American Cancer Society Cancer Action Network
Comments Regarding Centers for Medicare & Medicaid Services: Innovation Center New Direction

Submitted via Survey on November 17, 2017

Note: Survey text and questions are provided in bold text. ACS CAN response is provided in non-bold text.

Survey questions were omitted below if no response was submitted.

Guiding Principles

While existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons, CMS is setting a new direction for the Innovation Center. We will carefully evaluate how models developed consistent with the new directions can complement what we are learning from the existing initiatives. The Innovation Center will approach new model design through the following guiding principles:

1. **Choice and competition in the market – Promote competition based on quality, outcomes, and costs.**
2. **Provider Choice and Incentives – Focus on voluntary models, with defined and reasonable control groups or comparison populations, to the extent possible, and reduce burdensome requirements and unnecessary regulations to allow physicians and other providers to focus on providing high-quality healthcare to their patients. Give beneficiaries and healthcare providers the tools and information they need to make decisions that work best for them.**
3. **Patient-centered care – Empower beneficiaries, their families, and caregivers to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care across the care continuum.**
4. **Benefit design and price transparency – Use data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes.**
5. **Transparent model design and evaluation – Draw on partnerships and collaborations with public stakeholders and harness ideas from a broad range of organizations and individuals across the country.**
6. **Small Scale Testing – Test smaller scale models that may be scaled if they meet the requirements for expansion under 1115 A(c) of the Affordable Care Act (the Act). Focus on key payment interventions rather than on specific devices or equipment.**

Expanded Opportunities for Participation in Advanced APMs

In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that repealed the Sustainable Growth Rate formula for updating the Medicare physician fee schedule, and replaced it with a series of fixed statutory updates and a Quality Payment Program that includes the Merit-Based Incentive Payment System (MIPS) and Advanced APMs. CMS administers the Quality Payment Program, and the Innovation Center bears primary responsibility for development of policies and operations relating to Advanced APMs. Eligible clinicians who are Qualifying APM Participants (QPs) for a year from 2019 through 2024 receive a lump sum APM incentive payment and, beginning for 2026, a differentially higher update under the Medicare physician fee schedule. Eligible clinicians who are QPs for a year are also not subject to the MIPS reporting requirements and payment adjustment.

CMS expects that the number of eligible clinicians choosing to participate in Advanced APMs will grow over time. To facilitate this growth, CMS seeks comment on ways to increase opportunities for eligible clinicians to participate in Advanced APMs and achieve threshold levels of participation to become QPs. CMS has received feedback from the healthcare provider community on the extensive and lengthy process that is required for a model to qualify as an Advanced APM. CMS seeks feedback from stakeholders on ways the Administration can be more responsive to eligible clinicians and their patients, and potentially expedite the process for providers that want to participate in an Advanced APM. CMS also seeks guidance from the stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

Do you have comments on the guiding principles or Expanded Opportunities for Participation in Advanced APMs?

Yes

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Innovation Center's guiding principles and focus areas. 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.

The fee-for-service model of care rewards providers who deliver a high volume rather than high value healthcare services. Evidence shows that this model does not always lead to the best health outcomes for patients. In treating cancer, more services are not necessarily better. The goal must be finding the most effective treatment. As cancer treatments become more personalized – down to the genetic level – it is imperative that payment and delivery models reflect this approach. And since cancer patients and others with serious chronic illnesses are some of the more sophisticated and actively engaged health consumers, delivery models need to be designed around the needs of the patient.

While ACS CAN supports the proposed principle of "empowering beneficiaries, their families, and caregivers to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care across the care continuum," it does not go far enough. We believe any new model design should also be evaluated based on the principle of how well it actually meets the needs of beneficiaries and how well it engages consumers in the design of the model. The Medicare program learned a valuable lesson in the early days of managed care when models were created based

on what companies thought consumers wanted but relatively few beneficiaries enrolled. Once models began to reflect what consumers actually needed enrollment increased.

ACS CAN is supportive of expanding the use of Advanced APMs, which we believe can provide high-quality and high-value health care to Medicare beneficiaries. Advanced APMs have the potential to provide more patients with the type of patient-centered care for which we have long advocated: care that is tailored to meet high standards of quality care and to accomplish the goals of the patient. In particular, we believe APMs have the potential to incentivize the provision of care coordination, palliative care, patient navigation, and other care that is focused on the health and well-being of patients. We also hope that the more flexible structure of APMs will allow purchasers and healthcare systems to use a variety of professionals and lay people to deliver such care. We note that high-quality palliative care and patient navigation can, and often does, involve professionals who are not physicians or nurses – professionals for whom direct reimbursement in a fee-for-service system may not be available.

Additionally, as CMS designs new advanced APMs using the Innovation Center guiding principle #4 (using data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes) we encourage CMS to recognize that benefit design and transparency not only should result in better patient outcomes but also improved quality of care delivered.

