CANCER LEADERSHIP COUNCIL

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

October 7, 2014

Patrick Conway, MD, MSc
Deputy Administrator for Innovation and Quality
Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Dr. Conway:

The undersigned organizations, which represent cancer patients, physicians, pharmacists, other health care professionals, and researchers, are writing to express their support for the efforts of the Center for Medicare & Innovation (Innovation Center) to design, implement, and evaluate an oncology payment model, called the Oncology Care Model (OCM). We commend the Innovation Center for its efforts to foster a patient-centered model of chemotherapy treatment.

The Innovation Center, by identifying five requirements that practices must fulfill in order to participate in the Oncology Care Model, has set an important course for fostering practice change to achieve patient-centered care and quality improvement. We are pleased to see that one of the five elements of practice transformation is documentation that a care plan has been developed in accordance with the standards of the Institute of Medicine (IOM) Care Management Plan. As advocates for patients who are receiving cancer care, we have long considered a written care plan the critical first element in delivery of quality cancer care. We also support the requirements for practices to employ patient navigators, provide round-the-clock patient access to a clinician, engage in continuous quality improvement, and utilize electronic health records.

The standards for practice transformation are solid ones, but achieving the transformation will be difficult. We offer below some advice regarding the implementation of these standards through the Oncology Care Model.

The Beginning of the Episode of Care

The Oncology Care Model is structured around six-month episodes of chemotherapy treatment, with the first episode triggered by the initiation of chemotherapy. Although we understand the logic of the initiation of chemotherapy as the beginning of the episode for reimbursement purposes, the beginning of chemotherapy is not the optimal beginning

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of the episode for the patient. For example, a care planning process that meets the standards of the IOM Care Management Plan might foster shared decision-making that in turn encourages coordination of care. However, to achieve those goals, the care planning process should occur before the initiation of chemotherapy. The review of treatment goals, expected response to treatment, treatment benefits and harms, and the likely experience with treatment should occur before chemotherapy begins.

We concede that it is difficult to identify a consistent point for the initiation of the episode of care that is earlier than the first chemotherapy treatment. An indirect means of addressing this problem of design of the Oncology Care model is to ensure that the per-beneficiary-per-month (PBPM) payment is adequate to cover the practice costs associated with furnishing the enhanced services in the Oncology Care Model. Achieving this standard of payment may serve to encourage broad-based participation in the Oncology Care Model and transformation of many practices. Such broad-based practice transformation may indirectly address the costs and burden of undertaking cancer care planning outside the strict confines of the episodes of care.

Per-Beneficiary-Per-Month Payment

The description of the Oncology Care Model released by the Innovation Center states that the per-beneficiary-per-month (PBPM) payment should cover the costs of providing the five "enhanced" services that will result in transformation of oncology practice. As stated above, we believe that is a critical requirement. Oncologists indicate that in current practice, reimbursement for chemotherapy drugs may cover practice expenses. We encourage a PBPM payment level that would make such cross-subsidization unnecessary and that would establish a clear standard of fair payment for the enhanced services identified by the Oncology Care Model.

We also recommend that the Innovation Center consider additional options for the structure of the PBPM payment. Two divergent approaches deserve evaluation. One option would be to set the PBPM payment at a higher level for the first month of each episode of care, compared to months two through six; this higher payment level might cover the enhanced services, including care planning, that are necessary at the beginning of chemotherapy (or before, as discussed above). A second option would be to incorporate a performance-based element into the PBPM. Under this option, the PBPM might be increased after the practice has achieved practice transformation, which would be judged as performance of the five enhanced services. Higher payments might be set at each six-month interval and awarded on the basis of evaluation of performance. We offer these options as possible strategies for fostering practice transformation and also encouraging aggressive participation by practices in the Oncology Care Model.

Limit on Number of Episodes

The Oncology Care Model as currently defined includes a limit of two episodes of care. We encourage the Innovation Center to eliminate this arbitrary limit of episodes. There will be cancer patients whose chemotherapy might continue beyond the period of two

six-month episodes of care. Those patients should receive the "enhanced care" anticipated by the Oncology Care Model, and their oncologists should receive the PBPM for providing those services in a third (or additional) episode of care.

Transitions to Survivorship

We understand that the process of reforming cancer care delivery and payment is being undertaken in incremental fashion beginning with the voluntary Oncology Care Model. Although this approach is sensible from a practice and policy standpoint, it may actually result in some disruptions of care for patients in the short term. For example, we are concerned about the transition of patients from chemotherapy treatment to survivorship care. The care management plan that is one of the enhanced services in the episodes of care system anticipates the development of a "survivorship plan, including a summary of treatment and information on recommended follow-up activities and surveillance, as well as risk reduction and health promotion activities." The care management plan anticipates coordination of survivorship care, but the fee-for-service system does not reimburse for the kind of survivorship care that many Medicare beneficiaries need after active cancer treatment. In separate comments on the physician fee schedule for 2015, patient advocates proposed a cancer survivorship monitoring and care coordination code to ease the transition of patients to long-term survivorship. We believe that such a service would be a complement to and extension of the Oncology Care Model.

The Role of Patients in Evaluating the Oncology Care Model

The short description of the Oncology Care Model identifies performance-based payment measures and quality monitoring measures that will be used to assess performance of practices that participate in the model. The description of the model indicates that practices will report their performance on four of the enhanced services they provide through the Oncology Care Model and that the Centers for Medicare & Medicaid Services (CMS) will collect the practice attestation of electronic health records meaningful use.

We recommend that patient evaluations be utilized in the performance assessment process. We suggest a short patient satisfaction survey that would focus on a select set of the elements of the care management plan. For example, patients might be asked to evaluate whether their care planning process discussed treatment goals, the initial plan for treatment, treatment benefits and harms, and the patient's likely experience with treatment. They might be queried on how well they understand their care plan and whether there are elements that are confusing to them. The survey might also ask if the patient has round-the-clock access to a clinician. These are concrete elements of care that the patient can assess, and patient reports on these care aspects would serve as a solid complement to other efforts to evaluate oncology practice transformation.

The undersigned organizations can provide additional advice regarding patient evaluations of care and how they might be utilized.

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We appreciate the opportunity to comment on the Oncology Care Model plan. We look forward to publication of the final plan and the initiation of enrollment by payers and providers.

Sincerely,

Cancer Leadership Council

Cancer*Care*
Cancer Support Community
Fight Colorectal Cancer
Hematology/Oncology Pharmacy Association
International Myeloma Foundation
Kidney Cancer Association
The Leukemia & Lymphoma Society
LIVE**STRONG** Foundation
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National Coalition for Cancer Survivorship
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