American Cancer Society
Cancer Action Network
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April 10, 2014

Dr. Patrick Conway, MD, MSc
Acting Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Comments on Request for Information on Specialty Practitioner Payment Model Opportunities

Dear Dr. Conway:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide comments in response to the Center for Medicare & Medicaid Innovation's (CMMI's) request for information on specialty practitioner payment model opportunities. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

As the CMMI explores new payment and service delivery models for specialty practitioners, ASC CAN urges you to place particular attention on the impact various payment policies will have on a beneficiary's access to care. This is particularly important for those beneficiaries living with cancer who are high utilizers of the health care system. It is a well-known fact that payment often drives practice. As we develop new payment models in an effort to reduce health care expenditures, we must ensure that practitioners are provided the necessary tools and incentives to provide high-quality health care for their patients.

ASC CAN offers the following thoughts and comments on CMMI's request for information on specialty practitioner payment models. Many of these comments focus on episode-based payment models centered around medical oncology practices and we intend also to share these thoughts with the MITRE contractor as it continues its process.

A new payment model may offer an opportunity to provide high-quality, coordinated care to cancer patients.

We are encouraged that the CMMI has taken an interest in the quality of care provided to cancer patients, particularly those in the Medicare program. Medicare beneficiaries over the age of 65 account for more than half (54 percent) of all new cancer patients and the number of cancer survivors over age 65 will increase by more than 42 percent over the next ten years.[1] Any new payment model for medical oncology care first and foremost should be built around the needs of the patient and should not be used as a mechanism to deny or limit care to cancer patients.

Encourage greater access to palliative care services: As the CMMI works to develop a new payment model for care provided in an outpatient setting, ASC CAN urges the agency to consider ensuring that a new payment model includes consultation with a palliative care team. Ample evidence exists to demonstrate the benefits of palliative care in improving the quality of life, addressing the harmful effects of pain, symptoms, and emotional distress, and lessening caregiver burden. A number of studies have demonstrated that the use of palliative care services has significantly reduced health care expenditures[2] and enhanced survival for some cancer patients.[3]

Cancer patients represent a diverse group of individuals with unique health care needs.

As the CMMI develops its episode-based payment models, particularly for medical oncologists, it is imperative to keep in mind that cancer patients have very different and unique health care needs and it will be challenging to develop a payment model that addresses the myriad of needs for the cancer patient. For example, a 65 year-old breast cancer patient's health care needs would be different from that of a 75 year-old with late stage pancreatic cancer.

There are more than 100 different types of cancer,[4] the treatment of which varies considerably depending on a variety of factors including the type of cancer, stage of initial diagnosis, and individual patient choice. Any new payment model would need to ensure that beneficiaries have access to a panoply of treatment options. Some patients may require more services and procedures than others, and thus a new payment model must include some mechanism (e.g., outlier payments) to ensure that patients can have access to the services they need.

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[1] Lifeline: Why Cancer Patients Depend on Medicare for Critical Coverage, American Cancer Society Cancer Action Network.

[2] Morrison RS, et al., Cost Savings Associated with US Hospital Palliative Care Consultation Programs. *Arch Intern Med* 168(16)1783-1790 (2008); Morrison RS et al., Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries, *Health Affairs*, 30, no.3 (2011):454-463.

[3] Temel JS et al., Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer, N Engl J Med 2010;363:733-42.

[4] National Cancer Institute, Defining Cancer, available at: http://www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer.

In addition, it is unclear whether an episode-based payment model would be limited to beneficiaries who are undergoing active oncology treatment, or whether such a model would also encompass beneficiaries who are cancer survivors and thus need periodic access to a medical oncologist. Advancements in research and access to routine screening programs have significantly increased long-term survival rates. The number of cancer survivors over age 65 is expected to increase by more than 3 million (42 percent) over the next decade.[5] Any new payment model would have to ensure that beneficiaries who survive cancer continue to have access to their medical oncologist.

Episode-based payment models must encompass patient choice.

As the CMMI develops new payment models, it is vital that any new care model must ensure that patients have the opportunity to play an active role in their treatment.

Access to second opinions: Many cancer patients often seek a second opinion related to their diagnosis or treatment options. Any new payment model should ensure that beneficiaries have the option to seek a second opinion at the patient's request. In addition, the new payment model should not hinder patients' access to clinical trials.

Shared decision-making: Treatment for a cancer diagnosis is a very personal decision that is best made through a shared decision-making process between a patient (in consultation with his/her family or caregiver) and the provider. In order to accomplish this goal, patients must be provided with robust information to best explain their treatment options.