We are pleased to see expanding opportunities for participation in advanced APMs is a priority for CMS, but note that not all innovative payment models will necessarily meet the rigorous standards to become an Advanced APM. Given that clinicians meeting the threshold of participation in Advanced APMs receive higher Medicare payments, the standards to which they are held should be expected to be much higher than the standards for MIPS-eligible clinicians.

Regarding one of the Innovation Center's existing models, ACS CAN continues to be very supportive of the Oncology Care Model (OCM). We believe the process used to develop and implement the OCM has embodied the Innovation Center guiding principle #5: transparent model design and evaluation. We look forward to continuing work with the Innovation Center on this model – including opportunities for expanding it, which we discuss below. We encourage CMS to use a similar process that includes early outreach to stakeholders including patient groups to develop and implement other advanced APMs.

Citations:

Healthcare Transformation Task Force. Guiding Principles for Addressing Consumer Priorities in Value-Based Care. August 2016.
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

What Expanded Opportunities for Participation in Advanced APMs model designs should the Innovation Center consider that are consistent with the guiding principles?
ACS CAN remains very supportive of the Oncology Care Model (OCM). However, we note that the OCM focuses on the administration of chemotherapy, and thus does not include all types cancer care. We would be interested in working with CMMI on cancer-related demonstrations that focus on the administration of other types of cancer care (e.g., radiation, surgery) as well as models of care that include care that is provided before the administration of chemotherapy. We are also interested in

working with CMMI to provide further details regarding the services that are required to be provided under future oncology models, like patient navigation services, the availability of palliative care, and meaningful provider-patient discussion regarding treatment options.

ACS CAN welcomes the opportunity to collaborate with CMS on advanced APM models in the following areas: 1) other care coordination models for complex patients with advanced illness, like the Medicare Program Linking Uncoordinated Services (PLUS) model that has been proposed by Aetna (though ACS CAN believes participation in this model should be voluntary); 2) other models focused or incentivizing provision of palliative care; and 3) other models focused on preventing cancer or providing preventive and screening services, such as colorectal screening.

Citations:
Lauby-Secretan B. Scoccianti C, Loomis D, et al. Body Fatness and Cancer – Viewpoint of the IARC Working Group. N Engl J Med 2016; 375:794-798.

American Cancer Society. Cancer Facts & Figures 2017. Atlanta, GA: American Cancer Society; 2017.

Do you have suggestions on the structure, approach, and design of potential Expanded Opportunities for Participation in Advanced APM models? Please also identify potential challenges or risks associated with any of these suggested models.
Yes

As previously discussed, ACS CAN believes Advanced APMs are important opportunities to find ways to incentivize patients' access to palliative care, navigation services, and other services focused on the long-term health and wellbeing of the patient. As CMS designs new Advanced APMs that incorporate these services as part of their requirements, it is important to clearly define such requirements. For example, while we were pleased that "navigation services" were a requirement for practices applying for the Oncology Care Model (OCM), we note that there was no further definition beyond that phrase, and practices only have to attest they are providing the service. Presumably these requirements are being included in models so that quality of care and patient outcomes will improve, and therefore CMS should want to establish some type of definition and standards for such services. In the case of palliative care and navigation, there are evidence-based best practices that CMS could use to further define such requirements. ACS CAN encourages CMS to work with relevant stakeholders like ACS CAN to identify the correct standards, and incorporate them into future new models or revisions of existing models.

Furthermore, once an Advanced APM has been created, it is crucial that CMS coordinate ongoing technical assistance and educational opportunities for participating providers. The American Cancer Society and ACS CAN have been pleased to work with CMS on providing education and technical assistance to providers participating in the OCM, particularly on how to create and sustain a successful patient navigation service. We look forward to engaging with CMS in this and other ways regarding future relevant models.

As CMS creates, implements and evaluates specialty physician models, it must ensure that policies in the models do not: 1) discourage providers from taking on sicker patients who are likely to have worse outcomes; 2) disadvantage providers that treat the sickest patients; or 3) disadvantage small-practice or community providers. Any of these possible consequences, while unintended, could have a major impact on cancer patient access to providers and treatments.

ACS CAN believes that one way to avoid such unintended consequences is to ensure that APM evaluation components are robust and use the right quality measures. These quality measures are important for measuring the success (and level of payment/savings) of providers within the model, and they are also crucial to evaluating the overall success of the model – including from the patient's perspective. To evaluate quality performance and ensure delivery of high-quality care to patients, any new Advanced APM should be required to do ongoing assessment of quality outcomes and care experience, public reporting of quality performance data and implementation of continuous quality improvement programs. Quality data should be measured, tracked and inclusive of patient-reported data, including patient-report outcomes and care experience for patients and family caregivers.

In particular, measurement of and reporting on patient experience of care and patient reported outcomes should provide actionable data that helps providers improve care delivery and supports informed consumer decision making with respect to choosing health plans, providers and care settings. Advanced APMs should facilitate reporting quality performance data not only at the APM or delivery-system level, but also at the individual clinician/provider level.

