receiving both a higher professional fee and an additional facility fee, overall costs have therefore increased for both the Medicare program and its beneficiaries when cancer care is shifted to the hospital setting. In fact, an analysis from Milliman found that the shift of cancer care from independent community oncology practices to hospital-owned sites cost the Medicare program \$2 billion more in 2014 alone than if the care had stayed in the community practice setting.<sup>9</sup> In 2012, COA analysis found that treatments for patients receiving chemotherapy in a hospital outpatient department costs, on average, 24% more than **the same treatment** delivered in a physician’s office.<sup>10</sup>

**Recommendation:** COA supports the proposal to maintain the 40% Relativity Adjuster for non-expected outpatient departments and supports CMS’ efforts towards payment parity between physician offices and hospital outpatient departments. We recommend that CMS continue to drill down on the inequities of payment based on site-of-service and work to also bring parity with expected hospital-based departments.

### *AUC for Advanced Diagnostic Imaging Services*

The CY2018 PFS final rule delayed the start date of the Medicare AUC program for advanced diagnostic services until January 1, 2020 to allow providers more time to prepare for implementation. In the proposed CY 2019 PFS, CMS upheld the January 1, 2020 start date and provided additional guidance around provider consultation and documentation, including minor changes to the definition of an applicable setting and some flexibility to delegate the AUC consultation requirement. Specifically, to ease reporting burdens, CMS proposes allowing clinical staff "working under the direction of the ordering professional, subject to applicable state licensure and scope of practice law" to perform the consultation of AUC through a qualified clinical decision support mechanism.

COA strongly supports the administration’s goal of ensuring appropriate use of diagnostic imaging and the agency’s efforts to move forward with implementation of this important, congressionally-mandated utilization program. We agree that any diagnostic imaging service should fall within the realm of appropriate use but continue to believe that the responsibility for consulting AUC should be borne by the furnishing provider instead of the ordering provider or their staff. Ordering oncologists and hematologists already bear significant burdens associated with pre-certifying any number of services not actually provided by them. Furthermore, there are also an abundance of pre-authorizations mandated by the patient’s insurance. These requirements already expend significant resources within the practice, without any remuneration. According to a 2017 survey of oncology practices in the United States, oncologists were

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<sup>9</sup> Milliman, “[Cost drivers of cancer care, a retrospective analysis of Medicare and commercially insured patient claims data 2004-2014](#),” April 2016.

<sup>10</sup> Community Oncology Alliance (COA), “[Cost of Cancer Care](#),” prepared by Avalere Health LLC, March 2012.

inordinately burdened with prior-authorization requirements, overwhelmingly (78%) citing these pressures as a “pain point” in their clinical practice.<sup>11</sup> Combining the current workload with the new proposed requirement may actually increase the burden that CMS seeks to reduce, and therefore take clinical practice time away from patient care.

**Recommendation:** COA continues to strongly recommend that even though the ordering professional and their clinical staff will, in good conscience, order the appropriate procedure, the individual who provides the service should bear the responsibility of verifying the AUC prior to test administration.

### ***Telehealth: Recognizing Communication Technology-Based Services***

For 2019, CMS proposes to expand reimbursement for telehealth by establishing new payment codes for certain services that involve the use of digital technology. COA is pleased that CMS continues to advance patient access to care and remote patient monitoring. The ability to augment in-person visits with virtual care will greatly benefit oncology patients and their caregivers.

However, we disagree with the proposed PE inputs for the newly created codes (990X0, 990X1, 994X9), as well as code 99091, for communication technology-based services as outlined in the Proposed Rule. Namely, pharmacists or other drug dispensing oncology professionals play an essential role in advancing virtual medicine and telehealth services through programs like digital medication therapy management, but their time and effort is not currently accounted for by CMS. The cost of providing such services is incurred by practices, but not adequately captured because there is no PE input available for pharmacists. COA estimates that for each of the proposed new codes, clinical time ranges between 10 and 40 minutes for patient education and interactive communication with beneficiaries and their caregivers.

