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118TH CONGRESS
1ST SESSION

H. R. 5183

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 11, 2023

Mr. DESAULNIER (for himself, Mr. RASKIN, Ms. BLUNT ROCHESTER, Ms. WILD, Mr. KHANNA, Ms. CLARKE of New York, Mrs. WATSON COLEMAN, Mr. BISHOP of Georgia, Ms. NORTON, and Ms. WASSERMAN SCHULTZ) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

(a) SHORT TITLE.—This Act may be cited as the ''Cancer Care Planning and Communications Act''.

(b) FINDINGS.—Congress makes the following findings:

(1) Cancer care in the United States is often described as the best in the world because patients have access to many treatment options, including cutting-edge therapies that save lives and improve the quality of life.

(2) Access to the best treatment options is not equal across all populations and in all communities. The 1999 Institute of Medicine report entitled ''The Unequal Burden of Cancer'' found that low-income people often lack access to adequate cancer care and that ethnic minorities have not benefitted fully from cancer treatment advances.

(3) In addition, despite access to high-quality treatment options for many, individuals with cancer often do not have access to a cancer care system that incorporates shared decision making and the coordination of all elements of care.

(4) Cancer survivors often experience the under-diagnosis and under-treatment of the symptoms of cancer and side effects of cancer treatment, a problem that begins at the time of diagnosis and may become more severe with disease progression and at the end of life. The failure to treat the symptoms, side effects, and late effects of cancer and cancer treatment may have a serious adverse impact on

the health, survival, well-being, and quality of life of cancer survivors.

(5) Individuals with cancer often do not participate in a shared decision-making process that considers all treatment options and do not benefit from coordination of all elements of active treatment and palliative care.

(6) Quality cancer care should incorporate access to psychosocial services and management of the symptoms of cancer and the symptoms of cancer treatment, including pain, nausea, vomiting, fatigue, and depression.

(7) Quality cancer care should include a means for engaging cancer survivors in a shared decision-making process that produces a comprehensive care summary and a plan for follow-up care after primary treatment to ensure that cancer survivors have access to follow-up monitoring and treatment of possible late effects of cancer and cancer treatment, including appropriate psychosocial services.

(8) The Institute of Medicine report entitled ''Ensuring Quality Cancer Care'' described the elements of quality care for an individual with cancer to include—

(A) the development of initial treatment recommendations by an experienced health care provider;

(B) the development of a plan for the course of treatment of the individual and communication of the plan to the individual;

(C) access to the resources necessary to implement the course of treatment;

(D) access to high-quality clinical trials;

(E) a mechanism to coordinate services for the treatment of the individual; and

(F) psychosocial support services and compassionate care for the individual.

(9) In its report ''From Cancer Patient to Cancer Survivor: Lost in Transition'', the Institute of Medicine recommended that individuals with cancer completing primary treatment be provided a comprehensive summary of their care along with a follow-up survivorship plan of treatment.

(10) In ''Cancer Care for the Whole Patient'', the Institute of Medicine stated that the development of a plan that includes biomedical and psychosocial care should be a standard for quality cancer care in any quality measurement system.

(11) The Commission on Cancer has encouraged survivorship care planning by making the development of such plans for patients one of the standards of accreditation for cancer care providers, but cancer care professionals report difficulties completing the plans.

(12) Because more than half of all cancer diagnoses occur among elderly Medicare beneficiaries, addressing cancer care inadequacies through Medicare reforms will provide benefits to millions of Americans. Providing Medicare beneficiaries more routine access to cancer care plans and survivorship care plans is a key to shared decision making and better coordination of care.

(13) Important payment and delivery reforms that incorporate cancer care planning and coordination are already being tested in the Medicare program; the Oncology Care Model has been implemented in a number of oncology practices, and additional models that will include care planning have been proposed.

(14) The alternative payment models, including the Oncology Care Model, provide access to cancer care planning for Medicare beneficiaries who receive their cancer care in practices that are part of the

Oncology Care Model. Other Medicare beneficiaries who are not enrolled in these delivery demonstrations may not have access to a cancer care plan or appropriate care coordination.

(15) The failure to provide a cancer care plan to patients in many care settings relates in part to inadequate Medicare payment for such planning and coordination services.

(16) Changes in Medicare payment for cancer care planning and coordination will support shared decision making that reviews all treatment options and will contribute to improved care for individuals with cancer from the time of diagnosis through the end of the life. Medicare payment for cancer care planning may begin a reform process that helps us realize the well-planned and well-coordinated cancer care that has been recommended by the Institute of Medicine/National Academy of Medicine and that is preferred by cancer patients across the Nation.

SEC. 2. COVERAGE OF CANCER CARE PLANNING AND COORDINATION SERVICES.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by inserting ''and'' at the end of subparagraph (JJ); and

(B) by adding at the end the following new subparagraph:

''(KK) cancer care planning and coordination services (as defined in subsection (nnn));''; and

(2) by adding at the end the following new subsection:

''Cancer Care Planning and Coordination Services

''(nnn)(1) The term 'cancer care planning and coordination services' means, with respect to an individual who is diagnosed with cancer, the development of a treatment plan by a physician, physician assistant, or nurse practitioner that—

''(A) includes each component of the Institute of Medicine Care Management Plan (as described in the article entitled 'Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis' published by the Institute of Medicine);

''(B) is furnished in written form or electronically, at the visit of such individual with such physician, physician assistant, or nurse practitioner, or as soon after the date of the visit as practicable; and

''(C) is furnished, to the greatest extent practicable, in an appropriate form that appropriately

takes into account cultural and linguistic needs of the individual in order to make the plan accessible to the individual.

''(2) The Secretary shall establish frequencies at which services described in paragraph (1) may be furnished, provided that such services may be furnished with respect to an individual—

''(A) at the time such individual is diagnosed with cancer for purposes of planning treatment;

''(B) if there is a change in the condition of such individual or such individual's treatment preferences;

''(C) at the end of active treatment and beginning of survivorship care; and

''(D) if there is a recurrence of such cancer.''.

(b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—

(1) IN GENERAL.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(KK),'' after ''health risk assessment),''.

(2) INITIAL RATES.—Unless the Secretary otherwise provides, the payment rate specified under the physician fee schedule under the amendment made by paragraph (1) for cancer care planning and coordination services shall be the same payment rate

as provided for transitional care management services (as defined in CPT code 99496).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the first day of the first calendar year that begins after the date of the enactment of this Act.

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