

CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS
ADDRESSING PUBLIC POLICY ISSUES IN CANCER

April 10, 2014

Patrick Conway, M.D.
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7500 Security Boulevard
Baltimore, Maryland 21244

Re: Mitre Corporation Technical Expert Panel for Specialty Payment Models
Opportunities and Design Initiative and Request for Information on Specialty
Practitioner Payment Model Opportunities

Submitted via email at specialtypaymentreform@brookings.edu and to Centers for Medicare & Medicaid Services

Dear Dr. Conway:

The undersigned cancer patient, health professional, and research organizations submit these comments in response to the Request for Information on Specialty Practitioner Payment Model Opportunities and the work of Mitre Corporation and Brookings Institution related to oncology payment models.

We are pleased that the Centers for Medicare & Medicaid Services is committed to evaluating oncology payment models and testing them consistent with Section 3021 of the Affordable Care Act, which authorizes the Center for Medicare and Medicaid Innovation and grants it the power to test innovative health care payment and service delivery models. We understand that the current payment reform efforts will focus on medical oncology services. Although that leaves many more elements of oncology care still to be addressed, focusing on medical oncology services represents an important step.

Elements of Quality Cancer Care

In these comments, we share a patient-focused consensus statement identifying the elements of quality cancer care and then discuss the payment models (reviewed in the Brookings Institution environmental scan) that will foster the achievement of the standards we have articulated.

Each cancer patient should be served by a cancer care system that:

- Provides care that is based on the best available evidence and consistent with practice guidelines developed through a trustworthy process;
- Begins with a cancer care planning process that incorporates shared decision-making and a discussion of treatment intent and treatment choices, presents options for symptom management and permits early access to palliative care according to patient preference, facilitates a discussion of clinical trials enrollment opportunities, considers fertility preservation, where appropriate, and triggers the coordination of multi-disciplinary care;
- Fosters innovation in strategies for patient management of care and in patient-physician communication;
- Initiates care according to practice guidelines and without significant delay;
- Regularly assesses patient symptoms, including pain, performance status, diarrhea, nausea and vomiting, depression, distress, and neuropathy;
- Includes procedures and processes for response to patient questions and problems after regular office hours as well as response to email questions, especially during periods when chemotherapy is being administered;
- Provides adequate payment to permit the development of a multi-disciplinary cancer care team;
- Integrates all services and resources, including community-based services, necessary for post-treatment monitoring and care;
- Eliminates financial incentives that might favor one treatment choice or modality over another;
- Abandons a payment structure that rewards the volume of services provided;
- Eliminates cost-sharing structures that influence treatment choices in a significant way, causing patients to forgo treatments that are recommended and/or that are consistent with guidelines; and
- Measures the performance of the health delivery system by use of the best available quality measures and assesses patient and family satisfaction with the health system.

Specialty Payment Models that Will Advance Quality Cancer Care

Although each of the payment models reviewed by Brookings Institution may have advantages, we are not persuaded that all of them will encourage or require clinical practice improvements critical to delivery of the quality care we describe above. For example, we understand that adherence to clinical pathways will encourage delivery of care according to clinical practice guidelines, an important goal for a cancer care system. However, adherence to clinical pathways will not transform the care delivery system.

Neither will payments for episodes of care foster care improvement if the episodes are defined primarily by a period of time for delivery of care and not by specific elements of care.

We are aware of the elements of a successful patient-centered medical home, as defined by the National Committee for Quality Assurance (NCQA). We have also monitored efforts to experiment with a patient-centered oncology medical home, and we see the promise of this model to standardize processes so that care is planned with patient input, patients are evaluated routinely, and care is provided according to the best evidence.

The standardization of the processes of cancer care – as fostered by the patient-centered oncology medical home – will in turn permit the episode of medical oncology services or bundle of medical oncology services to be defined. Experts have identified a number of challenges to designing bundles and episodes of care, including the identification of the health care provider who will manage the episode/bundle and the services and goods that will be included in the bundle. These definitional and procedural challenges can be addressed in significant part by reference to the processes of patient-centered medical homes.