The CMMI must ensure that any new payment models not incentivize – either directly or indirectly – providers to skimp on care provided to a patient. For example, some cancer patients may make the affirmative decision to forego any treatment. Providers should neither be financially rewarded nor penalized based on the patient's decision.

Access to care: Some patients may have concerns about how a different model of care impacts the availability of their treatment options. Medicare beneficiaries often have several co-morbid conditions[6] which can impact their treatment options. Any payment model would need to ensure that beneficiaries continue to have access to any other Medicare providers.

In addition, it is not clear how a new payment model would accommodate a situation where a patient decides he or she no longer wishes to be cared for by an entity participating in the new payment model, perhaps due to dissatisfaction with the care being received or the treatment options being offered. Similarly, it is not clear whether and how patients under such a new

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[5] Lifeline: Why Cancer Patients Depend on Medicare for Critical Coverage, American Cancer Society Cancer Action Network.

[6] According to one CMS report, more than two-thirds of Medicare beneficiaries had at least two or more chronic conditions. Centers for Medicare & Medicaid Services. Chronic Conditions Among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

payment model would continue to have access to specialized treatment centers if they deemed such access to be important at some stage of their care.

In addition, the new payment model should not limit beneficiaries' access to treatment locations. If a beneficiary is currently undergoing chemotherapy in one location, she should not be forced to change locations simply because her provider has chosen to participate in a new payment model. Often patients—particularly low-income patients – have challenges getting to and from treatment.

Additional items to consider regarding the operationalization of a new episode-based payment model.

Quality measures are critical: In order to ensure that patients have access to high-quality health care, it is imperative that any new payment model be evaluated using robust quality measures, including measures specifically related to patient experience. Further, payment models developed around specialty practices also should include quality measures specific to those practice areas. Existing quality measures may be insufficient to accurately measure the quality of the patient experience.

Robust patient volume: The CMMI envisions offering providers the opportunity to participate in this new payment model, conceivably similar to its other ongoing shared-savings and bundled care initiatives. As further details of this program are developed, we encourage the CMMI to require that potential applicants have demonstrated a robust volume of patients in order to ensure that the CMMI can appropriately test the model. If CMMI accepts applications from providers who have a relatively small patient population there is concern that any results generated may be skewed by the inclusion of a handful of outlier patients. In addition, adequate patient volume will help ensure that the averaging principle will apply, in that there will be an increased likelihood that any patients requiring more than the average amount of care will be counterbalanced by patients requiring less than the average.

Patient access to providers: The CMMI must ensure that beneficiaries have access to their oncologists, regardless of whether the provider opts to participate in the new payment model. It is unclear whether by agreeing to participate in a new payment model, all patients seen by the participating provider will be reimbursed under the new model or whether the new model will be similar to the Accountable Care Organization (ACO) demonstrations in which only some patients are not attributed to the ACO.

The CMMI will need to monitor beneficiary access to ensure that patients have access to oncologists and that sicker beneficiaries are not discouraged from seeing a provider through the use of longer wait times for appointments and limited office hours. The CMMI will need to include an appropriate risk-adjustment modifier to account for older and sicker patients. Such a policy raises concerns that a participating provider may be discouraged from treating a

patient with unique or high-cost needs. This issue would be particularly problematic in rural areas where few oncologists choose to practice.

Items and services included in the episode of care: The RFI notes that the CMMI seeks input on "specialty practitioner services furnished mainly as outpatient care". Many treatments – like chemotherapy – can be provided on a hospital outpatient basis. If these treatments are included in the new payment model, the CMMI will need to ensure that beneficiaries have access to not only the oncologist, but also to the participating facility (e.g., hospital).

Access to innovative treatments: While a new payment model has the potential to improve health care quality and care coordination, there is concern that unless properly designed, such a model could hinder beneficiaries' access to all available treatment options. For example, what if a beneficiary wanted access to a new, innovative, high-cost treatment option? Under the episode-based payment model, it is unclear whether patients would be provided access to this new treatment. Any new payment model must ensure that beneficiaries have a mechanism to have access to new and innovative treatments if medically necessary. Further, as noted earlier, a patient's view may change during the course of treatment and any new payment model must not have the effect of locking a patient into an inflexible arrangement that no longer meets his or her needs.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the request for information on specialty practitioner payment model opportunities. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Kirsten Sloan
Senior Policy Director
American Cancer Society Cancer Action Network