ACS CAN notes that the National Quality Forum has a Cancer Standing Committee that oversees a portfolio of tested and evidence-based cancer measures. More information is available at http://www.qualityforum.org/Cancer.aspx. The National Quality Forum also operates a Geriatrics and Palliative Care Standing Committee that oversees measures regarding geriatric issues, palliative care, and end of life care. More information is available at http://www.qualityforum.org/Geriatrics_and_Palliative_Care.aspx

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?
No comments

How can CMS further engage beneficiaries in development of Expanded Opportunities for Participation in Advanced APM models and/or participate in new models?
ACS CAN is pleased to see that CMS has made engaging beneficiaries such a priority in the development and implementation of new models. We encourage CMS to carry this priority to its rightful conclusion and also engage beneficiaries in the evaluation of models.

Patients who are diagnosed with a serious illness like cancer often have no choice but to become extremely engaged in the healthcare system. This is also true of not only of patients in active cancer treatment, but also their caregivers and family members. Many cancer patients enter survivorship more educated and engaged in healthcare and benefits, and are interested in staying engaged and making improvements for future cancer patients. ACS CAN has the pleasure of working with many such cancer patients, survivors and caregivers. In addition to reaching out directly to patients, ACS CAN encourages CMS to engage with patient advocacy groups like ACS CAN to better reach the right patients and incorporate patient perspectives.

ACS CAN supports and participated in the writing of the Healthcare Transformation Task Force's Guiding Principles for Addressing Consumer Priorities in Value-Based Care. The guiding principles specify that when created APMs, healthcare systems: 1) include patients/consumers as partners in decision-making at all levels of care, 2) deliver person-centered care, 3) design alternative payment models (APMs) that

benefit consumers, 4) drive continuous quality improvement, 5) accelerate use of person-centered health information technology, and 6) promote health equity for all.

For more information and detailed recommendations, please visit:
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?
No comments

Consumer-Directed Care & Market-Based Innovation Models

CMS believes beneficiaries should be empowered as consumers to drive change in the health system through their choices. Consumer-directed care models could empower Medicare, Medicaid, and CHIP beneficiaries to make choices from among competitors in a market-driven healthcare system. To better inform consumers about the cost and quality implications of different choices, CMS may develop models to facilitate and encourage price and quality transparency, including the compilation, analysis, and release of cost data and quality metrics that inform beneficiaries about their choices. CMS will consider new options for beneficiaries to promote consumerism and transparency. For example, beneficiaries could choose to participate in arrangements that would allow them to keep some of the savings when they choose a lower-cost option, or that incentivize them to achieve better health. Models that we are considering testing include allowing Medicare beneficiaries to contract directly with healthcare providers, having providers propose prices to inform beneficiary choices and transparency, offering bundled payments for full episodes of care with groups of providers bidding on the payment amount, and launching preferred provider networks. CMS solicits feedback from patient and consumer advocacy groups, the healthcare provider community, as well as experts in the technology industry, and other stakeholders that can provide creative ideas on how to operationalize these principles in models that best serve patients in terms of cost, quality, and access to care.

Do you have comments on the guiding principles or Consumer-Directed Care & Market-Based Innovation Models?
Yes

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Innovation Center's guiding principles and focus areas. 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.

ACS CAN supports CMS' focus on increasing transparency on quality metrics. We believe cancer patients would benefit from receiving more information about the quality of care provided by potential providers and models. The information provided should be what is most relevant to the patient, so we encourage CMS to also include information on patient experience and outcomes in these transparency efforts. Additionally, we encourage CMS to engage in consumer testing to ensure that the information that is provided to consumers is easily understood, delivered at the right time and in the right format for the consumer to meaningfully use.

ACS CAN has long supported policies that make costs and prices more transparent for consumers. As representatives of cancer patients and survivors, we are particularly focused on transparency in the price the consumer pays as well as the quality of care provided. Patients must be able to find information easily about their copays, coinsurance and deductibles, and how much a particular treatment or medication is expected to cost them. This transparency must be provided to consumers as they are making choices about their insurance coverage so they are enrolled in coverage that is right for them. In the context of CMS beneficiaries, this transparency is crucial for Part D plans, Medicare Advantage plans, Medicaid managed care plans, and any other current or future coverage option where patients are asked to choose coverage that involves a formulary, provider network, or other mechanism that defines patient costs.

Transparency in patient costs also must be provided to patients once they are enrolled in coverage so they can anticipate and plan for out-of-pocket costs. If carefully implemented, this transparency may also assist patients in making choices between treatments, providers, or medications (to the extent that a patient has multiple choices for treatment given her disease or condition).

ACS CAN urges CMS to proceed cautiously with any policies or models that ask consumers to make choices about treatment solely based on price information. We encourage CMS to focus on transparency efforts first and ensure that these efforts are enabling consumers to understand and use information about quality and cost before introducing additional elements or requiring consumers to "shop" based on price.

We also caution CMS that "promoting consumerism" cannot simply mean finding ways to shift more upfront costs onto beneficiaries. For example, ACS CAN is concerned about the trend towards high deductible health plans (HDHPs) in private insurance. HDHPs – even when accompanied by a health savings account – are not appropriate for everyone. While some preventive services and cancer screenings are currently required to be exempt from deductibles in private plans, some HDHP enrollees still assume they will be charged in full for their preventive services and are discouraged from seeking care. One study showed that switching to an HDHP was associated with a downward trend in overall colorectal cancer screening rates after two years (Wharham et al., 2011).

