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June 22, 2015

The Honorable Johnny Isaakson
Senate Finance Committee

The Honorable Orrin Hatch
Chairman
Senate Finance Committee

The Honorable Mark R. Warner
Senate Finance Committee

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee

BY ELECTRONIC DELIVERY

Re: Chronic Care Working Group

Dear Chairman Hatch, Ranking Member Wyden, Senator Isaakson and Senator Warner,

The Association of Community Cancer Centers (ACCC) appreciates this opportunity to provide comments on chronic disease management in the Medicare population. ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC represents more than 20,000 cancer care professionals from approximately 1,100 hospitals and more than 1,000 private practices nationwide. These include Cancer Program Members, Individual Members, and members from 32 state oncology societies. It is estimated that 60 percent of cancer patients nationwide are treated by a member of ACCC. Our members encounter chronically ill patients daily, including both those with non-cancer chronic disease and those with cancer that through drug and other treatments has become a manageable chronic disease.

ACCC commends the Senate Finance Committee for taking up this important issue of chronic disease care. This is increasingly important to the oncology profession as new treatments transform many cancers into chronic diseases, and as cancer patients increasingly require care for non-cancer chronic diseases. Our members are on the front line interfacing directly with patients, and they see the impact of rising healthcare costs. ACCC would like to be part of this dialogue and offer our input. There are key considerations that will need to be addressed as this transformation in oncology care occurs. Payment systems need to better account for the costs of caring for chronic cancer patients. Furthermore, as patients become stable and no longer need intensive oncology services, and as patients increasingly present with non-cancer chronic disease, coordination between primary care and oncology professions will need to improve. The rising burden on patients to cover the cost of chronic cancer drugs needs to be addressed to ensure patients have access to life-saving treatments. Finally, as more patients are now living with cancer, the oncology workforce needs to grow to meet the needs of this rising patient population.

Payment Reform

Cancer is becoming a chronic condition, but payment systems are designed for acute care. We have seen the introduction of a Medicare alternative payment model specific to oncology, the Oncology Care Model (OCM), and welcome this effort toward tying payments for cancer care to value. However, the OCM is limited in both participation numbers and duration, and notably, is focused on payment for acute episodes of care requiring treatment with specific chemotherapy agents. Payment models specific to other cancer treatments, such as radiation oncology, also should be considered. Expansion of private payer episode-based bundled payments for radiation therapy services underway since 2012¹, as well as the American College of Radiation Oncology's proposal to include episode-based bundled payments for radiation therapy services under Medicare alternate payment models are two examples.

A comprehensive oncology payment model that accounts for cancer treated as a chronic condition requires a payment system that incorporates costs of stable patient monitoring and medication management. A care monitoring fee for stable patients is one option (*see the American Society of Clinical Oncology's payment model*). CMMI's Comprehensive End Stage Renal Disease Care Model may also be utilized as a model of chronic disease treatment. This 3-year model is set to commence this summer and may provide a useful example of a system for long-term coordinated treatment of chronic disease.

ACCC also suggests the creation of an Medicare Accountable Care Organization (ACO) model that includes oncology services, and an oncology specific ACO model. These models would allow for the long-term and coordinated care of chronic cancer patients and cancer patients with non-cancer chronic disease, ensuring adequate care through relevant, pre-defined quality measures. Patients would be assigned to these ACOs based on the care they receive from specialists who most often are involved in treating cancer, including oncologists, hematologists, radiation oncologists, and radiologists. The Centers for Medicare & Medicaid Services (CMS) could test new payment models for these ACOs that would encourage better coordination of care for beneficiaries being treated for cancer. CMS can look to ACOs created by private payers and providers, such as the oncology ACOs created by First Coast, Moffitt Cancer Center in Tampa, and Baptist Hospital in Miami, for models in developing an oncology ACO model for Medicare.

As these models are developed, it is essential that they include appropriate financial incentives to ensure that patients have access to the most appropriate care for their cancers and other chronic conditions. In addition to using suitable quality measures to determine whether participants qualify for shared savings, the models must include other mechanisms to protect access to high-quality care. For example, risk adjustment methods must recognize differences in patient populations so that practices that treat particularly difficult or rare cancers are not penalized. Costs and benefits must be assessed over a relevant time period for each type of cancer and treatment regimen so that short-term savings are not valued over long-term outcomes. The costs of new drugs and other treatments should be excluded from spending benchmarks, so that providers are not discouraged from providing the latest advancements in care, and patients should be encouraged to participate in clinical trials so that cancer care can continue to evolve.

¹ Reuters, *21st Century Oncology and Humana Break New Ground with Case Rate Reimbursement Agreement*, 8 August 2012

Care Coordination

Cancer patients may indeed have other chronic illnesses and their overall care must be managed in a coordinated manner. If primary care doctors are to manage patient care, it will be important for oncology practices to convey necessary information, including any limitations in exposures to radiation, hormones, or other agents, to primary care professionals. In the case of stable chronic cancer patients, care may be transferred to the primary care setting, freeing oncology programs to manage treatment of acute disease states. However, there must be a mechanism for oncologist oversight of chronic patient screenings and tests, as well as medication management. Additionally, patient education will be necessary if chronic cancer care management is to be transferred to the primary care setting, ensuring patients know where to bring health concerns. Chronic cancer patient care decision-making should include input from the treating oncologist as well as the primary care physician and other specialist physicians. Any legislative change should account for the unique challenges of chronic disease treatment by specialty programs. It is key to not hamper patient access to specialty providers, nor create disincentives for primary care doctors to send patients to specialists when there is truly a need.

Financial Burdens on Patients

The cost of cancer care is unique in that a significant portion is attributable to drug costs. In the case of many cancer patients, access to affordable drugs transforms an acute, life-threatening disease into a chronic manageable one. Barriers to drug access include high cost-sharing and non-coverage of necessary drugs. While limiting co-pays and restricting placement of drugs on specialty tiers may provide for better patient access, it will likely increase Medicare and insurer spending. Drug costs for chronic cancer patients may need to be evaluated in contrast to acute disease management costs that would result without these drugs. Insurers that cover the high upfront cost of a life-saving treatment need a mechanism for realizing savings through improved long-term patient health. ACCC supports several legislative efforts to increase patient access to needed cancer drugs. Specifically, we support legislation to ensure oral chemotherapy treatments are covered equivalently to provider administered chemotherapy (S 1566/ HR 2739).

Workforce Issues

As a result of better treatments that enable many cancers to become chronic diseases, more people are now living with cancer for longer periods of time. While this is a wonderful outcome, it does stretch providers' resources, and we anticipate a need for more cancer care providers of all disciplines in the coming years. Any effort to address chronic care should include provisions that encourage growth in the care provider workforce. Measures including loan repayment programs, training programs, and even preferred immigration status for needed healthcare workers would alleviate this impending worker shortage.

Thank you for this opportunity to share the oncology care provider perspective on chronic care treatment reform policies. As the association representing the multidisciplinary cancer team, ACCC is uniquely suited to participate in this dialogue. Please feel free to contact Leah Ralph, Manager,

Provider Economics and Public Policy, at (301) 984-5071 if you have any questions or need any additional information. Thank you again for your attention to this very important matter.

Respectfully submitted,

A handwritten signature in cursive script that reads "Steven D'Amato".

Steven D'Amato, BSPHarm, BCOP
President
Association of Community Cancer Centers