The design and implementation of the patient-centered oncology medical home triggers the reform of the processes of care, and this new system of care could be financed by a bundle or episode of care payment system that would reflect in large part the elements of care in the medical home.

Measurement of Cancer Care Quality in New Payment Models

The transition from a fee-for-service reimbursement system that rewards the volume of services provided to payment models that reimburse for an episode or bundle of care represents a significant change for both medical oncologists and patients. It is important that such a system be carefully evaluated and its implementation consistently monitored. Although some are concerned that current cancer care quality measures are inadequate and the qualification process for new measures is too long, a core set of measures could be immediately used to evaluate the quality of care in a reformed system, even as additional quality measures are developed.

We recommend that these measures be utilized at the outset of implementation of a new delivery/payment system:

- A measure of delivery of chemotherapy according to National Comprehensive Cancer Network or other appropriate guideline, to ensure proper utilization and to protect against under-treatment as the payment system moves away from volume-based reimbursement and rewards;
- A measure to ensure that there has been a care planning discussion between patient and medical oncology team that reviews the intent of treatment and treatment choices;
- A measure of care team efforts to assess patient symptoms -- performance status, pain, diarrhea, nausea and vomiting, neuropathy, distress, depression -- at each visit and to utilize a patient-reported outcomes tool;
- A measure of adherence to clinical practice standards in delivery of all elements of care (in addition to chemotherapy), including but not limited to advanced imaging;
- Documentation that palliative care is delivered according to patient preference; and
- Documentation that advanced illness needs have been discussed.

We also urge that new systems for oncology care reimbursement incorporate protections to ensure that patients do not experience barriers to innovations in treatment, including new prescription drugs and other services and products. Adherence to practice guidelines may be sufficient to offer these protections, but we urge special attention to access to new therapies that represent treatment advances.

Reform of the Cost-Sharing Responsibilities for Cancer Patients

The cost of cancer care has been identified as a common cause of medical bankruptcy. Even those who are not pushed to bankruptcy by the cost of their care may find that their cost-sharing responsibilities influence their decisions about treatment. Patients may choose chemotherapy drugs according to their route of administration, if one has a different – and more manageable – cost-sharing amount. Patients may also choose not to finish a course of cancer treatment because the “financial toxicities” of the treatment are simply too great. These choices may mean that patients reject the treatment that is best for them, based on the evidence, and choose instead a more affordable treatment.

The overhaul of the payment system presents an opportunity to reconsider the cost-sharing responsibilities for those whose care is reimbursed by a bundled payment or an episode-based payment. Care should be taken to ensure that cost-sharing is reasonable and that it does not unreasonably influence treatment choices. The overhaul of cancer care reimbursement presents an important opening for bringing a more rational approach to patient cost-sharing, and we urge careful attention to this matter.

Special care must also be directed to the rules for participation in cancer clinical trials. If a patient who is cared for through a patient-centered oncology medical home and whose care is reimbursed through an episode of care payment enrolls in a cancer clinical trial, there must be clear standards or rules for the cost-sharing that patient will shoulder for the trial. In the

Medicare Advantage system, which bears some similarities to the situation described above, beneficiary enrollment in a clinical trial triggers fee-for-service reimbursement and cost-sharing responsibilities. This practice serves to discourage Medicare Advantage enrollees from participating in clinical trials. Steps must be taken to avoid the same result in a patient-centered oncology medical home/episode or bundled payment system.

We appreciate the opportunity to offer these comments on the work of CMS and CMMI and Mitre and the Brookings Institution on payment reform.

Sincerely,

Cancer Leadership Council

CancerCare

Cancer Support Community

Free to Breathe

Hematology/Oncology Pharmacy Association

International Myeloma Foundation

Kidney Cancer Association

The Leukemia & Lymphoma Society

LIVESTRONG Foundation

Lymphoma Research Foundation

Ovarian Cancer National Alliance

National Coalition for Cancer Survivorship

Prevent Cancer Foundation

Susan G. Komen

Us TOO International Prostate Cancer Education and Support Network