HDHPs are even more concerning for cancer patients and survivors. Once a patient is suspected of having cancer, he or she undergoes many tests that are not considered preventive services and therefore are subject to the deductible. Costs continue after the patient is diagnosed and undergoes surgery, radiation and/or chemotherapy. These costs are high, and they come fast – many cancer patients face paying their whole deductible in the first month or two after diagnosis. Being required to pay for these high costs up-front can cause delays in treatment, especially for low-income patients. Research is starting to show the negative consequences of HDHPs to cancer treatment and outcomes. One study showed that HDHP enrollment was associated with a decrease in imaging tests (Zheng et al., 2016) – the tests a patient needs if she has a positive screening test for suspected cancer. ACS CAN would be extremely cautious of any proposals to implement elements of high deductible health plans or similar policies for CMS beneficiaries.

ACS CAN would like to learn more about CMS' interest in "having providers propose prices to inform beneficiary choices and transparency." While having providers propose prices up front to beneficiaries would seem to accomplish our goal of helping patients understand and anticipate their costs, such a concept would have to be implemented carefully. Cancer patients and others with serious and/or multiple illnesses are already dealing with a lot of information that is hard to understand, and choices that are hard to make. Many cancer patients feel overwhelmed with this information and these choices, at just the time that they are also undergoing serious treatment that is physically and emotionally draining. We would not want cancer patients to be required to engage in an onerous process where they, for example, would have to solicit bids from multiple providers before being allowed to receive treatment. ACS CAN encourages CMS to reach out to us and other patient groups early on when considering such a policy.

We note that some payers have been using preferred provider networks as a way to encourage enrollees to seek high-value care. Such a practice may be beneficial to the enrollee if the provider network is robust enough to provide coverage for the enrollee's providers – including access to specialists and subspecialists where appropriate.

In addition, to the extent that a payer is permitted to use tiered networks (where the enrollee's cost-sharing differs depending on the tier of the provider) we strongly urge CMS to establish strict criteria to ensure that the tiering of a provider network not designed in a manner that is discriminatory to beneficiaries, particularly beneficiaries with complex needs. Robust analysis of the adequacy of the plan's network must be undertaken and any network adequacy standard must be applied to the lowest-cost tier of any tiered network to ensure that the enrollee can access any medically appropriate provider.

Citations:
Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. Med Care. 2011 Sep;49(9):865-71. doi: 10.1097/MLR.0b013e31821b35d8.

Zheng, S; Ren, ZJ; Heineke, J; Geissler, KH. Reductions in Diagnostic Imaging with High Deductible Health Plans. Medical Care. February 2016 - Volume 54 - Issue 2 - p 110–117. doi: 10.1097/MLR.0000000000000472

What Consumer-Directed Care & Market-Based Innovation Model designs should the Innovation Center consider that are consistent with the guiding principles?
ACS CAN encourages CMS to focus on transparency efforts first and ensure that these efforts enable consumers to understand and use information about quality and cost before introducing additional elements or requiring consumers to "shop" based on price.

ACS CAN encourages CMS to consider a model that promotes consumerism by giving more patients access to patient navigators. Patient navigators work with patients and families to help with many different needs and overcoming barriers associated with the health care system. This may include helping with insurance problems, finding doctors, explaining treatment and care options, going with patients to visits, communicating with their health care team, assisting caregivers, and managing medical paperwork. ACS CAN believes that patient navigators benefit patients and the healthcare system in multiple ways – one way is helping patients make better choices about their care. We would welcome the opportunity to work with CMS to develop such a model.

Do you have suggestions on the structure, approach, and design of potential Consumer-Directed Care & Market-Based Innovation Models? Please also identify potential challenges or risks associated with any of these suggested models.
Yes.

If CMS moves forward with models that promote consumerism by requiring patients to make choices based on price or shifting more upfront costs onto patients, it is crucial that the success of such models is measured carefully. CMS must track more than just treatment utilization or systemwide costs to determine whether such models are successful. CMS must carefully evaluate these models to ensure that any reduction in treatment utilizations or costs are not effecting quality of care, treatment outcomes, or increasing costs on the beneficiary.

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?
No comment.

How can CMS further engage beneficiaries in development of Consumer-Directed Care & Market-Based Innovation Models and/or participate in new models?
ACS CAN is pleased to see that CMS has made engaging beneficiaries such a priority in the development and implementation of new models. We encourage CMS to carry this priority to its rightful conclusion and also engage beneficiaries in the evaluation of models.

Patients who are diagnosed with a serious illness like cancer often have no choice but to become extremely engaged in the healthcare system. This is also true of not only of patients in active cancer treatment, but also their caregivers and family members. Many cancer patients enter survivorship more educated and engaged in healthcare and benefits, and are interested in staying engaged and making improvements for future cancer patients. ACS CAN has the pleasure of working with many such cancer patients, survivors and caregivers. In addition to reaching out directly to patients, ACS CAN encourages CMS to engage with patient advocacy groups like ACS CAN to better reach the right patients and incorporate patient perspectives.

