



NATIONAL COALITION
FOR CANCER SURVIVORSHIP

The power of survivorship. The promise of quality care.

April 10, 2014

Patrick Conway, M.D.
Deputy Administrator for Innovation and Quality
Chief Medical Officer
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

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

Dear Dr. Conway:

The National Coalition for Cancer Survivorship (NCCS) appreciates the opportunity to comment on the Request for Information on Specialty Practitioner Payment Model Opportunities and the work of Mitre Corporation and Brookings Institution related to oncology payment models. Our comments will focus primarily on the work of Mitre/Brookings in evaluating oncology payment models. We will also refer to the questions regarding the design and implementation of episode-based payment models that were included in the Request for Information, which we found useful in considering the transition process from fee-for-service reimbursement to payment according to episodes, bundles, or other systems that move away from a volume-based methodology.

NCCS represents survivors of all types of cancer in public policy efforts to improve cancer treatments and enhance access to quality cancer care. The goal of NCCS public policy activities is to foster a cancer care system that is evidence-based, quality-driven, patient-focused and affordable and accessible to all. NCCS convenes cancer and health policy interests on a regular basis to deliberate and develop common policy positions and undertake collaborative activities focused on cancer care quality improvement.

We commend the Centers for Medicare & Medicaid Services for its commitment to reforming medical oncology payments and its investment in a design contract to assist the agency in exploring models for oncology reform.

Principles to Guide Medical Oncology Payment Reform

The manner in which Medicare currently reimburses for cancer care is unsatisfactory to all, as it fails to pay adequately for physician services necessary for quality care, forces cancer care providers to rely on drug payments to support cognitive services, and rewards the volume of services instead of the quality of care. We are pleased that there is broad-based agreement to reform the current system.

Public payers, patients, and cancer care professionals must build on the consensus for change in cancer care reimbursement to do more than rationalize medical oncology payments. Simply recalibrating fee-for-service payments into a bundle or episode of care payment without creating incentives for quality improvement is not adequate and does not guarantee patients a system that is centered on their cancer care needs. Payment reform must create incentives for medical oncologists to undertake practice improvement activities and to standardize processes for evaluating patients, planning and coordinating their care, and delivering care according to high quality clinical practice guidelines.

The Institute of Medicine (IOM), in its recommendations for improving a cancer care system “in crisis,” proposed capitalizing on ongoing efforts to reform payment and eliminate waste. Such efforts are necessary for cancer care patients today and to preserve the Medicare system for future generations. Simply rearranging cancer care payments is not bold enough to meet the pressing needs of cancer patients.

Blending Elements of the Patient-Centered Oncology Medical Home and Bundled Payments/Episodes of Care

In its environmental scan for oncology payment models, The Brookings Institution has identified the advantages and disadvantages of clinical pathways, patient-centered oncology medical homes, bundled payments, and oncology accountable care organizations. The best possible payment reform package might combine elements of all four, but we recommend as a first step the blending of features of the patient-centered oncology medical home and bundled payments. We believe the patient-centered oncology home triggers the standardization of processes of care, and bundled payments may represent a rational means of paying for this new model of care.

The standardization of the processes of cancer care fostered by the patient-centered oncology medical home (PCOMH) is central to cancer care quality enhancement.¹ For many years, NCCS has advocated the establishment of a Medicare fee-for-service code that would reimburse for a cancer care planning service including a discussion between patient and cancer care professional regarding the intent of treatment, treatment choices, and symptom management strategies. We have envisioned this service as a means of fostering patient-centered care and as an initial but important step toward coordination of care and bundling of payments for coordinated care or defining an episode of care that might be reimbursed.

The patient-centered oncology medical home embraces care planning and also standardizes processes of care necessary to implement and honor a care plan developed through a shared decision-making process. The Brookings Institution environmental scan describes the oncology-specific goals for patient-centered medical homes (beyond the goals for patient-centered medical homes defined by the National Committee for Quality Assurance, or NCQA). These goals relate to efforts to achieve a focus on the patient in the system of care. For example, the goals include promotion of an interdisciplinary approach to management of the system, constant collaboration between the clinical support and treatment teams, an emphasis on patient education, engagement and compliance, and practical efforts to improve communication such as extended hours, telephone triage, and physicians on call.

¹ NCCS is a collaborator on a project of the National Committee on Quality Assurance to evaluate the impact of patient-centered oncology care. The research was funded by Patient-Centered Outcomes Research Institute (“PCORI”) and includes American Society of Clinical Oncology, Independence Blue Cross, Oncology Management Services and the RAND Corporation, as well as a broader multi-stakeholder advisory group.

The goals of the patient-centered oncology medical home are consistent with the attributes of a quality cancer care system typically identified by patients and patient advocates and begin with a discussion about treatment intent and treatment choices.

