

CANCER LEADERSHIP COUNCIL

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

December 13, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Oncology Care First Model: Informal Request for Information

Dear Administrator Verma:

The undersigned cancer organizations are writing regarding the Oncology Care First model, as outlined in the document, "Oncology Care First Model: Informal Request for Information." We appreciate the opportunity to offer our views about the model.

We commend the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) for designing and testing models for the delivery of quality cancer care and for accepting advice and guidance not only from providers but also from patients who may be affected by these models. This has been the case with the ongoing Oncology Care Model, and we are pleased to be engaged in the early stages of Oncology Care First model design.

We understand that the fundamental goals of the Oncology Care First model are to move toward a prospective payment system for management and drug administration services combined with total cost of care accountability. The Request for Information articulates a goal that the model "reduces program expenditures while preserving or enhancing the quality of care for Medicare beneficiaries with cancer or a cancer-related diagnosis." We support the effort to protect Medicare resources and ensure the long-term viability of the program. However, in our comments we will stress the need to ensure that the model includes adequate resources – in the prospective payment amounts and in the total cost of care accountability structure – to protect the quality of cancer care.

Oncology Care Model

We have previously expressed our approval for the Oncology Care Model (OCM) for the benefits that it provides people with cancer. The "care transformation" requirements of the OCM have, in substantial measure, met the goal of transforming care in a way that is positive for cancer

patients. We applaud the requirements of the model for patient navigation services, a care plan that contains core elements defined by the Institute of Medicine, 24/7 access to a clinician with access to medical records, and other requirements. The OCM, which we understand has been difficult for some practices to implement, has made important strides toward patient-centered care.

We are pleased that the Oncology Care First model will make enhanced services payments for some of these care transformation services and would also encourage the gradual implementation of electronic PROs, or ePROs, to enhance care coordination. We urge that practices be permitted, at least at the outset, to continue experimentation with ePROs to determine the one that is best for their practice. We recommend this flexibility instead of a choice of a single ePRO for use by all Oncology Care First practices.

Care for Survivors

Patient advocates have, since the initiation of the Oncology Care Model, urged that a parallel model be developed that would provide for an episode of care for survivors who are post-treatment. We have strongly recommended this move because, years after the Institute of Medicine found that care survivors were “lost in transition,” that term still describes the situation facing many survivors of all ages. Survivors, including pediatric cancer survivors, often complete treatment without clarity about where they should receive monitoring services and follow-up care. Some oncology practices continue to care for survivors after active treatment, but others make referrals to primary care providers and/or other specialists.

Defining an episode of survivorship care and paying for it adequately will encourage cancer care providers to continue to care for patients after active treatment. However, even as we have urged the Innovation Center to consider a delivery and payment model for survivorship care, we have acknowledged the serious challenges to defining the episode and reimbursement for it.

We commend the Innovation Center for including survivorship care in the Oncology Care First model, and we believe that a system of prospective payment could work well for encouraging delivery of survivorship care by practices participating in the Oncology Care First model. If quality survivorship care is to be provided, the prospective payment amount must be reasonable. We are concerned that basing payments on medical national historical Medicare payments may result in prospective payments that underpay for the scope of care that survivors need. Because survivors have often been “lost” in the system and not received survivorship care, using historical payments would create a benchmark predicated on underserving the survivor population. We urge the Innovation Center to give careful consideration to this issue, including how enhanced services payments might be appropriate for survivorship care.

We would also note that CMS, in the recent proposed physician fee schedule for calendar year 2020, identified the under-utilization of certain care coordination codes and recommended changes to encourage their appropriate utilization. If those codes are under-utilized by oncologists to provide care that is properly planned and coordinated, will historical Medicare payments serve as an adequate basis for the prospective payments for all patients in the Oncology Care First model, including those receiving chemotherapy and hormonal therapy? We encourage the Innovation Center to consider these issues in establishing prospective payment levels.

Comprehensive Biomarker Testing

As knowledge regarding the molecular basis of cancer expands, the importance of appropriate testing of patients also becomes more critical. For some patients, such tests are essential to knowing their cancer diagnosis, including disease subtype, and to guiding treatment decisions. We note that the Innovation Center, in its outline of the Oncology Care First model, asks for specific feedback regarding the inclusion of additional services in the Monthly Population Payment (MPP).

We are concerned that historical data may not be a good predictor of the future use of biomarker test and that simply including biomarker tests in the MPP will not be sufficient. As a result, we recommend additional efforts in model design to ensure appropriate molecular diagnostic test utilization. In addition to MPP payments adjusted to include biomarker tests, the Innovation Center might consider biomarker testing as a care transformation activity or consider, over time, the addition to the measure set of a measure related to appropriate utilization of such tests. We recommend these multiple approaches to biomarker testing to ensure that payment is adequate to support appropriate utilization and that practices consider these tests, when appropriate.

Protecting Cancer Care Quality and Ensuring Access to Appropriate Therapies

We understand the interest of the Innovation Center in designing a model incorporating performance-based payments for performance related to total cost of care. However, we have concerns about a total cost of care model and the difficulties of designing a model that does not create obstacles to access to new therapies and that does not create incentives or disincentives for use of particular therapies that might not be optimal for patient care. We also believe that the model may create obstacles to radiation therapy.

We offer as an alternative the incorporation of clinical pathways into the model, if those pathways are developed through a process that is patient-centered and evidence-based. We urge consideration of this approach, because of the potential that solid clinical pathways can guide quality care, eliminate wide variations of care that undermine quality, and have a positive impact on overall spending. Use of clinical pathways may help address concerns about the proper utilization of drug therapies, while ensuring that patients receive the treatments that they require.

We also suggest that radiation oncology services be excluded from the total cost of care, as evaluations of the Oncology Care Model raise questions about prompt access to radiation therapy services when they are. In addition, we are persuaded that the radiation oncology model should advance, even if the Oncology Care First model also is implemented.

Our concern as patient advocates is that the total cost of care model not create barriers to care and not disrupt fair payment to cancer care providers.

Beneficiary Cost-Sharing

We urge the Innovation Center to offer an explanation of how beneficiary cost-sharing will be treated in the Oncology Care First model. We have two concerns. First, there must be clear communication to beneficiaries that their cost-sharing will relate to a Monthly Population Payment and not to specific services on a fee-for-service basis. Our second, and greater concern, is that beneficiary cost-sharing for Monthly Population Payments may exceed those that would have been required under fee-for-service payment methodology. At a time when the financial toxicity of cancer is a growing problem for all cancer patients, this could be a trend in the wrong direction.

Quality Measures

Throughout the term of the Oncology Care Model, the Innovation Center has been open to discussion regarding the quality measures that are used in the model. We urge the Innovation Center to continue a dialogue with stakeholders regarding additional quality measures that might be incorporated in the Oncology Care First model. Patient organizations are actively engaged in the measure development process, including to develop measures through a patient-driven process. We believe that these measures, when developed and validated, might strengthen the quality measurement element of the Oncology Care First model.

Communication with Beneficiaries about the Oncology Care First Model

In connection with the Oncology Care Model, the Innovation Center engaged with patient advocates regarding beneficiary education materials, including those describing the model and survey instruments used in the model. We trust that this collaborative approach to beneficiary education will continue.

We appreciate the opportunity to comment and look forward to additional discussion about the Oncology Care First model.

Sincerely,

Cancer Leadership Council

CancerCare
Children's Cancer Cause
Fight Colorectal Cancer
Hematology/Oncology Pharmacy Association
International Myeloma Foundation
LUNgevity Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
Ovarian Cancer Research Alliance
Prevent Cancer Foundation
Susan G. Komen