ACS CAN supported and participated in the writing of the Healthcare Transformation Task Force's Guiding Principles for Addressing Consumer Priorities in Value-Based Care. The guiding principles specify that when created APMs, healthcare systems: 1) include patients/consumers as partners in decision-making at all levels of care, 2) deliver person-centered care, 3) design alternative payment models (APMs) that benefit consumers, 4) drive continuous quality improvement, 5) accelerate use of person-centered health information technology, and 6) promote health equity for all.

For more information and detailed recommendations, please visit:
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?
No comment.

Physician Specialty Models

Physician Specialty Models

The Innovation Center is interested in increasing the availability of specialty physician models to improve quality and lower costs and engage specialty physicians in alternative payment models, especially for independent physician practices. One potential option may be to include specialty physician management of a defined population of beneficiaries with complex or chronic medical conditions, including multiple chronic conditions. This may include the specialist serving as the primary source of care and providing care coordination for medically complex beneficiaries. Another option may be paying healthcare providers for limited episodes of care based on quality measure performance and competitive pricing. For cancer care in particular, a model could test full prepayment for Medicare and Medicaid beneficiaries, with care provided in collaborative networks, possibly incorporating elements from the existing Oncology Care Model. CMS solicits feedback from the provider community, patient and consumer advocacy groups, and other stakeholders regarding their best ideas for new physician specialty models and appropriate quality measures.

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended Models

In addition to creating MIPS and Advanced APMs, MACRA also creates incentives for physicians to participate in Alternative Payment Models (APMs), including the development of physician-focused payment models (PFPMs). Section 101(e)(1) of MACRA creates the Physician Focused Payment Model Technical Advisory Committee (PTAC). PTAC makes comments and recommendations to the Secretary on proposals for physician-focused payment models submitted by individuals and stakeholder entities. The Secretary may choose to recommend Innovation Center testing of models recommended by PTAC.

Do you have comments on the guiding principles or Physician Specialty Models?
Yes

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Innovation Center's guiding principles and focus areas. 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.

ACS CAN is supportive of expanding the availability of physician specialty models, which we believe have the potential to provide high-quality and high-value health care to Medicare beneficiaries. Physician specialty models have the potential to provide more patients with the type of patient-centered care for which we have long advocated: care that is tailored to meet high standards of quality care and to accomplish the goals of the patient. In particular, we believe there is great opportunity in creating physician specialty models focused on the provision of palliative care. Palliative care is by definition "patient-centered care," which is called for in the Innovation Center guiding principle #3 – it empowers beneficiaries, their families and caregivers to take ownership of their health. ACS CAN believes that all patients with a serious diagnosis of cancer should have access to palliative care, but we recognize that palliative care providers sometimes struggle creating sustainable programs. We are excited about the opportunities to create physician specialty models that could address some of these programs.

We are also excited about the potential for physician specialty models that embody Innovation Center guiding principle #3 by designing models around the specific needs of patients and with patient input in those designs. While we recognize that physicians are crucial participants in physician specialty models, we urge CMS to continue to find ways to engage patients in the design, implementation and evaluation of such models. For recommendations regarding such patient engagement, see response below and the Healthcare Transformation Task Force's Guiding Principles for Addressing Consumer Priorities in Value-Based Care (citation provided below).

Regarding one of the Innovation Center's existing models, ACS CAN continues to be very supportive of the Oncology Care Model (OCM), and is pleased to see that CMS implies it could be a model for other physician specialties. We believe the process used to develop and implement the OCM has embodied the Innovation Center guiding principle #5: transparent model design and evaluation.

We are also very interested in opportunities to expand the OCM. We are interested in the proposal for CMS to move forward with consideration of a "prepayment model for Medicare and Medicaid beneficiaries, with care provided in collaborative networks." ACS CAN hopes to work closely with CMS staff to explore such a model, as we have in the past encouraged CMS to expand the OCM to include beneficiaries from the point of their diagnosis. We encourage CMS to use a similar process to the original OCM that includes early outreach to stakeholders including patient groups to develop and implement this model. While ACS CAN is supportive of the concept, we know that the details of implementation matter a great deal, and we stand ready to work with CMS to get those details right.

Additionally, ACS CAN agrees that care for beneficiaries with complex or chronic medical conditions, including multiple chronic conditions, is a worthwhile focus for CMS under this category of model development. We know that often when a patient is diagnosed with cancer, her oncologist or palliative care specialist becomes her primary care doctor – coordinating her care amongst other cancer doctors, and also care for other conditions she may have. The medically complex/seriously ill/high-cost, high-need population would potentially benefit from new models focused on the intense care needed by these beneficiaries. Currently, fee-for-service incentives, and even shared savings options like the Independence at Home demonstration, do not provide sufficient upfront funding for the multi-disciplinary, time-intensive, 24/7 responsive care that is needed for these patients. ACS CAN encourages CMS to consider two patient-centered models currently being considered by PTAC: the Advanced Care Model and the Patient and Caregiver Support for Serious Illness model.

