

CANCER LEADERSHIP COUNCIL

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

January 29, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chair
Chronic Care Working Group
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
Co-Chair
Chronic Care Working Group
475 Russell Senate Office Building
Washington, DC 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document
Submitted electronically at chronic_care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The undersigned organizations representing cancer patients, health care professionals, pharmacists, and researchers appreciate the opportunity to comment on the Policy Options Document of the Bipartisan Chronic Care Working Group. We commend the commitment of the Working Group to the development of a responsible and aggressive range of options for improving care for those with chronic conditions.

Cancer as a Chronic Disease

One of the consequences of the progress in cancer research and development is the substantial transformation of some forms of cancer into chronic diseases. For many, a cancer diagnosis is a diagnosis of a chronic disease, a condition defined as lasting three months or longer. As the “war against cancer” began, individuals who were diagnosed with cancer were very often told to get their affairs in order. Today, even those with some forms of metastatic cancer may have many options for managing their cancer and living with cancer as a chronic disease.

In the discussion among cancer experts following the recent announcement of a “cancer moonshot,” the focus has been on fostering progress in the management of cancer so that cancer patients are able to live with cancer for years. Control of cancer is the ambitious but realistic goal of cancer research and development efforts.

In addition, Medicare beneficiaries with cancer may have other chronic conditions. In a report from July 2012, the National Center for Health Statistics notes the increase from 2000 to 2010 in prevalence of those with multiple chronic conditions, where one of the conditions is cancer.¹

Medicare beneficiaries diagnosed with cancer typically require multi-disciplinary care, appropriate symptom management, and the coordination of all elements of care. Cancer patients benefit from well-coordinated care across the continuum of care, from diagnosis through treatment and long-term survivorship.

As the Working Group moves forward in evaluation of options for chronic care management, we urge that you remember the burden of cancer as a chronic disease and the needs of cancer patients across the continuum of care.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

We are pleased that the working group is considering a new high-severity chronic care management code that clinicians could bill for coordination of care outside a face-to-face encounter. The successful management of multi-disciplinary cancer care often requires clinician services that are performed outside face-to-face encounters, and we support efforts to reimburse that time adequately.

We are aware of the risk that adding new codes or modifying existing codes in the fee-for-service system may increase Medicare expenditures without improving the quality of care for those with chronic diseases. Cancer interests, including patients and cancer care providers, have for some years been focused on strategies for improving the process of planning and coordinating cancer care. In these efforts, we have weighed carefully the risks and benefits of new codes, as well as the range of services that oncologists must undertake for successful management of cancer care.

We support a movement toward payment on the basis of episodes of care, because this sort of alternative payment model will encourage well-planned and coordinated care. However, until that transition is complete, it is important that the fee-for-service system be refined to foster care management. In general, we find that health providers are not adequately reimbursed for the scope of services necessary to manage cancer care. This management effort requires coordination of all elements of active treatment, symptom management, psychosocial services, and shared decision-making at key junctures in the cancer care continuum. Some elements of this management effort occur outside the context of face-to-face encounters.

¹ NCHS Data Brief. No. 100, July 2012. Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past 10 Years.

Although we understand the potential costs associated with new fee-for-service codes, in the case of cancer care management we believe that payment for management services outside face-to-face encounters will produce significant patient benefits.

The Working Group asked for feedback regarding the patient criteria for the potential new code for care management services. The coordination of complex and multi-disciplinary cancer care and the management of treatment side effects and the symptoms of cancer present significant enough challenges to suggest that any cancer patient should be eligible for the potential new care management services. If the Working Group is reluctant to adopt that standard, we recommend that a cancer patient with one other chronic condition be considered eligible for care management services.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

The Working Group has solicited feedback on a one-time payment to clinicians “to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer’s/Dementia.” The Policy Options Document states:

Diagnoses of serious of life-threatening illnesses, such as Alzheimer’s/Dementia, are devastating to Medicare beneficiaries and their families. Some of these illnesses do not have a predictable disease progress, do not have an arsenal of treatment options that can be immediately deployed, and symptoms may not manifest for years. These circumstances make it imperative that a discussion between the patient and their doctor occurs upon diagnosis.

A diagnosis of cancer does not present precisely the same issues as a diagnosis of Alzheimer’s, but a cancer diagnosis does present the patient and family with serious matters that would necessitate a discussion between patient and doctor. Cancer patients should discuss with their cancer care team the goals of their treatment, review the treatment options and make treatment decisions, and review the plan for coordinating multi-disciplinary care as well as the management of treatment side effects. In this encounter between patient and physician, the patient must make decisions about the course of active treatment and if and when palliative care will be incorporated in care. The shared decision-making visit should also produce a care plan – in written or electronic form -- that is available to the patient.

