Society of Gynecologic Oncology

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September 9, 2024

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 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1807-P)

Dear Administrator Brooks-LaSure

The Society of Gynecologic Oncology (SGO) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year (CY) 2025.

The SGO is the premier medical specialty society for healthcare professionals trained in the comprehensive management of gynecologic cancers. Our more than 3,000 members include physicians, advanced practice providers, nurses, and patient advocates who collaborate with the SGO's foundation, the Foundation for Women's Cancer, to increase awareness of gynecologic cancers and improve the care of those diagnosed with gynecologic cancers. Our mission focuses on supporting research, disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies, and collaborating with other organizations dedicated to gynecologic cancers and related fields, all with the ultimate vision of eradicating gynecologic cancers.

Conversion Factor Update

On January 1, 2025, the conversion factor will decrease by 2.80 percent, primarily driven by the expiration of the conversation factor update which Congress approved in March. We understand that an act of Congress is required to increase the conversion factor and to also provide regular updates to the MPFS. However, we encourage the agency to work with Congress to develop a permanent solution that allows for regular inflationary updates to the rates paid for physician services within the Medicare program. As the SGO has stated in the past, the uncertainty of fee schedule payment levels plagues our members from year to year, creating anxiety and burnout. A stable payment system is needed to alleviate uncertainty, and to maintain confidence among the physicians that rely on this payment system.

Other Medicare payment systems receive regular updates, including the Inpatient Prospective Payment System and the Outpatient Prospective Payment System. We believe that the MPFS

should be treated similarly to ensure Medicare beneficiary access to care and while reimbursing physicians fairly for the care they provide.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology

The agency continues to examine ways to regularly update practice expense (PE) inputs and to examine the types of data used to make the updates. In this year's proposed rule, CMS has asked for comments on how the agency can improve the stability and predictability of future updates to the practice expense inputs.

The SGO encourages CMS to collaborate with the American Medical Association (AMA) while the agency continues its work to update the practice expense inputs used in the MPFS. The AMA's Physician Practice Information Survey (PPIS), currently in the field, will have the most up-to-date information available that captures the costs of operating a medical practice. The SGO encourages the agency to use this data to update the MPFS PE inputs in a manner that captures the true costs of operating a medical practice.

Additionally, the SGO supports the use of regularly updated PE data to account for changes in practice patterns as well as to account for the inevitable changes in technology, clinical labor rates, and other factors that influence practice expense inputs. As we have stated in previous comment letters, we believe that PE inputs should be updated at least every five years, and the any revised data should be phased-in over a 4-year period. A phased-in approach to updating the PE inputs will help negate large swings in the redistribution of RVUs across the MPFS and will create stability to allow for medical practices to adjust to changes in payment levels.

Payment for Telehealth Services

Frequency Limitations of Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

The agency proposes to permanently remove frequency limitations for E/M services when provided via telemedicine for the following Current Procedural Terminology (CPT) and HCPCS codes; subsequent inpatient visits (99231, 99232, and 99233), subsequent nursing facility visits (CPT codes 99307, 99308, 99309, and 99310), and critical care consultation services (HCPCS G codes, G0508 and G0509).

Prior to the COVID pandemic, there were frequency limitations (i.e., the number of times a provider may bill for a service during a given period) for these services. However, during the pandemic, CMS lifted the frequency restrictions to allow greater access to care.

Our members continue to use telehealth to secure and improve access to services for all gynecologic cancer patients, and our society supports policies that allow greater access to care for Medicare beneficiaries. We support permanently removing frequency limitations for the services as listed in this policy. The SGO has supported the telehealth flexibilities established during the COVID pandemic, and we believe that patients with gynecologic cancers and other

conditions have benefited from increased access to care. The use of telehealth allows Medicare beneficiary access to the expertise of a gynecologic oncologist that might not otherwise be available in rural hospitals and nursing facilities. Frequency limitations could limit this access. We encourage CMS to finalize the proposal as written.

Audio-only Communication Technology to Meet the Definition of "Telecommunications Systems"
CMS proposes to revise the definition of an interactive telecommunications system to include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician is technically capable of using an audio/video system, but the patient is not capable of, or does not consent to, the use of video technology.

The SGO supports the change in definition, which will allow the use of audio-only as type of communication technology that is covered under the Medicare program. Many elderly people prefer to use a telephone, while others may not have access to devices with video capabilities, and some may not have access to internet services needed to support the use of video technologies. The use of audio-only communication expands access to care by providing patients with choices as to how they would like to communicate with their practitioner. Additionally, greater access to audio-only services helps mitigate transportation challenges Medicare beneficiaries may have if they do not have access to public transportation or cannot drive long distances.

However, permanent legislative changes are needed for the change in definition to have any effect. Without Congressional action, the telehealth flexibilities, which allow Medicare beneficiaries to receive audio-visual and audio-only telehealth services, expire at the end of 2024. We encourage CMS to work with Congress to implement permanent changes that support access to all covered telehealth modalities.

Valuation of Specific Services
Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (CPT codes 96547 and 96548)
CMS proposed to accept the RUC-recommended work RVUs without modification for CPT codes 96547 (*Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)* and 96548 (*Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure),* used to report HIPEC services. SGO participated in the RVS Update Committee (RUC) survey process to value these services, and we support the final work RVUs as proposed.

