NATIONAL COALITION FOR CANCER SURVIVORSHIP

The power of survivorship. The promise of quality care.

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 National Coalition for Cancer Survivorship (NCCS) is a national organization that represents survivors of all forms of cancer in public policy efforts aimed at improving access to quality cancer care. We appreciate the opportunity to comment on proposed revisions to the Medicare physician fee schedule for calendar year 2016.

NCCS commends the efforts of the Centers for Medicare & Medicaid Services (CMS) to enhance comprehensive care management for certain Medicare beneficiaries. Through improvements in fee-for-service payments and various demonstration initiatives, CMS has made important strides in enhancing quality of care for many Medicare patients. NCCS strongly supports the Oncology Care Model, a demonstration project to be launched in 2016, because it will improve the care experience of cancer patients and will also foster the transformation of participating practices into patient-centered medical homes. We have also lent our support to establishment of the transitional care management (TCM) and chronic care management (CCM) codes as these new payment reforms encourage care management.

Additional improvements to fee-for-service payment could enhance the quality of cancer treatment decision-making and overall quality of care. We appreciate the efforts of CMS to solicit input from stakeholders regarding approaches for improving payment for the professional work of care-management services.

Improving Care Coordination

NCCS and colleagues in the cancer community have for almost a decade pursued legislation that would establish a separate Medicare service for cancer-care planning and coordination. Our goals in this effort were to define the elements of a cancer-care planning and coordination services and to provide adequate payment for the professional work that we believed would be necessary for providing these patient-centered services. This effort is currently reflected in the Planning Actively for Cancer Treatment Act (HR 2846). We are pleased that CMS has included cancer-care planning as a core element of the Oncology Care Model. Including this service in the demonstration project essentially focuses on this service as a clinical practice improvement effort for those professionals who participate in the pilot payment and delivery program.

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The cancer-care planning and coordination service we have endorsed represents an effort to provide care management in a Medicare payment system that remains oriented toward episodic treatment, a description of Medicare offered by CMS in the preamble to the proposed rule. Cancer-care planning and coordination fit well into the general CMS concept of an "add-on" service that would be performed and reimbursed in addition to face-to-face evaluation and management (E/M) codes. The cancer-care planning and coordination service would include both face-to-face and non-face-to-face elements, and the professional work required would be significant.

A cancer-care planning and coordination service, as defined by the Institute of Medicine[1] and embraced by patient advocates as a pivotal element of quality care, would include the elements below:

- Development by the physician of a plan that includes diagnosis, prognosis, the aims of treatment, treatment options, and strategies for the coordination of all aspects of active treatment and management of side effects of treatment. This professional work would be non-face-to-face work.

- Communication to the patient, family, and caregivers of the treatment plan and completion of a shared decision-making process. We anticipate that this work, which will of course be face-to-face, will be in addition to an evaluation and management visit. A shared decision-making process for a cancer patient should include a consideration of treatment aims and treatment options and is not a process that can or should be rushed.

- Coordination of all elements of care, including active treatment and symptom management, would be a non-face-to-face service. Cancer care is often multi-disciplinary care, and symptom management requires engagement of additional health professionals; coordination of all of the health providers on a cancer team is a substantial undertaking for the physician coordinator.

We anticipate that the cancer-care planning and coordination service might occur more than once during a cancer patient's treatment, but we do not anticipate that it would occur monthly. It is our expectation that a plan would be developed and communicated and that coordination would be undertaken at the beginning of treatment, would be revised and communicated if there is a major change in disease progression and/or treatment approach, and would also be developed and communicated at the end of active treatment and passage to long-term survivorship. The final plan would include a summary of the patient's treatment to date and a plan for survivorship monitoring and follow-up care.

It is our expectation that a single Medicare provider would be reimbursed for cancer-care planning and coordination for a Medicare beneficiary. However, there are situations when this standard may not be appropriate. For example, in the case of referral of a patient for treatment, a second physician may assume care planning and coordination responsibilities. In the situation where a patient is pursuing multiple opinions about diagnosis and treatment options, there may arise questions about when the care planning and coordination services begin and who will be reimbursed for them.

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

We have defined a care planning and coordination process that is specific to Medicare beneficiaries with cancer. It is possible that the level and intensity of services that we recommend would be appropriate for Medicare beneficiaries with other serious and life-threatening conditions or with multiple complex chronic conditions. We have simply focused on the system of care that we know.

There are strong early indications of the benefits of cancer-care planning to the individual patient, cancer-care providers, and the Medicare program. Patients report greater satisfaction with their care if they participate in shared decision-making, and cancer-care professionals who provide planning and coordination services also report greater professional satisfaction. Practices that undertake cancer-care planning have reported a more rational use of cancer resources, including avoidance of repeat tests and less inappropriate chemotherapy at the end of life. A small study of lung cancer patients found that the early incorporation of palliative care with curative treatment resulted in better outcomes, greater patient satisfaction with care, and less costly care.[2] Although the study did not focus on cancer-care planning, we anticipate that care planning will encourage appropriate symptom management and palliative care for cancer patients.

Cancer care is complex for those who have early stage curable disease as well as those with more advanced disease; regardless of diagnosis, patients face the challenges associated with multi-disciplinary treatment and symptom management and the financial, family, professional, and other challenges associated with cancer and its treatment. For all these patients, care planning and coordination will provide significant advantages. Treatment planning and shared decision-making will be of critical importance for those who may consider targeted therapies. For those patients, accurate diagnosis and proper targeting of therapy and planning for treatment, financial, and other toxicities will be vitally important. The care management changes that we have recommended – in combination with the Oncology Care Model – will ensure that Medicare responds to the needs of cancer patients who are dealing with a complex disease and treatment options and a complex health care delivery system.

Advance Care Planning

We are pleased that CMS is seeking comment on whether payment for advance care planning is necessary. We strongly encourage CMS to provide reimbursement for the advance care planning codes (CPT code 99497 and add-on CPT code 99498) that have been created by the CPT Editorial Panel but that have not been valid for Medicare purposes to date.

It is important that payment be made for the conversation between the patient and health care provider about the patient's treatment preferences and for preparation of an advance care plan. This planning process, which we think should be available at any time at the preference of the Medicare beneficiary, holds the promise of ensuring that Americans receive care according to their wishes.

For cancer patients, the advance care planning process will be complementary to treatment planning that will occur at the time of diagnosis and throughout the disease trajectory.

[2] Temel JS, Greer JA, Muzikansky A, et al. Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer. New Engl J Med. 2010.

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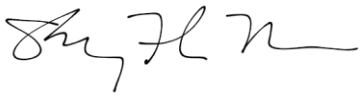
NCCS appreciates the work of CMS to reform and refine cancer-care delivery and payment, in the Oncology Care Model and through changes to the fee-for-service payment system. We are pleased to have the opportunity to offer advice about these efforts.

Sincerely,



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