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June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
104 Hart Senate Office Bldg.
Washington, DC 20510

The Honorable Johnny Isakson
Senate Finance Committee
131 Russell Senate Office Bldg.
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Mark Warner
Senate Finance Committee
475 Russell Senate Office Bldg.
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

I am pleased to provide recommendations on behalf of the American Society of Clinical Oncology (ASCO) on evidence-based approaches for improving the care of Medicare beneficiaries with chronic conditions. ASCO is a national organization representing over 35,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis, and prevention. ASCO members also are dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans, including Medicare beneficiaries.

We strongly support the focus of the Senate Finance Committee's chronic care working group on identifying strategies to address the difficult challenges involved in caring for individuals with chronic diseases. We note that over the past two decades the outcome for many patients with cancer has improved such that this is now a chronic disease for a growing number. Oncology care is one of the most important and challenging aspects of chronic care management facing our nation, and the majority of new cancer cases are diagnosed in individuals who are over 65. The traditional approach under fee-for-service Medicare to outpatient oncology care is outdated, emphasizing outmoded codes for face-to-face office visits with clinicians and the intravenous administration of anticancer drug regimens. Unfortunately, the current Medicare codes and payment levels are inadequate to describe and support the complete scope of oncology services that are necessary to

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provide cancer patients with the high-quality, high-value oncology care they require and deserve.

There has been significant work in the area of developing transformative models in oncology care that rely on the delivery of an expanded set of professional services that promote efficiencies and reduce the odds of avoidable adverse outcomes, such as unplanned hospitalizations and unplanned emergency department visits. By providing adequate resources to oncology practices for the full scope of medically necessary services, these new models take a patient-centered approach to promoting value and improved patient outcomes in oncology care with the ability to achieve lower aggregate expenditures under Medicare. As a number of initiatives in the private sector have demonstrated, the financial savings that can be achieved by transforming the oncology delivery model are significant.^{1,2}

Although there are a number of positive aspects within the Oncology Care Model (OCM) recently initiated by the Innovation Center within the Centers for Medicare & Medicaid Services (CMS), the OCM and other payment innovations introduced under Medicare in recent years fall short in addressing many of the issues you raise. Successful transformation of care in oncology requires testing of multiple oncology models under Medicare and we urge your support in accomplishing this without delay.

While Congress took an important step in incentivizing adoption of alternative payment models in MACRA, current models being tested for oncology are extremely limited. Models developed outside of CMS need to be tested immediately in order to understand the impact on practices, patients and the Medicare program. We urge you in the strongest possible terms to allow CMS to mandate and the flexibility to expedite CMS piloting of models like ASCO's Patient-Centered Oncology Payment model.³

The volunteer group that developed this model was composed of individuals with significant experience implementing alternative payment models and oncology medical homes, including more than 30 leading medical oncologists, seasoned oncology practice administrators and experts in physician payment models.

ASCO's Patient-Centered Oncology Payment (PCOP) model moves away from fee for service Medicare, matches payments to the services patients need, including care coordination, treatment planning and survivorship planning, and offers a range of options for practices to engage, depending on where they are in the transformation process. It allows practices to organize care in the way that best meets their environment and, because it is not driven by

¹ Newcomer LN, Gould B, Page RD, Donelan SA and Perkins M. Changing physician incentives for affordable, quality cancer care: result of an episode payment model. *Journal of Oncology Practice*. 2014; 10: 322-326.

² Sprandio JD. Oncology patient-centered medical home. *Journal of Oncology Practice*. 2012; 8: 47s-49s.

³ American Society of Clinical Oncology. Patient-Centered Oncology Payment Model: Payment Reform to Support Higher Quality, More Affordable Cancer Care. May, 2015. Available at:

<http://www.asco.org/advocacy/physician-payment-reform>

face to face encounters with physicians, allows flexibility to optimize participation by all members of the health care team. The PCOP targets all three of the bipartisan goals for proposed policies to improve outcomes for Medicare beneficiaries with chronic conditions. It increases resources for care coordination and other vital services required by patients with cancer, it simplifies the current payment system and it includes accountability for the quality and value of care provided.

There is a significant sense of urgency in moving forward to test multiple transformative models in the chronic care of cancer. The flaws in the current reimbursement system are undermining one of our most important national resources for providing high-quality, high-value oncology services. According to a recent report by the Community Oncology Alliance, the past 7 years has seen more than 300 community-based oncology practices close and over 500 community-based oncology practices have been acquired by hospitals. Nearly 400 community-based oncology practices report that they are struggling financially. In ASCO's 2015 State of Cancer Care in America report, practices continued to signal the trend toward consolidation and closure, reporting cost and payer pressures as their most pressing concerns with 146 practices reporting they were planning to close or sell their practice.