Citations:

Healthcare Transformation Task Force. Guiding Principles for Addressing Consumer Priorities in Value-Based Care. August 2016.
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

See this link for more information regarding the proposed Advanced Care Model:
https://aspe.hhs.gov/system/files/pdf/253406/ACM.pdf

See this link for more information regarding the Patient and Caregiver Support for Serious Illness proposal: https://aspe.hhs.gov/system/files/pdf/255906/ProposalAAHPM.pdf

What Physician Specialty Model designs should the Innovation Center consider that are consistent with the guiding principles?
ACS CAN supports the creation of physician specialty models that can help patients who are seriously ill receive coordinated, patient-focused care like palliative care. We encourage CMMI to seriously consider the Patient and Caregiver Support for Serious Illness and the Advanced Care Model Service Delivery and Advance Alternative Payment Model submitted to PTAC.

ACS CAN also believes cancer patients have the best outcomes if they are provided coordinated, patient-focused care like palliative care from the point of diagnosis. Therefore, we support expanding the OCM or creating a new physician specialty model that incorporates cancer care from point of diagnosis. We also support the creation of additional models that directly focus on care coordination, chronic care management or palliative care from point of diagnosis.

Citations:
See this link for more information regarding the proposed Advanced Care Model:
https://aspe.hhs.gov/system/files/pdf/253406/ACM.pdf

See this link for more information regarding the Patient and Caregiver Support for Serious Illness proposal: https://aspe.hhs.gov/system/files/pdf/255906/ProposalAAHPM.pdf

Do you have suggestions on the structure, approach, and design of potential Physician Specialty Models? Please also identify potential challenges or risks associated with any of these suggested models.
Yes

As CMS creates, implements and evaluates specialty physician models, it must ensure that policies in the models do not: 1) discourage providers from taking on sicker patients who are likely to have worse outcomes; 2) disadvantage providers that treat the sickest patients; or 3) disadvantage small-practice or community providers. Any of these possible consequences, while unintended, could have a major impact on cancer patient access to providers and treatments.

ACS CAN believes that the way to avoid such unintended consequences is to ensure that all physician specialty models have adequate risk adjustment and robust evaluation component that uses the right quality measures. These quality measures are important in measuring the success (and level of payment/savings) of providers within the model, and they are also crucial to evaluating the overall success of the model. To evaluate quality performance and ensure delivery of high-quality care to patients, any new models should incorporate ongoing assessment of quality outcomes and care experience, public reporting of quality performance data and implementation of continuous quality improvement programs. Quality data should be measured, tracked and inclusive of patient-reported data, including patient-report outcomes and care experience for patients and family caregivers.

In particular, measurement of and reporting on patient experience of care and patient reported outcomes should provide actionable data that helps providers improve care delivery and supports informed consumer decision making with respect to choosing health plans, providers and care settings.

ACS CAN notes that the National Quality Forum has a Cancer Standing Committee that oversees a portfolio of tested and evidence-based cancer measures. More information is available at http://www.qualityforum.org/Cancer.aspx. The National Quality Forum also operates a Geriatrics and

Palliative Care Standing Committee that oversees measures regarding geriatric issues, palliative care, and end of life care. More information is available at http://www.qualityforum.org/Geriatrics_and_Palliative_Care.aspx

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?
No comment.

How can CMS further engage beneficiaries in development of Physician Specialty Models and/or participate in new models?
ACS CAN is pleased to see that CMS has made engaging beneficiaries such a priority in the development and implementation of new models. We encourage CMS to carry this priority to its rightful conclusion and also engage beneficiaries in the evaluation of models.

Patients who are diagnosed with a serious illness like cancer often have no choice but to become extremely engaged in the healthcare system. This is also true of not only of patients in active cancer treatment, but also their caregivers and family members. Many cancer patients enter survivorship more educated and engaged in healthcare and benefits, and are interested in staying engaged and making improvements for future cancer patients. ACS CAN has the pleasure of working with many such cancer patients, survivors and caregivers. In addition to reaching out directly to patients, ACS CAN encourages CMS to engage with patient advocacy groups like ACS CAN to better reach the right patients and incorporate patient perspectives.

ACS CAN supports and participated in the writing of the Healthcare Transformation Task Force's Guiding Principles for Addressing Consumer Priorities in Value-Based Care. The guiding principles specify that when created APMs, healthcare systems: 1) include patients/consumers as partners in decision-making at all levels of care, 2) deliver person-centered care, 3) design alternative payment models (APMs) that benefit consumers, 4) drive continuous quality improvement, 5) accelerate use of person-centered health information technology, and 6) promote health equity for all.

For more information and detailed recommendations, please visit:
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?
No comment.

