

CANCER LEADERSHIP COUNCIL

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

September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-1631-P, Medicare Program; Revisions to Payment Policies Under the
Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Mr. Slavitt:

The undersigned organizations of the Cancer Leadership Council, which represent cancer patients, health professionals, and researchers, appreciate the opportunity to offer comments on revisions to the physician fee schedule.

The Centers for Medicare & Medicaid Services (CMS) recently proposed a demonstration project that will test a new oncology care payment system combining fee-for-service and episode of care payments and requiring participating practices to meet certain standards of patient-centered care. We commend the agency for its approach to the design of that demonstration project, including open communication with cancer community stakeholders about features of the demonstration project and its implementation, and we look forward to the launch and ongoing evaluation of the payment pilot.

We appreciate the request, in the preamble to the proposed rule on the calendar year 2016 physician fee schedule update, for stakeholder perspectives regarding payment for collaborative care. Cancer care planning and coordination, key elements of a quality cancer care system, are in effect the collaborative care model for cancer patients. Our advice below focuses on the payment structures and strategies that will make cancer care planning and coordination a reality for Medicare beneficiaries with cancer and also responds to questions from CMS about how collaborative care might be provided and reimbursed.

Improving Payment Accuracy for Primary Care and Care Management Services

We have in recent years proposed that a Medicare cancer care planning and coordination service, accompanied by appropriate payment, be established. Such a service would include these elements:

- Development of a cancer treatment plan that would include information about diagnosis, prognosis, treatment aims, treatment options, and management of symptoms of cancer and treatment side effects. The plan should also focus on the financial impact of cancer treatment and a strategy for patients to manage the cost of care.
- A face-to-face visit including the patient, family, caregivers, and cancer care provider, during which the treatment plan would be discussed and shared decision-making completed.
- Coordination of all elements of care, including active treatment, symptom management, and psychosocial services.

The cancer care planning and coordination service would include non-face-to-face services – the development of the treatment plan and the coordination of care among all oncologists and primary care providers – and a face-to-face service that would focus on communication of the plan and treatment decisions. The cancer care planning and coordination service that we endorse has been defined by the Institute of Medicine and was incorporated as the care planning standard in the Oncology Care Model.¹

The planning and coordination process that we are recommending goes beyond a presentation of treatment options and initiation of cancer care. Because cancer care planning would require development of a written plan and coordination of all care for the cancer patient, it will require a significant amount of professional work that must be reimbursed. We anticipate that this would be an add-on service and would be reimbursed separately from evaluation and management services.

The potential benefits for Medicare beneficiaries, cancer care providers, and the Medicare program are significant. Patient engagement and satisfaction with care, quality of life, and quality of care are likely to improve in a system that incorporates cancer care planning. There are also indications that provider satisfaction with practice will improve. Finally, reports from practices that have undertaken cancer care planning efforts suggest a more rational utilization of cancer care resources when care is planned.

We suggest that the cancer care planning and coordination service should be initiated at the time of diagnosis and treatment decision-making, when there is a significant change in prognosis or treatment options, and at the end of active treatment and transition to survivorship. The end-of-treatment plan should include a summary of treatment and a monitoring/follow-up care plan.

¹ Institute of Medicine, *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*, 2013.

We are concerned about the billing requirements that might accompany the cancer care planning services we have described above. CMS notes that it has received feedback from providers regarding the administrative and service burdens associated with the transitional care management and chronic care management codes. To avoid that experience, we recommend that the development of a written plan that meets the standards outlined by IOM and certification that a face-to-face decision-making process has occurred would be adequate for payment for the cancer care planning and coordination service.

CMS asks if collaborative care models should be tested as Center for Medicare & Medicaid Innovation (CMMI) models, with a waiver of beneficiary financial liability. In light of the soon-to-be launched Oncology Care Model, we caution against another CMMI test of oncology payment. Instead, we trust that the lessons learned from chronic care management code and transitional care management code implementation and a clear definition of cancer care planning will permit efficient implementation of cancer care planning as a collaborative care service. We look forward to continued communication with CMS regarding the establishment of a cancer care planning service, an action that would complement the Oncology Care Model test.

Advance Care Planning

In the physician fee schedule proposal, CMS seeks comment on whether there should be Medicare payment for the advance care planning codes created by the CPT Editorial Panel. To date, these codes have not been reimbursed by Medicare. We support Medicare payment for the two advance care planning codes, and we suggest that the service should be reimbursed at any time that the beneficiary would like to have the advance care planning conversation.

Most Medicare beneficiaries have NOT developed an advance care plan in collaboration with their medical provider. We hope that the availability of payment for this service will encourage the planning conversation and the development of the advance care plan.

Merit-Based Incentive Program Under MACRA

The Medicare Access and CHIP Reauthorization Act (MACRA) requires the establishment of a Merit-Based Incentive Payment System (MIPS) by 2019. Clinical practice improvement activities are one of the performance categories that will be utilized to assess the performance of health care professionals. We are pleased to offer advice regarding a specific clinical practice improvement activity that would fit into the performance assessment subcategories that CMS has identified. These subcategories include expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participate in alternative payment models.

We suggest cancer care planning and coordination as a specific practice activity that would advance the goals of better care coordination and beneficiary engagement and might also accomplish expanded practice access. We recommend that performance of cancer care planning and coordination be assessed according to the definitions we have offered above and that completion of such a planning effort would serve as one measure of a professional's MIPS performance.

We look forward to continued dialogue with CMS regarding MACRA implementation and the assessment of patient-centered care delivery.

Revision of Medicare Physician Fee Schedule Payments and Patient Access

We support the efforts of CMS to refine Medicare payments so that they are supported by the best available data and ensure the efficient use of Medicare resources. However, we are concerned that abrupt modification of Medicare payments and payment methodologies may result in disruptions among Medicare providers and may thus have an impact on patient access to care.

These concerns have come to our attention in connection with the changes in radiation oncology that are proposed for 2016, as well as the proposed changes in payment for colonoscopy services for 2016. When making changes to these payments, CMS should seek to protect patient access to quality cancer care and cancer prevention services. We have seen in the past that significant changes in payment and shifts in the site of cancer care can have an adverse impact on availability of services access as well as patient adherence to recommended therapy. We urge CMS, when making final decisions about proposed payment changes, to consider potential disruptions to the system and to patients.

We appreciate the opportunity to comment on efforts to improve cancer care and to assess performance of important cancer care quality improvement efforts.

Sincerely,

Cancer Leadership Council

American Society for Radiation Oncology
CancerCare
Cancer Support Community
Fight Colorectal Cancer
International Myeloma Foundation
Kidney Cancer Association
The Leukemia & Lymphoma Society
LIVESTRONG Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
National Patient Advocate Foundation
Ovarian Cancer National Alliance
Prevent Cancer Foundation
Susan G. Komen