



September 12, 2014

Patrick Conway, MD, MSc
Deputy Administrator for Innovation and Quality
Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Dr. Conway:

The National Coalition for Cancer Survivorship (NCCS) represents survivors of all forms of cancer in public policy efforts to improve the quality of cancer care. In its nearly 30-year history, NCCS has supported efforts to educate and empower patients to make informed care decisions, developed materials that guide patients through the cancer care system, and engaged in a wide range of policy efforts to improve cancer care delivery and payment.

We are writing to commend the efforts of the Center for Medicare & Medicaid Innovation (Innovation Center) to develop and define the Oncology Care Model, an episode-based payment model that emphasizes care planning and coordination and cancer care system transformation. We recommend some refinements in the plan, identify issues to be addressed, and propose that the per-beneficiary-per-month (PBPM) payment for enhanced services in the Oncology Care Model be set at a fairly aggressive level.

The Oncology Care Model (OCM) represents an important step forward in guaranteeing patient-centered cancer care. We are pleased that the model identifies five specific activities that practices must undertake in order to participate in OCM. We agree with the assessment of the Innovation Center that these activities will drive the cancer care transformation process to improve overall quality of care.

NCCS especially commends the decision to require that the cancer care plan in the OCM contain the 13 components that were identified by the Institute of Medicine as care management plan elements in its report, "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis." Over the course of long involvement in efforts to encourage cancer care planning, NCCS has determined that the cancer care plan must be comprehensive in order to foster shared decision-making, appropriate symptom management, and care coordination. We also maintain that the development of strong and specific cancer care plans will trigger practice transformation and encourage appropriate utilization of health care resources.

The Per-Beneficiary-Per-Month (PBPM) Payment

We recommend that the Center for Medicare & Medicaid Services (CMS) establish a per-beneficiary-per-month (PBPM) payment amount that will provide adequate financial support for the practice transformation that the OCM seeks to accomplish. To achieve the comprehensive cancer care planning outlined by IOM and adopted by the Innovation Center, oncology practices will be required to fundamentally reconsider and redesign their procedures and systems. In addition to the care planning requirement, practices must employ patient navigators, provide patients 24/7 access to an appropriate clinician, utilize data for continuous quality

improvement, and use electronic health records and meet certain meaningful use requirements. Undertaking these efforts for practice transformation will be resource-intensive.

Establishing the per-beneficiary-per-month payment amount presents serious challenges. We believe the PBPM amount should be pegged at a rate that is adequate to support the transformation of practice through adherence to the standards of the care model and at a level that will serve to encourage provider participation in the OCM. However, there may also be advantages to structuring the PBPM as an incentive system, with payments set at a higher rate in the second and later years of the project. Providers would be eligible for higher payments if they have achieved the transformation of practice that is outlined in the OCM.

The payment of a higher PBPM based on performance would, of course, require measurement of practice transformation. The measures that are identified in the description of the OCM would serve in large part to measure this process, but it may be necessary to supplement the measures of practice transformation and delivery of patient-centered care.

We anticipate that there will be no patient cost-sharing for the PBPM, but that beneficiary protection is not specifically discussed in the OCM description. We urge clarity on that issue.

Limit on Six-Month Episodes

The OCM as outlined by the Innovation Center would be structured around a six-month episode, with the possibility of a second six-month episode. We believe that this structure will be appropriate and adequate for most cancer patients. However, for certain patients the two, six-month episodes may not be adequate. These patients might include those whose cancer is treated as a chronic disease and other patients who are in active treatment over a period of many months, treated by a series of different treatment regimens over that time.

We recommend that, for patients who are treated with chemotherapy beyond the second six-month episode, the PBPM payment be available for additional episodes. These patients will benefit from care planning, patient navigation, clinician access and other attributes required of practices in the OCM.

We understand that the data from six-month episodes after the first two episodes may not be robust enough to support performance-based payments to participating oncologists. Even if such payments cannot be determined and made available to participating physicians, we urge that the PBPM payments be available for episodes beyond the second six-month episode.

In separate comments to the CMS on the physician fee schedule, NCCS and its colleagues in the patient advocacy community urged fee-for-service reforms to ensure that there is appropriate payment for the monitoring, care coordination, and treatment of cancer survivors after active treatment. Cancer survivors face significant challenges as they transition from active treatment to long-term survivorship monitoring and care, and we urge the Innovation Center in the future to consider payment options that will foster smooth transitions from episodes of care to survivorship care.

Extending the OCM to All Cancers

We support the decision to extend the OCM to all cancers. We appreciate that the data on certain rare cancers may not be adequate to support performance-based payments. However, we urge that rare cancers be included in the OCM so that patients with those cancers may benefit from the improved cancer care delivery supported by PBPM payments.

Quality Measurement

Patient advocates are typically concerned about revisions or changes in payment methods that they fear will create incentives to reduce the volume of cancer care provided to the individual patient. A fundamental concern is that any such pressure or incentive could influence the overall quality of care. NCCS is pleased that the OCM will require physicians to reform their practices, meet performance-based payment measures, and also meet certain quality monitoring measures. We are hopeful that these quality requirements will ensure that changes in utilization of services in the OCM do not result in a decline in quality of care.

NCCS also believes that planning and coordination of care, proper symptom management, and early incorporation of palliative care will encourage the appropriate utilization of cancer care resources while also protecting the quality of cancer care and ensuring patient satisfaction with care. These conclusions are supported by research, the experience in patient-centered oncology medical homes, and the practice of oncologists who have been engaged in practice transformation in advance of the OCM.¹ NCCS is pleased that the OCM emphasizes these attributes of practice, which encourage high quality of care and the proper utilization of cancer care resources.

Chemotherapy Payments

We understand that the OCM focuses on practice change and improvement while retaining the fee-for-service payment system. In this structure, the current system of payment for physician-administered chemotherapy drugs will not be modified. As the OCM moves forward and is evaluated, presumably to support additional payment and delivery reforms, we trust that the drug reimbursement system will be addressed. We understand that there are efficiencies to the current system in terms of the prompt and efficient delivery of chemotherapy to practices for administration to their patients. However, there are also incentives in the system that may not be in the best interests of patients and physicians. We support efforts to assess and modify this system.

Conclusion

For a number of years, NCCS has advocated through legislative and regulatory efforts the establishment of a distinct cancer care planning and coordination service. We anticipated a cancer care planning and coordination service that would be reimbursed in addition to other services, including chemotherapy administration and certain evaluation and management services, provided to cancer patients. In our efforts, we have defined the care planning and coordination service with specificity to ensure that patients are provided the necessary coordination. In these efforts, we have considered the cancer care planning service as the beginning of a transformation of the systems of care.

¹ Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010; 363: 733-742.



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More recently, we have been involved in initiatives of the Patient-Centered Outcomes Research Institute to foster the development and replication of patient-centered oncology medical homes. We support this patient-centered medical home because of its potential to accomplish practice transformation.

NCCS sees the OCM making progress toward many of the goals we have pursued in our work related to cancer care planning initiatives and patient-centered care. We applaud the work of the Innovation Center in the development of the program and look forward to its implementation on a voluntary basis. We will encourage physicians and payers to participate in the OCM and to continue the pursuit of patient-centered care.

Sincerely,

A handwritten signature in black ink, appearing to read "Shelley Fuld Nasso", is written in a cursive style.

Shelley Fuld Nasso
Chief Executive Officer