September 13, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1751-P – Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies
86 Fed. Reg. 39104 (July 23, 2021)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the calendar year (CY) 2022 Medicare Physician Fee Schedule proposed rule. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

III. PROVISIONS OF THE PROPOSED RULE FOR THE PFS

E. Valuation of Specific Codes

4. Proposed Valuation of Specific Codes for CY 2022

43. Comment solicitation on separate PFS coding and payment for chronic pain management

HHS notes that "there are no existing codes that specifically describe the work of the clinician involved in performing the tasks necessary to perform pain management care." HHS solicits comments on whether the agency should create "separate coding and payment for medically necessary activities involved with chronic pain management and achieving safe and effective dose reduction of opioid medications when appropriate."

ACS CAN supports the addition of a code to adequately compensate providers for the time they spend managing patients' pain and coordinating related care. Managing pain is an integral and necessary part of treating most cancer patients, and ACS CAN works to ensure that cancer patients and survivors have access to all the pain treatments appropriate for their condition and symptoms. Adequately addressing pain at all stages of a patient's treatment is dependent upon having providers who are willing and able to spend the time on pain management. Adding a specific code (or add-on code) for chronic pain management will be a helpful step towards ensuring access to pain treatment.

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However, we are concerned about the focus on opioid tapering in some of the language regarding the potential new code. While we recognize this is a legitimate goal for some patients who need pain management, it is not and should not be the focus of all pain management services, especially for cancer patients. We urge HHS to be clear when establishing the parameters of this new pain management code or add-on code that the code can be used for managing pain with any treatments that are medically appropriate for the patient. We urge HHS to also make this clear in any communications with providers that promote this potential new code.

I. Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests

The Consolidated Appropriations Act (CAA) of 2021 phased-in a policy that would waive cost-sharing for beneficiaries who undergo a screening colonoscopy that detected and removed polyps. The reduced coinsurance will be phased-in beginning January 1, 2022.

In 2021, an estimated 104,270 cases of colon cancer will be diagnosed in the United States, a majority of which will be diagnosed in individuals age 45 and older.[1] An estimated 53,200 people will die from the disease this year.[2] Colorectal cancer remains one of the deadliest forms of cancer.[3]

Colorectal cancer is one of the few cancers that can be completely prevented through screening. Polyps, or abnormal precancerous growths, can be detected during the screening process and entirely removed, thereby stopping any cancer formation that may have occurred without intervention. Regular screening is the most effective way of detecting precancerous growths and early colorectal cancer. Cancers that are found at an early stage can be treated more easily, and lead to greater survival.[4] For colorectal cancer, the five-year survival rate is 90 percent for those patients whose cancer is discovered and treated early. In contrast, individuals whose colorectal cancer is found at a later stage, after the cancer has metastasized, have a 14 percent five-year survival rate.[5]

ACS CAN applauds the Department for its plan to phase-in the CCA requirements related to colonoscopies. Waiving beneficiary cost-sharing for these colonoscopies will remove a financial barrier faced by Medicare beneficiaries and help to ensure these beneficiaries take advantage of this important preventive service benefit.

As more beneficiaries choose to undergo colorectal cancer screening using modalities other than colonoscopies, beneficiaries may face another financial burden when completing their colorectal cancer screening. Some beneficiaries who receive a positive result for a non-invasive screening test require a follow-up colonoscopy to complete the colorectal cancer screening process.

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[1] American Cancer Society. Colorectal Cancer Facts & Figures 2020-2022. Atlanta: American Cancer Society; 2020.
[2] Id.
[3] Siegal RL, Miller KD, Fuchs HE Jemal A. Cancer statistics, 2021. *Cancer.* 2021; 71:7-33, doi 10.3322/caac.21654.
[4] American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2019-2020. Atlanta: American Cancer Society; 2019.
[5] Colorectal Cancer Facts & Figures 2020-2022.

Follow-up colonoscopies are a vital component to the screening process. In its May 2021 colorectal cancer screening guidelines, the United States Preventive Services Task Force (USPSTF) stated that "positive results on stool-based screening tests require follow-up with colonoscopy for the screening benefits to be achieved."[6] The USPSTF statement is in line with guidance from the American Cancer Society, the US Multi-Society Task Force on Colorectal cancer, the American College of Radiology, and the National Colorectal Cancer Roundtable who have made clear that follow-up colonoscopy after a positive stool test is an integral part of the screening process that should be covered with no cost-sharing to the patient.[7] Additionally, studies have demonstrated that increased time to colonoscopy after an abnormal non-invasive screening test is associated with higher risk of colorectal cancer incidence, death, and late-stage colorectal cancer.[8]

Providing access to follow-up colonoscopy without cost-sharing obligations to the beneficiary is important in addressing cancer disparities and inequities given that Black, Hispanic, and Native Americans are diagnosed at later stages of colorectal cancer.[9]

CONCLUSION

Thank you for the opportunity to comment on the calendar year 2022 Medicare Physician Fee Schedule proposed rule. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network

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[6] U.S. Preventive Services Task Force. *Screening for Colorectal Cancer*. May 18, 2021. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#fullrecommendationstart.

[7] Wolf AMD. Fontham ETH. Et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. CA: May 30, 2018. Available at https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21457.

[8] San Miguel Y. Demb J. et al. Time to colonoscopy after abnormal stool-based screening and risk for colorectal cancer incidence and mortality. *Gastroenterology*. Feb. 2, 2021. Available at https://www.gastrojournal.org/article/S0016-5085(21)00325-5/fulltext.

[9] Colorectal Cancer Facts & Figures 2020-2022.