

CANCER LEADERSHIP COUNCIL

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

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 undersigned organizations represent cancer patients, physicians, and researchers who support health care payment and delivery reforms that will foster patient-centered cancer care. We appreciate the opportunity to respond to the Request for Information regarding the Merit-Based Incentive Payment System and Alternative Payment Models. We look forward to ongoing interaction with the Centers for Medicare and Medicaid Services (CMS) during the process of physician payment transformation that is outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The comments below focus on two of the performance categories in the Merit-Based Incentive Payment System (MIPA) and recommend an Alternative Payment System that would ensure the delivery of high-quality survivorship care to Medicare beneficiaries who are cancer survivors. We provide specific feedback on the measures and activities related to two of the four performance categories under the MIPS.

Resource Use Performance Category

MACRA requires the Secretary to evaluate costs – or resource use – based on a composite of appropriate measures of costs. The methodology for evaluating resource use is defined in MACRA, and the experience of CMS in the Value-Based Payment Modifier (VM) system is

assumed to be relevant to this evaluation. The Request for Information seeks comment on the development of a resource use measure that, in addition to measuring overall costs of care, would evaluate harmful or over-used services, including those identified in the Choosing Wisely initiative.

Instead of a resource measure that would focus only on potential over-utilization, we urge development of a resource measure for cancer care delivery that would focus on appropriate, or targeted, utilization of services. Cancer therapies are increasingly targeted according to the molecular profile of a patient's cancer. Not all cancer treatments are targeted medicines, of course. However, for those medicines that developed for specific targets, there are too many failures related to their delivery.

If patients do not undergo proper molecular diagnosis, they may not receive medicines that would provide benefit. On the other hand, patients who will not benefit from targeted therapies may receive them inappropriately because they are not properly diagnosed. In this case, there is over-utilization of the targeted therapy, but mostly importantly, the patient is not receiving the treatment best for him or her. These delivery failures result in improper utilization – both overutilization and underutilization. We urge that a measure for proper molecular diagnosis and subsequent use of targeted cancer therapies be incorporated in the resource use performance category. Such an effort is necessary for proper resource utilization, including of new targeted cancer therapies, and to ensure that patients receive the right treatment at the right time. We understand that diagnostic tests are not available for all therapies and that not all cancer therapies are “targeted.” However, accurate diagnosis, including molecular diagnosis where appropriate, should guide treatment decisions.

Clinical Practice Improvement Activities Performance Category

The term “clinical practice improvement” is defined in the Social Security Act, as amended by MACRA, as “an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.” Moreover, the Act specifies that the measures and activities for the clinical practice improvement activities performance category must include at least these efforts: expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an alternative practice model.

Our comments focus on defining a subcategory of clinical practice improvement activity, which might most logically be classified under the “care coordination” performance activity. We propose a treatment planning and coordination activity subcategory that would include 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.

Cancer care that is planned according to the patient’s preferences and that coordinates active treatment and symptom management from the beginning of treatment holds the promise of boosting patient satisfaction with care, improving outcomes, and enhancing the appropriate utilization of cancer care resources.¹ If a practice undertakes this sort of treatment planning and coordination, the process of practice transformation will be accelerated, quality of care and patient satisfaction will be improved, and appropriate resource utilization will be encouraged.

The “subcategory activity” of treatment planning and coordination can be reported by cancer care providers through a qualified registry or electronic health record. We also propose that a Consumer Assessment of Healthcare Providers and Systems (CAHPS) item set focusing on treatment planning and coordination be developed and utilized as part of the reporting and assessment of clinical practice improvement activities and specifically treatment planning and coordination. There exists a CAHPS item set that gathers information on patient experience in a patient-centered medical home; a modification of that item set might be useful in assessing cancer care provider implementation of the activities of treatment planning and coordination.

The Request for Information seeks comment on the benchmark for assessing performance on clinical practice improvement activities. We urge CMS to develop a MIPS performance benchmark for clinical practice improvement activities that will not penalize those oncology practices that have already made progress toward practice transformation through clinical practice improvement. These would include oncology practices that are already testing the patient-centered medical home concept and others that are undertaking practice improvements. These practices would include certain participants in the American Society of Clinical Oncology Quality Oncology Practice Initiative.

An Alternative Payment Model for Cancer Survivorship Care

Congress anticipated that MACRA would encourage the development of alternative payment models by medical professionals, their professional societies, and health systems. In fact, the law describes the new payment models as “physician-focused,” and requires that they be evaluated for implementation by the “Physician-focused Payment Model Technical Advisory Committee.” We propose a patient-focused payment and care model that could be implemented under the framework of a “physician-focused” system.

We recommend an alternative payment system for the delivery of comprehensive cancer survivorship care. Individuals who have been diagnosed with cancer and received treatment that might include surgery, radiation, and chemotherapy are often “lost in transition” as they move from active treatment to long-term survivorship.²

¹ 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.

² 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.

In a 2006 report on the problems of cancer survivors, the National Cancer Policy Board of the Institute of Medicine identified the essential 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.³

An alternative payment system including providers caring for cancer survivors holds great promise for addressing the serious and complex chronic health care needs of many cancer survivors and fairly compensating cancer care professionals providing this complex care. The need for a system of this sort is clear. 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 2012.⁴

The burden of cancer and cancer survivorship on individuals, families, and the nation is significant. Medicare beneficiaries and the Medicare program bear significant financial responsibility for the cancer care system simply because of the incidence of cancer and the number of cancer survivors in this population. An alternative payment system might focus initially on Medicare beneficiaries who are cancer survivors and be expanded to other populations of cancer survivors.

We anticipate challenges associated with the development of an alternative payment system that would focus on a specific population, but its potential benefits argue for its consideration as a range of alternative payment systems are developed and implemented. We encourage CMS to entertain proposals for cancer survivorship care and to take an additional step by providing guidance that would address ways to combine a patient-centered payment system with the physician-focused payment reform structure.

³ Hewitt M, et al. From Cancer Patient to Cancer Survivor. 2006.

⁴ 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 appreciate the opportunity to offer comments on MIPS and on alternative payment systems and look forward to additional discussion with CMS about ensuring a patient focus in these payment reform efforts.

Sincerely,

Cancer Leadership Council

American Society for Radiation Oncology

CancerCare

Cancer Support Community

The Children's Cause for Cancer Advocacy

Fight Colorectal Cancer

International Myeloma Foundation

The Leukemia & Lymphoma Society

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

Susan G. Komen

Us TOO International Prostate Cancer Education and Support Network