Intra-Abdominal Tumor Excision or Destruction (CPT codes 4X015, 4X016, 4X017, 4X018, and 4X019)
CPT codes for intra-abdominal tumor excision or destruction were developed by the CPT Editorial Panel to replace the existing three-code family, which did not address the size of the tumors or cysts removed during the procedure. SGO participated in the survey of this revised code family, approved at the September 2023 RUC meeting.

The SGO appreciates that CMS proposed to accept the RUC recommended work values for 4X015-4X017. However, we are concerned that CMS proposed to reduce the RUC recommended work values for CPT codes 4X018 and 4X019 based on the rationale that the RUC recommended the 25th percentile values for the rest of the family and chose to elevate the work values for these two services to inappropriately high levels. The reductions are based on the times for these services and do not consider other crucial factors, like intensity. These two codes are used to report services associated with surgeries on large tumors or cysts or small tumors that may be difficult to distinguish from other critical structures, like blood vessels and the ureter. This increases the difficulty and risk of the procedure. Given the increased intensity of the work, the SGO supports the RUC's recommended work values of 45.00 RVUs and 55.00 RVUs for CPT codes 4X018 and 4X019, respectively, and urges CMS to adopt these values, which consider the intensity and complexity of the revised services, rather than those proposed in the final rule.

Strategies for Improving Global Surgery Payment Accuracy

The SGO remains concerned with CMS's conclusion that physicians are not performing post-operative care for their surgical patients or that the value of post-operative is inappropriately captured within the MPFS. The SGO has previously provided detailed comments on the valuable care that our members provide to Medicare beneficiaries during the global surgical period.

The agency has proposed changes that require the use of modifiers to capture global surgical care, and the agency has proposed a new HCPCS code to capture post-operative care provided by a practitioner who did not perform the procedure. While the SGO appreciates the need for the collection of additional data to better understand how global surgical services are provided and by whom, we do not think the collection of this data should rest solely on the shoulders of physicians and their administrative staff. Operationalizing this policy will create an administrative burden for physicians at a time when administrative burden continues to be a driver of physician burnout.

The SGO recommends that the agency use well-established processes for valuing services under the MPFS, including identifying services that may be misvalued. If there are surgical services that the agency believes are indeed misvalued, including the number and type of post-operative visits valued in the service, the agency should follow the process of nominating the service as misvalued, and allowing the RUC and the specialty societies to assist with revaluation. The SGO would welcome the opportunity to meet with the agency to discuss the global surgical package issue, and we are available should the agency have questions about the valuable care we provide to our patients during the post-operative period.

Request for Information: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

CMS recognizes that primary care teams coordinate with specialists more now than ever before, and this coordination is critical to the ongoing management of chronic conditions. CMS is considering a model that would increase the engagement of specialists in value-based payment and encourage specialty care providers to engage with primary care providers and beneficiaries. Specifically, CMS is exploring development of a model for specialists in ambulatory settings that would leverage the MVP framework.

SGO appreciates that CMS envisions this model to reach a broad range of clinicians of various specialty types that have limited opportunity to participate in advanced alternative payment models (APM). We have continued to recommend that CMS focus on expanding the availability of APMs in which specialists can successfully participate, including implementing condition-specific APMs that have been developed by physicians and medical specialty societies.

Our organization believes that the integration between primary and specialty care is essential and should be actively encouraged and appropriately reimbursed. However, before making this model mandatory, the agency must clarify the criteria for successful implementation, ensure adequate resources are available for providers to participate, and establish clear guidelines for reimbursement and accountability. For example, the agency should clarify how providers will be required to demonstrate that they are actively engaging in care coordination. Additionally, the agency will need to work with organizations, like SGO, to effectively narrow the measure set, particularly given the wide range of clinician specialties.

SGO eagerly welcomes the opportunity to work with the agency to identify solutions for more specialists, like gynecologic oncologists, to participate in advanced APMs and other specialty care models.

Transforming the QPP

In this proposed rule, CMS clarified its intent to move to full MVP adoption and to sunset traditional MIPS in the future. CMS does not propose a target year to sunset traditional MIPS; however, the agency seeks feedback on clinician readiness for MVP reporting and MIPS policies needed to sunset traditional MIPS in the CY 2029 performance period/2031 MIPS payment year.

SGO believes that the CY 2029 target date is premature as many practitioners, including SGO members, still do not have an MVP that applies to their specialty. While SGO members could potentially participate in the Advancing Cancer Care or the Focusing on Women's Health MVP, an MVP specific to gynecologic oncology has yet to be developed. SGO welcomes the opportunity to work with CMS to develop an MVP specific to gynecologic oncology to ensure that the unique needs and complexities of our members and their patients are fully addressed and captured in a model.

Additionally, when CMS does decide to transition to MVPs, SGO believes that MVPs should remain a voluntary pathway for practitioners and traditional MIPS should remain an option to ensure that practitioners are able to participate in a way that best reflects their patient population and practice needs. As CMS continues to develop and evaluate new pathways suitable for a wide range of practices of varied sizes and specialties, MVPs should remain voluntary.

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

Sincerely,

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