A cancer diagnosis is life-changing, and for many cancer patients a one-time visit after diagnosis begins the planning of treatment that may last for months or years. In a visit that occurs post-diagnosis, the patient may evaluate the benefits and risks of treatment options and consider the finances of cancer care. The patient may also consider quality of life issues and how to live with cancer and through cancer treatment.

Cancer patients and providers have for a number of years proposed a treatment planning discussion and visit to occur immediately after a cancer diagnosis. This effort is reflected in the Planning Actively for Cancer Treatment (PACT) Act (HR 2846), which would establish a cancer care planning visit in Medicare. In addition, the Oncology Care Model, an "episodes of care" payment demonstration model to be implemented in 2016, would require participating oncologists to complete a shared decision-making and treatment planning process. These efforts – the refinement of fee-for-service payment and the Oncology Care Model – adhere to the standards for cancer care planning that were defined in the Institute of Medicine (IOM) report, "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis."

The IOM identifies these elements of a cancer care plan:

- Patient information
- Diagnosis (including specific tissue information, relevant biomarkers, and stage)
- Prognosis
- Treatment goals (curative, life-prolonging, symptom control, palliative care)
- Initial plan for treatment and proposed during (chemotherapy, radiation therapy, and surgery, as applicable)
- Expected response to treatment
- Treatment benefits and harms
- Who will take responsibility for specific aspects of care
- Advance care plans
- Estimated cost of care, including out-of-pocket and overall cost
- A plan for addressing psychosocial needs, legal, financial, legal, and vocation needs
- A survivorship plan that would include risk reduction and health promotion activities²

Initiating cancer care with a planning process will honor the treatment preferences of the patient and encourage appropriate utilization of cancer care resources. Ensuring a post-diagnosis visit and decision-making process between the cancer patient and physician will also foster quality cancer care.

We also recommend that survivorship care planning be undertaken when a cancer patient transitions from active treatment to long-term survivorship. The survivorship care plan should summarize all elements of treatment for the patient (this will be aided if a treatment plan was completed) and include a roadmap for monitoring and treatment of late and long-term effects of cancer treatment. We recommend that the survivorship care planning visit be considered the "initial" phase of survivorship care.

² Institute of Medicine, Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis, Box 3-3, information in a Cancer Care Plan, 2013.

Developing Quality Measure for Chronic Conditions

We support the proposal to require the Centers for Medicare & Medicaid Services (CMS) to develop quality measures that focus on the health outcomes of those with chronic diseases. The list of topic areas for measure development, if it guides the measure development work of CMS, would result in solid measures of cancer care quality.

A measure that evaluated adherence to a comprehensive cancer care planning and shared decision-making process, as described above, would be appropriate. We urge that any such measure require completion of a comprehensive care planning process. In contrast, a discussion between patient and physician that does NOT include consideration of treatment goals and does NOT set the standards for care coordination would fall short of meeting a measure assessing cancer care planning.

Ensuring Medicare Advantage is Responsive to Beneficiaries with Chronic Conditions

We note that the options document seeks comments on several proposals to reform Medicare Advantage to make it more responsive to the needs of those with chronic conditions. We direct the attention of the Working Group to a longstanding barrier to participation in clinical trials by cancer patients who are enrolled in Medicare Advantage plans.

For some cancer patients, enrollment in a clinical trial may represent their best cancer treatment option. In addition, their participation in clinical research may contribute to the knowledge about investigational treatments and may also lead to development of new cancer treatments. Unfortunately, there are barriers to Medicare Advantage enrollees' participation in clinical trials.

A Medicare Advantage enrollee who wishes to participate in a trial will revert to fee-for-service status for care in the trial, and the Medicare Advantage plan is responsible for reimbursing patients for the difference in cost-sharing they experience as fee-for-service patients, compared to their cost-sharing in Medicare Advantage. It is our experience as patients and providers that this policy discourages participation in trials by Medicare Advantage patients. This matter could be addressed by making adjustments in the payments to Medicare Advantage plans for the costs associated with participation in trials by their enrollees. Patients who are enrolled in Medicare Advantage have an expectation that their cost-sharing will be predictable and limited, and they have been dissuaded from clinical trials participation by the requirement that they revert to fee-for-service status, which is accompanied by uncertainties about cost-sharing.

Thank you again for the opportunity to comment on the Policy Options Document for improving chronic care for Medicare beneficiaries.

Sincerely,

Cancer Leadership Council

CancerCare

Cancer Support Community

Fight Colorectal Cancer

Hematology/Oncology Pharmacy Association

International Myeloma Foundation

LIVESTRONG Foundation

Lymphoma Research Foundation

Multiple Myeloma Research Foundation

National Coalition for Cancer Survivorship

National Patient Advocate Foundation

Ovarian Cancer National Alliance

Pancreatic Cancer Action Network

Prevent Cancer Foundation

Sarcoma Foundation of America

Susan G. Komen

Us TOO International Prostate Cancer Education and Support Network