**Recommendation:** We urge CMS to account for such time and expense of pharmacy personnel in developing new virtual codes. COA looks forward to serving as a resource for the administration on these important issues and would appreciate the opportunity to offer our experience and data to help shape virtual care and remote patient services.

### ***Quality Payment Program Updates***

For CY2019, CMS proposes to increase the cost category weight in the Merit-based Incentive Program (“MIPS”) to 15% (up from 10% in 2018), while lowering the weight of the quality category to 45% (down from 50% in 2018).

COA remains very concerned about the cost performance category and, therefore, its weighting. Specifically, we are concerned with the accurate attribution of costs to individual providers and believe that CMS needs to more carefully analyze cost performance data and its accuracy. We believe this is especially important if CMS implements its proposal to increase the weighting of this performance measure for the 2021 payment year (CY2019). Our experience with the OCM, another model that relies on accurate patient attribution, shows troubling error rates. Our survey of OCM participants revealed that on average participants estimated 44% more patients than those attributed to them by CMS.<sup>12</sup> Only two respondents had less than a 10% variance with the CMS attribution report.

**Recommendation:** COA urges CMS to make MIPS cost measure information more readily available and accessible on a monthly basis. We believe this information needs to be as transparent as possible and provided to all MIPS participating clinicians, even those reporting as a group.

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<sup>11</sup> Lin, N., Bichkoff, H., Hassett, M., “[Increasing Burden of Prior Authorizations in the Delivery of Oncology Care in the United States](#),” American Society of Clinical Oncology (ASCO) Journal of Oncology Practice, August 2018.

<sup>12</sup> COA survey of OCM participants’ experience with OCM beneficiary attribution reports, 2018



## Conclusion

COA appreciates the opportunity to comment on the Proposed Rule and hopes that CMS will carefully consider the changes it has proposed and impact they will have on Medicare seniors with cancer. We look forward to working closely with CMS staff to advance meaningful, patient-centered policies that improve both the quality and cost of oncology care for all Americans. We offer access to our staff and extensive modeling work to explain any of the findings in this comment letter in greater detail.

We are available to discuss any of our concerns and recommendations provided in this letter and thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'JV', with a long horizontal flourish extending to the right.

Jeffrey Vacirca, MD, FACP

President

## 2019 CMS Changes - Preliminary Final Rule

### Infusion - Reflects RVU Changes

Use this calculator to estimate the impact on your practice of the CMS Preliminary changes for 2019. Enter any codes not listed below in the space provided. Be sure to indicate 2018 and 2019 rates for an accurate comparison. Contact Bo Gamble, [bgamble@COAcancer.org](mailto:bgamble@COAcancer.org) if you have any question.

Revenue is based on Medicare's allowable for each CPT code with no geographic adjustment included (Carrier/Locality is 0000000)