We believe that the PCOMH, after it has standardized processes of care, can define an episode of cancer care or a cancer care bundle. The PCOMH can accept the responsibility for reforming the processes of care, and payment for an episode of care or care bundle can effectively support the comprehensive and multi-disciplinary care provided by a PCOMH. We realize that there are initial costs associated with establishing a PCOMH which might not be captured in payment for an episode of care or care bundle. If new systems of delivery and payment – including the patient-centered oncology medical home and bundled payments we propose – are tested in demonstration or pilot programs, those tests should evaluate means of financing the initial medical home costs. That might be achieved through initial direct funding to practices through the demonstration or a modest payment modifier in the first year of the demonstration or pilot.

Not all medical oncologists will embrace organizing or joining a PCOMH. We assume that the payment reform effort will encourage but not require participation in new payment systems. On the other hand, we hope that new payment models will provide incentives to medical oncologists to embrace reform to foster patient-centered care.

Quality Measures

Many have raised concerns about the adequacy of current cancer care quality measures to assess performance in a reformed payment system. Others have suggested that payment reform must be slowed until the process for qualification of measures is simplified to be more responsive to a dynamic payment system.

We recommend instead that a limited set of measures – including but not limited to process measures at the outset – would be appropriate for quality assessment in a patient-centered oncology medical home/bundled payment system. We focus on measures that will be meaningful to patients and their families.

These measures include:

- Documentation that there has been a care planning discussion between patient and medical oncology team that assesses treatment intent and outlines coordination of active treatment and symptom management before chemotherapy is initiated;
- Delivery of chemotherapy according to the best available evidence;
- Assessment of patient symptoms, including pain, performance status, diarrhea, nausea and vomiting, neuropathy, and depression, at each visit and according to a patient-reported outcomes tool;
- Documentation that palliative care is initiated according to patient preference;
- Documentation that advanced illness needs are discussed, if appropriate;
- Reliance of the best available evidence in the delivery of all elements of care – in addition to chemotherapy and including but not limited to advanced imaging.

Accountability for Prescription Drugs in Bundles or Episodes of Care

The need for practices to utilize income from oncology drugs to support cognitive services to patients might be eliminated by the adoption of a delivery and payment model that combines features of a patient-centered oncology medical home and bundles or episodes of care. We assume that a delivery and payment reform of this sort would be accompanied by changes in payment and distribution of physician-administered chemotherapy drugs, including through some sort of pass-through mechanism that would also be adequate for expenses associated with distribution and handling of the drugs but that would not include a margin above that amount.

We recommend immediate additional study of this issue to determine the most effective method for reimbursement and distribution of chemotherapy drugs. We note below that there may be patient cost-sharing implications depending on the drug reimbursement methodology adopted. We are not certain about the immediate incorporation of these drugs in bundles or episodes of care, but a decision about this issue is necessary to ensure patients access to appropriate therapies and also to guarantee reasonable cost-sharing.

Patient Cost-Sharing Responsibilities in a Reformed Payment System

Patients and their families increasingly report that they face serious financial burdens as a result of their cancer diagnosis. One devastating result for families is medical bankruptcy, but even those who are not pushed to that extreme will nonetheless experience serious ramifications of their cost-sharing burdens. Increasingly, patients and families indicate that they make treatment decisions based at least in part on the financial burden associated with those choices. For example, a patient may choose a chemotherapy regimen that has the lesser cost-sharing responsibility. This may mean choosing a physician-administered drug instead of a self-administered one, or it may mean a specific choice among drugs with the same route of administration. In addition, patients may not adhere to a chemotherapy regimen because of the cost-sharing burden associated with the drug. Moreover, the effects of cost-sharing are not limited to chemotherapy choice or adherence but are seen in all cancer treatment decisions.


In designing a reformed cancer delivery and payment system, there should be adequate and appropriate focus to guarantee that care is delivered according to practice guidelines and the best available evidence. Patients may effectively choose a treatment that is less appropriate because of their concerns about cost of care.

We strongly recommend that serious attention be directed to patient cost-sharing as part of the effort to reform payment for cancer care. The responsibility of patients related to cost-sharing should not unreasonably affect their decisions about care and should not cause them to choose options that might be less effective, that might have more significant side effects, or may be significantly less convenient simply because they are less expensive for the patient. The impact on the patient should guide decisions about benefit and cost-sharing design, but it is important to note that decisions that buffer patients from significant cost-sharing in the short term may be more expensive for the cancer care system in the long term.

In addition, we recommend that there be transparency in communication with patients and their families about new payment systems. If cost-sharing is different in a PCOMH and bundled payment system, that information should of course be communicated. In addition, the fact the patient will be enrolled in a system of care that differs from a fee-for-service system should be clearly communicated.

We applaud the approach of CMS and CMMI to the reform of oncology care payment. We have requested a meeting with the agency to begin an ongoing dialogue that we hope may bring us closer to a more patient-centered system of care.

Sincerely,

A handwritten signature in black ink, appearing to read "Shelley Fuld Nasso". The signature is fluid and cursive, with the first letters of each name being capitalized and prominent.

Shelley Fuld Nasso
Chief Executive Officer