Prescription Drug Models

CMS wants to test new models for prescription drug payment, in both Medicare Part B and Part D and State Medicaid programs that incentivize better health outcomes for beneficiaries at lower costs and align payments with value. Models that better align incentives and engage beneficiaries as consumers of their care can continue to improve patient outcomes while controlling drug costs. Models that contemplate novel arrangements between plans, manufacturers, and stakeholders across the supply chain, including, but not limited to innovative value based purchasing arrangements, and models that would increase drug pricing competition while protecting beneficiaries' access to drugs are of particular interest.

Do you have comments on the guiding principles or Prescription Drug Models?
Yes

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Innovation Center's guiding principles and focus areas. 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.

ACS CAN believes that there is merit in testing new payment models that focus on or include prescription drugs. These models, especially bundled payment models, have the potential to make out-of-pocket costs for consumers and payers more affordable. However, such models must be developed carefully and include crucial patient protections, including:

1) Access to Innovative Therapies: Cancer patients need to have access to the latest and most effective cancer therapies. Safeguards must be in place to ensure that a model does not create a disincentive for the provider to use or prescribe the most effective drug therapies.

2) Payment for Risk: Models must be risk adjusted so that there are no disincentives for providers to accept higher-costs patients.

3) Protection Against Cost-Shifting: Payment models that simply shift greater costs onto beneficiaries are not acceptable.

4) Payment for Full Cost of Episode: Payment bundles and other models should encompass the full cost of an episode of care, such as the full course of chemotherapy or radiation treatment, across all providers and all settings.

5) Ability to Appeal: If, as a result of a bundled payment or other requirement of a model, a decision is made to exclude a particular prescription drug from the treatment regimen patients using or needing that drug must have the ability to appeal the decision.

6) Transparency: Patients need to know specifically what items, services and prescription drugs are included in a payment bundle or other cover provided via a payment model, as well as the duration of the payment period, and their total out-of-pocket liability.

7) Measuring Impact: Any bundled payment or other payment model approach should include metrics – including patient experience metrics – that measure the overall effectiveness of the program on both reducing costs for patients and payors as well as improving quality.

How can CMS further engage beneficiaries in development of Prescription Drug Models and/or participate in new models?
ACS CAN is pleased to see that CMS has made engaging beneficiaries such a priority in the development and implementation of new models. We encourage CMS to carry this priority to its rightful conclusion and also engage beneficiaries in the evaluation of models.

Patients who are diagnosed with a serious illness like cancer often have no choice but to become extremely engaged in the healthcare system. This is also true of not only of patients in active cancer treatment, but also their caregivers and family members. Many cancer patients enter survivorship more educated and engaged in healthcare and benefits, and are interested in staying engaged and making improvements for future cancer patients. ACS CAN has the pleasure of working with many such cancer patients, survivors and caregivers. In addition to reaching out directly to patients, ACS CAN encourages CMS to engage with patient advocacy groups like ACS CAN to better reach the right patients and incorporate patient perspectives.

ACS CAN supports and participated in the writing of the Healthcare Transformation Task Force's Guiding Principles for Addressing Consumer Priorities in Value-Based Care. The guiding principles specify that when created APMs, healthcare systems: 1) include patients/consumers as partners in decision-making at all levels of care, 2) deliver person-centered care, 3) design alternative payment models (APMs) that benefit consumers, 4) drive continuous quality improvement, 5) accelerate use of person-centered health information technology, and 6) promote health equity for all.

For more information and detailed recommendations, please visit:
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

Medicare Advantage (MA) Innovation Models

CMS wants to work with Medicare Advantage (MA) plans to drive innovation, better quality and outcomes, and lower costs. CMS seeks to provide MA plans the flexibility to innovate and achieve better outcomes. CMS is currently implementing an MA plan model, the Medicare Advantage Value-Based Insurance Design (VBID) model, that provides benefit design flexibility to incentivize beneficiaries to choose high-value services; but this model could be modified to provide more flexibility to MA plans and potentially add additional states. More generally, CMS is interested in more models in the MA plan space and regulatory flexibility as necessary for purposes of testing such models. CMS is potentially interested in a demonstration in Medicare Advantage that incentivizes MA plans to compete for beneficiaries, including those beneficiaries currently in Medicare fee-for-service (FFS), based on quality and cost in a transparent manner. CMS is also interested in what additional flexibilities are needed regarding supplemental benefits that could be included to increase choice, improve care quality, and reduce cost. Additionally, CMS seeks comments on what options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as alternatives to FFS and MA.

Do you have any comments on the guiding principles or Medicare Advantage (MA) Innovation Models?
Yes

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Innovation Center's guiding principles and focus areas. 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.

ACS CAN is supportive of the MA program. However, we recognize that the majority of Medicare beneficiaries are not enrolled in MA programs. While developing new models for MA programs could benefit some enrollees and MA programs may provide a convenient testing ground for new concepts, we hope that CMS will look beyond the MA program and make changes that will benefit all Medicare beneficiaries. We also caution CMS that while flexibility for MA plans is good, some policy changes could unintentionally disadvantage beneficiaries who remain in traditional fee-for-service Medicare. These tend to be the very the beneficiaries who could most benefit from improvements in chronic or complex care, and who are the costliest patients. ACS CAN urges CMS to take lessons from any models implemented in the MA program and find solutions for implementing them in the fee-for-service population.