**Input your annualized chemotherapy volume, E&M volume and % Medicare below.**

Chemo Room Infusion Codes	Quantity	2019	2019 Revenue	2018	2018 Revenue	Variance by code	Revenue Change
96360	998	\$ 38.57	\$ 38,492.40	\$ 47.52	\$ 47,424.43	\$ (8.95)	\$ (8,932.03)
96361	2,396	\$ 12.98	\$ 31,092.10	\$ 14.04	\$ 33,639.47	\$ (1.06)	\$ (2,547.37)
96365	4,972	\$ 69.21	\$ 344,106.63	\$ 74.16	\$ 368,719.42	\$ (4.95)	\$ (24,612.79)
96366	2,034	\$ 21.27	\$ 43,257.72	\$ 22.32	\$ 45,398.38	\$ (1.05)	\$ (2,140.65)
96367	6,746	\$ 29.20	\$ 196,966.36	\$ 32.04	\$ 216,139.44	\$ (2.84)	\$ (19,173.08)
96368	-4	\$ 19.83	\$ (79.30)	\$ 21.24	\$ (84.96)	\$ (1.41)	\$ 5.66
96369	0	\$ 167.25	\$ -	\$ 176.76	\$ -	\$ (9.50)	\$ -
96370	0	\$ 14.78	\$ -	\$ 15.84	\$ -	\$ (1.06)	\$ -
96371	0	\$ 64.16	\$ -	\$ 64.80	\$ -	\$ (0.64)	\$ -
96372	8,696	\$ 16.94	\$ 147,325.55	\$ 20.88	\$ 181,570.46	\$ (3.94)	\$ (34,244.91)
96373	4	\$ 19.47	\$ 77.86	\$ 19.44	\$ 77.76	\$ 0.03	\$ 0.10
96374	1,102	\$ 38.21	\$ 42,106.40	\$ 47.16	\$ 51,969.74	\$ (8.95)	\$ (9,863.34)
96375	20,586	\$ 15.50	\$ 319,081.13	\$ 18.36	\$ 377,954.76	\$ (2.86)	\$ (58,873.63)
96377	0	\$ 20.91	\$ -	\$ 20.88	\$ -	\$ 0.03	\$ -
96401	2,278	\$ 72.81	\$ 165,869.21	\$ 81.72	\$ 186,156.09	\$ (8.91)	\$ (20,286.88)
96402	1,598	\$ 29.92	\$ 47,809.65	\$ 31.32	\$ 50,048.80	\$ (1.40)	\$ (2,239.15)
96405	0	\$ 80.02	\$ -	\$ 82.44	\$ -	\$ (2.42)	\$ -
96406	0	\$ 120.03	\$ -	\$ 120.96	\$ -	\$ (0.92)	\$ -
96409	1,254	\$ 99.13	\$ 124,305.67	\$ 111.60	\$ 139,944.85	\$ (12.47)	\$ (15,639.18)
96411	5,054	\$ 54.07	\$ 273,267.00	\$ 59.76	\$ 302,023.68	\$ (5.69)	\$ (28,756.68)
96413	16,646	\$ 129.05	\$ 2,148,095.62	\$ 144.72	\$ 2,408,982.35	\$ (15.67)	\$ (260,886.73)
96415	6,394	\$ 28.48	\$ 182,079.23	\$ 31.68	\$ 202,559.67	\$ (3.20)	\$ (20,480.44)
96416	2,042	\$ 130.85	\$ 267,191.76	\$ 147.24	\$ 300,660.74	\$ (16.39)	\$ (33,468.98)
96417	5,080	\$ 62.72	\$ 318,620.45	\$ 69.48	\$ 352,954.48	\$ (6.76)	\$ (34,334.02)
96420	0	\$ 104.53	\$ -	\$ 108.00	\$ -	\$ (3.46)	\$ -
96422	72	\$ 158.96	\$ 11,445.42	\$ 188.64	\$ 13,581.93	\$ (29.67)	\$ (2,136.51)
96423	0	\$ 72.81	\$ -	\$ 85.68	\$ -	\$ (12.87)	\$ -
96425	0	\$ 167.62	\$ -	\$ 197.28	\$ -	\$ (29.66)	\$ -
96440	0	\$ 865.11	\$ -	\$ 803.87	\$ -	\$ 61.24	\$ -
96446	0	\$ 196.45	\$ -	\$ 212.04	\$ -	\$ (15.59)	\$ -
96450	46	\$ 182.39	\$ 8,390.14	\$ 186.84	\$ 8,594.54	\$ (4.44)	\$ (204.41)
96521	2	\$ 148.15	\$ 296.30	\$ 150.12	\$ 300.24	\$ (1.97)	\$ (3.94)
96522	0	\$ 116.07	\$ -	\$ 121.68	\$ -	\$ (5.61)	\$ -
96523	1,166	\$ 25.95	\$ 30,261.59	\$ 28.44	\$ 33,160.67	\$ (2.49)	\$ (2,899.08)
96542	0	\$ 126.88	\$ -	\$ 136.44	\$ -	\$ (9.56)	\$ -
99195	628	\$ 94.08	\$ 59,082.77	\$ 104.04	\$ 65,336.39	\$ (9.96)	\$ (6,253.62)
<b>Total Impact on Infusion Room Services</b>			<b>\$ 4,799,141.66</b>		<b>\$ 5,387,113.34</b>		<b>\$ (587,971.68)</b>
				<b>% Increase (Decrease) from 2018 to 2019</b>			<b>-10.91%</b>