

November 17, 2015

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

RE: CMS-3321-NC, Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Mr. Slavitt:

The National Coalition for Cancer Survivorship (NCCS) represents survivors of all types of cancer in public policy efforts to improve the quality of cancer care. We appreciate the opportunity to comment on the Request for Information regarding the Merit-Based Incentive Payment System and Alternative Payment Models.

NCCS is a partner with cancer care providers, payers, the National Committee for Quality Assurance (NCQA), and the Patient-Centered Outcomes Research Institute (PCORI) in efforts to encourage the development, assessment, and replication of patient-centered oncology medical homes. Our experience in connection with those efforts informs our comments below.

We look forward to continued conversations with the Centers for Medicare & Medicaid Services (CMS) as the payment reform plan outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is implemented.

Alternative Payment Models for Cancer Care

We believe there is great promise in the patient-centered oncology medical home (PCOMH) as an alternative payment model for cancer care. The PCOMH models developed to date have fostered the transformation of clinical practice so that care is truly patient-centered. This means that patients and their care teams identify the goals of treatment and initiate and pursue care consistent with such plans. Evaluation of these models should inform the development of additional alternative payment systems.

To date, the PCOMH models have focused on the delivery of active treatment to cancer patients. We recommend that a variation on the PCOMH be designed to provide care to survivors of cancer as they move from active treatment to survivorship. The needs of these patients are significant; they are individuals with complex, chronic health care needs. The Institute of Medicine has referred to patients moving from active

treatment to long-term survivorship as individuals “lost in transition.”¹ The 2006 report, “From Cancer Patient to Cancer Survivor: Lost in Transition,” also identified core components of survivorship care. These are:

- Prevention of recurrent and new cancers and the prevention of other late effects;
- Surveillance for cancer spread, recurrence, and second cancers, as well as the assessment of medical and psychosocial late effects;
- Intervention for the consequences of cancer and its treatment. These consequences might include lymphedema and sexual dysfunction, pain, fatigue, depression, psychological distress, and concerns related to employment, insurance, and disability; and
- Coordination between primary care providers and specialists to ensure that survivors’ health needs, as described above, are addressed.²

Just as PCOMH models have transformed active cancer treatment for certain populations of cancer patients, the PCOMH approach holds promise for transforming survivorship care. The planning and coordination of care that are key features of PCOMH models could yield comparable benefits in the improvement of survivorship care. The numbers underscore the need for new, efficient, and well-coordinated systems of care for survivors. There will be a 30% increase in the number of cancer survivors by 2022 and a 45% increase in cancer incidence by 2030. Approximately 53% of cancer diagnoses were in individuals 65 and older in 2012, and 59% of cancer survivors were 65 years or older in 2012.³ The burden of survivorship is significant for senior citizens and their families and for the Medicare program.

We appreciate the challenges of developing an alternative payment system that focuses on a specific patient population requiring primary and specialty care, especially in a system that is generally designed to foster physician-focused payment systems. However, the numbers of cancer survivors among Medicare beneficiaries and their complex chronic care needs argue for efforts to design a cancer survivorship model and to find flexible approaches for such a model in a physician-focused reform system.

Clinical Practice Improvement Activities Performance Category

We are pleased that MACRA focuses on clinical practice improvement activities as one of the categories that will be assessed in the Merit-Based Incentive Payment System (MIPS). We recommend that cancer treatment planning and coordination should be included as one of the subcategories of activity in the clinical practice improvement activity category of MIPS. NCCS has pursued a number of policy initiatives to achieve the incorporation of treatment planning in the care process for every cancer patient. Our initiatives include an ongoing effort to establish a new cancer care planning service in Medicare and an effort to establish a payment code for cancer care planning. We have also undertaken physician and patient education to foster cancer care planning discussions.

¹ Hewitt M, Greenfield S, and Stovall E. From Cancer Patient to Cancer Survivor: Lost in Transition, National Cancer Policy Board of Institute of Medicine, 2006.

² Hewitt M, et al. From Cancer Patient to Cancer Survivor. 2006.

³ Levitt LA, Balogh EP, Nass SJ, and Ganz PA. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. Institute of Medicine, 2013.

We urge that a subcategory of cancer treatment planning and coordination be included in MIPS and be defined as including these elements: 1) shared decision-making that considers treatment goals and outlines all elements of active treatment and symptom management in a written plan, 2) coordination of all elements of multi-disciplinary cancer care, and 3) appropriate management of the side effects of treatment and symptoms of cancer.

Research indicates that planning of care combined with early incorporation of palliative care helps to boost patient satisfaction with care, improve outcomes, and contribute to appropriate utilization of cancer care resources.⁴ It is our view that treatment planning and coordination can help us replicate these promising improvements in the overall cancer care system.

The “subcategory activity” of treatment planning and coordination can be reported by cancer care providers. We would describe this as a process measure that can be reported through a qualified registry or electronic health record. Treatment planning and coordination could also be reported by patients through a Consumer Assessment of Healthcare Providers and Systems (CAHPS) item set focusing on treatment planning and coordination. We understand the basic goal of moving toward outcome measures for assessing new payment and care delivery systems. However, if there is “process adherence” with the treatment planning and coordination service that meets the standards above, we believe it will lead to improved outcomes. In this circumstance, a process measure is appropriate and useful.

We are concerned about the benchmark for assessing performance on clinical practice improvement activities. As we indicated above, NCCS is collaborating with practices that have already made significant progress in practice transformation for patient-centered care. These practices should not be penalized because they have already made such progress. We urge CMS to develop a MIPS performance benchmark for clinical practice improvement activities that will take in account the variable progress of practices in clinical practice improvement and that will not penalize early reformers.

Resource Use Performance Category

The methodology for evaluating resource use is defined in MACRA, and the experience of CMS in the Value-Based Payment Modifier (VM) system will also inform this evaluation. We urge CMS to be aware of the rapid pace of therapeutic development in cancer and to ensure that resource utilization measures reflect this fact. In the Request for Information, CMS asks if the resource use measure should evaluate harmful or over-used services, including those identified in the Choosing Wisely initiative.

We do not object to consideration of the Choosing Wisely initiative, but we think the more prudent and forward-looking effort would consider molecular diagnosis and appropriate utilization of targeted medicines. The resource use measure should incorporate standards for molecular testing and targeting of treatments.

Cancer therapies are increasingly targeted according to the molecular profile of a patient’s cancer. Ensuring that the right medicine reaches the right patient at the right time will require appropriate molecular diagnosis and treatment targeting.

⁴ Temel JS, Greer JA, Muzikansky A, et al. Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer. *N Engl J Med.* August 19, 2010.



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We do not support overutilization, which might see patients receive a targeted therapy although they do not have the molecular profile for that drug. Neither do we want to see underutilization of targeted therapies, where those whose cancer is specifically targeted by a new therapy fail to receive it. A resource use measure that took molecular diagnosis into account might help to protect against both underutilization and overutilization of targeted treatments and encourage progress toward delivery of the right treatment to the right patient at the right time. We realize that not all cancer medications are targeted and that not all require the utilization of molecular diagnosis for proper treatment. However, the trend is toward more targeting of therapies. We support practice standards and reimbursement policies that encourage the appropriate diagnosis and delivery of cancer treatments.

We appreciate the opportunity to participate early in the process of physician payment reform by offering these preliminary comments. We look forward to ongoing dialogue with CMS on the transformation of physician payment systems.

Sincerely,

A handwritten signature in black ink, appearing to read "Shelley Fuld Nasso".

Shelley Fuld Nasso
Chief Executive Officer