What Medicare Advantage (MA) Innovation Model designs should the Innovation Center consider that are consistent with the guiding principles?
ACS CAN shares CMS' goals of using payment models like Medicare Advantage to provide high quality care to beneficiaries – and to give providers the flexibility to provide the best care they can. We note, however, that sometimes this highest quality care for a cancer patient involves enrollment in a clinical trial. Yet under current Medicare policy beneficiaries enrolled in MA plans are required to relinquish their MA coverage and revert to fee-for-service Medicare if they want to participate in a clinical trial.

ACS CAN is concerned that this policy creates a strong disincentive for MA beneficiaries to enroll in clinical trials. For many serious or life-threatening diseases – like cancer – clinical trials may offer the best hope for successful treatment. Further, Medicare beneficiaries are notoriously underrepresented in clinical trials and, as a result, the effectiveness of a particular therapy in the Medicare population may not be known until after the product is introduced into the general marketplace. Thus, the Medicare program should consider incentivizing beneficiaries – not creating disincentives – to participate in clinical trials. We encourage CMS to explore creating these incentives within the MA problem as part of its new direction for the Innovation Center.

How can CMS further engage beneficiaries in development of Medicare Advantage (MA) Innovation Models and/or participate in new models?
ACS CAN is pleased to see that CMS has made engaging beneficiaries such a priority in the development and implementation of new models. We encourage CMS to carry this priority to its rightful conclusion and also engage beneficiaries in the evaluation of models.

Patients who are diagnosed with a serious illness like cancer often have no choice but to become extremely engaged in the healthcare system. This is also true of not only of patients in active cancer treatment, but also their caregivers and family members. Many cancer patients enter survivorship more educated and engaged in healthcare and benefits, and are interested in staying engaged and making improvements for future cancer patients. ACS CAN has the pleasure of working with many such cancer patients, survivors and caregivers. In addition to reaching out directly to patients, ACS CAN encourages CMS to engage with patient advocacy groups like ACS CAN to better reach the right patients and incorporate patient perspectives.

ACS CAN supports and participated in the writing of the Healthcare Transformation Task Force's Guiding Principles for Addressing Consumer Priorities in Value-Based Care. The guiding principles specify that when created APMs, healthcare systems: 1) include patients/consumers as partners in decision-making at all levels of care, 2) deliver person-centered care, 3) design alternative payment models (APMs) that benefit consumers, 4) drive continuous quality improvement, 5) accelerate use of person-centered health information technology, and 6) promote health equity for all.

For more information and detailed recommendations, please visit:
https://static1.squarespace.com/static/548b623fe4b0991231a05ff0/t/57ab68e98419c2acafa34a5e/1470851306250/HCTTF_Addressing+Consumer+Priorities+in+Value-Based+Care+White+Paper__FINALPDF++FOR+DISTRIBUTION.pdf

Final Question

Are there any other comments or suggestions related to the future direction of the Innovation Center?

Yes

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Innovation Center's guiding principles and focus areas. 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.

ACS CAN views the Innovation Center as a crucial tool in improving healthcare and reducing costs in this country, and specifically in improving the healthcare for cancer patients and survivors. We are pleased to see that policymakers intend to use the Center to continue testing innovations and finding solutions to our healthcare delivery challenges. We have appreciated the open, transparent process CMMI has used in creating and implementing some of its most recent models, including the Oncology Care Model (OCM). We encourage the Innovation Center to continue to reach out to stakeholders early in the process of model development, and also to allow stakeholders to participate during multiple points of the model development and implementation process. We trust this will indeed continue given that "transparent model design and evaluation" is one of the guiding principles identified in the survey for the Innovation Center's "new direction." ACS CAN stands ready to work with the Innovation Center in continuing to accomplish our shared goals.

Regarding an already-existing CMMI model, ACS CAN is supportive of the Medicare Care Choices Model, which allows Medicare beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers. ACS CAN encourages CMS to continue to evaluate this model and make course-corrections where necessary. We support the recommendations contained in the letter sent by the Patient Quality of Life Coalition (of which ACS CAN is a leading member) to Dr. Patrick Conway on August 21, 2014, including: 1) work with organizations who are experts in palliative care and hospice during the evaluation of this model to ensure that the inferences drawn from the evaluation are as accurate as possible; 2) narrowly tailor research questions, and inferences made from the results, to the model that is being studied during evaluation of the model; and 3) consider amending the eligibility criteria to include beneficiaries who within the previous twelve months meet two criteria: (a) have experienced three office visits and (b) have two inpatient hospitalizations (hospital observation admissions or emergency room visits).

Beyond considering these changes to the eligibility criteria for the Medicare Care Choices Model, we also urge CMS to consider further expanding the model – or create a new model – to include the provision of palliative care services at the point of diagnosis of a serious illness. Palliative care is beneficial to patients, healthcare systems, and to cost-savings, from the point of diagnosis of a serious illness.