In addition to PCOP, ASCO is actively engaged in other initiatives to advance high value, patient centered care:

The ASCO Value Framework

Value and cost are among the biggest issues in healthcare today, however there are few tools to help doctors and patients objectively assess benefits, side effects and costs. To address this need, ASCO has developed a conceptual framework for assessing the value of new cancer treatment options based on clinical benefit, side effects, and cost. The framework will serve as the basis for simple, standardized tools that doctors can use with their patients to discuss the relative value of new cancer therapies over existing ones. ASCO is developing the framework at a time when patients are increasingly affected by the costs of cancer care. Costs have risen sharply in recent years, and cancer drugs are the fastest-growing component of these costs. Newly approved cancer drugs now cost an average of \$10,000 per month, with some exceeding \$30,000 per month. Many patients are feeling the impact because they pay a significant share of drug costs through health insurance deductibles, co-payments, and other out-of-pocket expenses. The ASCO Value Framework, published in the Journal of Clinical Oncology, was developed by ASCO's Value in Cancer Care Task Force, with input from oncologists, patient advocates, representatives of the pharmaceutical and insurance industries, and others. ASCO is now soliciting comments on the framework, which is available online at www.asco.org/value.

Value Measures in Oncology

As demand to curb healthcare costs has grown, measure development is increasingly being focused not only on improving the quality of care, but also on reducing its cost. With the proliferation of national and state value-based health care initiatives, there is a strong need

for consistency in how value is defined and measured in oncology. Reaching agreement on meaningful and valid measures will depend on collaborative partnerships across the entire continuum of healthcare stakeholders. To address this need, ASCO has assembled a multi-disciplinary group including oncology providers, payers, and patient advocates to develop an initial core set of measures to assess value in cancer care. Through a consensus-based process, the group will develop a set of criteria for measuring value in oncology and identify an initial set of measures. Once developed, the measures will be tested among payers and, it is hoped, ultimately adopted at a national level. Our goal is to: 1) achieve a common set of value measures in oncology and 2) see these measures used in performance assessment and recognition programs, consumer ratings, payment models and other initiatives across all payer, provider, consumer and standard setting organizations. A common understanding—and measurement—of value in oncology will streamline reporting, reduce administrative burden and—most important—produce consistent high value, high quality care for our patients.

Oral Parity and Specialty Tiers

ASCO strongly supports a pair of initiatives to reduce the out of pocket burden for cancer patients. The Cancer Drug Coverage Parity Act, S 1566, which was introduced recently in the Senate and legislation to address specialty tiers, introduced recently in the House, seek to prohibit excessive cost sharing requirements on patients.

The Cancer Drug Coverage Parity Act seeks to resolve the so-called “oral parity” issue by requiring private health insurance plans offering intravenous cancer drug benefits to provide parity for orally administered and self-injectable cancer drugs. While scientific advances have enabled oncologists to treat individuals with cancer with oral and other self-administered anticancer medications that provide clinical advantages over more traditional forms of cancer medications, some health plans have begun to impose significantly higher cost sharing requirements (copayments, coinsurance, etc.) on cancer patients for oral cancer drugs than for intravenous or injected cancer drugs. The cost sharing burdens imposed on patients for oral cancer drugs are often insurmountable, making the treatment inaccessible for the patient. We urge you to pass S. 1566 without delay.

Similarly, the imposition of high cost-sharing requirements, including co-payment and co-insurance, to prescription drugs in a specialty drug tiers for non-preferred brand drugs is increasingly becoming a barrier for cancer patients. Legislation in the House of Representatives, the Patients’ Access to Treatments Act, H.R. 1600 would rein in excessive coinsurance practices in order to increase patient access to critical treatments. We urge you to support similar legislation in the Senate.

Thank you for the opportunity to provide these comments to the Senate Finance Committee’s chronic care working group. We hope to meet with you in the near future, and we will make our experts available to discuss these issues and to provide further guidance on next steps. If you have any questions, please do not hesitate to contact Shelagh Foster at 571-483-1612 or Shelagh.foster@asco.org.

Sincerely,

A handwritten signature in black ink on a light-colored background. The signature reads "Julie Vose" in a cursive, flowing script. The first letter 'J' is large and loops around the 'u'. The 'V' is also large and loops around the 'o'. The 'e' is written with a long, sweeping tail that extends to the right.

Julie Vose, MD, MBA, FASCO
Incoming ASCO President