Community Oncology Alliance
Dedicated to high quality, affordable, and accessible cancer care

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June 19, 2015

The Honorable Orrin Hatch
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

This letter is in response to your request for "*recommendations and thoughtful policies from health care stakeholders based on real world experience and data-driven evidence that will improve care for this vulnerable population* [Medicare patients with chronic conditions]." The Community Oncology Alliance (COA) is a non-profit organization dedicated to preserving and fostering cancer care in the community setting, where close to 70% of Americans with cancer are treated. Although in the past thought of as a "death sentence," cancer is increasingly a chronic condition that adds to those other chronic medical conditions experienced by an increasing proportion of the Medicare population. As such, we offer these brief comments and welcome the opportunity to meet with committee staff to explain the initiatives outlined in this letter.

During the past 4 years, COA has been developing the Oncology Medical Home (OMH) model of cancer care and an associated oncology payment reform model. In embarking on the OMH, it is interesting to note that we mirrored the bipartisan policy goals identified for the Senate Finance chronic care working group; namely:

- Increase care coordination;
- Streamline the Medicare payment system to incentivize efficient care; and
- Increase quality while reducing costs.

What is a "Medical Home?"

In basic terms, the patient has a "medical home" that is the central coordinator of their medical care, and as importantly becomes a source of hope and comfort. Typically, the medical home is a primary care physician who becomes the point person for coordinating the patient's total care, including both primary and specialty care. The theory is that the medical home model of patient-centered care results in important positive outcomes relating to the quality, efficiency, and cost of patient care by optimizing care coordination. The medical home model has been around for over 40 years and has been evolved and piloted since its introduction.

What is the Logic of an Oncology-Specific Medical Home?

At first glance, it would appear that the concept of an oncology-specific medical home flies in the face of reason by defeating the purpose of a medical home managed by the primary care physician. However, the rationale is seen in the complexity and severity of cancer treatment. When a person is diagnosed with cancer, in the majority of cases, the treatment of the cancer becomes the primary focus of medical care. Other medical care needs to be coordinated in the

context of the primary goal of treating the cancer. In many cases, the patient receives highly specialized treatment, such as chemotherapy and radiation. Chemotherapy and other types of cancer drugs are potentially toxic and require administration at the site of care by specially trained oncology nurses. These drugs can cause serious side effects that need to be treated in the context of the patient's overall cancer care.

Few primary care physicians have the expertise and facilities to administer cancer treatment. Additionally, primary care physicians are not trained or comfortable with the intensity of symptom management (e.g., related to pain, nausea/vomiting, neuropathy, and blood count management) typically required in providing cancer treatment. As such, because treating the cancer becomes the medical priority, in most cases the oncologist functions as the patient's primary medical caregiver during the phase of active cancer treatment and follow-up care.

As the medical home for the cancer patient, the oncologist is in the best position to ensure that treatment is optimized and that adverse events are minimized — with a goal of eliminating them based on process improvements. These events include treatment side effects that require additional care and, in cases, can lead to emergency room visits and/or hospitalizations, which can be detrimental to patient outcomes and substantially increase the cost of patient care.

What is the OMH Model?

The OMH model is about delivering, ensuring, and measuring quality cancer care. In short, it is a patient-focused system of delivering quality cancer care that is coordinated and efficient. As such, it is designed to meet the needs of patients, payers, and providers. Some of the key aspects of the OMH model are:

- Cancer care that is coordinated with the central focus on the patient and their entire medical condition
- Cancer care that is optimized based on evidence-based medicine to produce quality outcomes
- Cancer care that is accessible and efficient, with treatment provided in the highest quality, lowest cost setting for the patient
- Cancer care that is delivered in a patient-centric, caring environment that optimizes patient satisfaction
- Cancer care that is continuously improved by measuring and benchmarking results against other facilities providing care so that best practices "raise the bar" in delivering care

In terms of the associated oncology payment reform model, the key attributes are as follows:

- A payment system based on results (i.e., quality and value)
- Payment that is realistic in terms of maintaining the viability of the model
- A payment system that allows the right care to be delivered at the right time, without hurdles to providing care

What is the Progress of the OMH Model and Oncology Payment Reform?

COA established a Steering Committee to direct the overall efforts of the OMH initiative. The committee is comprised of oncologists, patient representatives, private payers, practice administrators, and ancillary personnel. To date, the committee has helped define the OMH model and has identified and endorsed a set of quality and value measures of cancer care. Additionally, the committee backed the development of a patient satisfaction tool, which is modification of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool. The quality/value measures have been used in several private payer pilots, as well

as in the CMMI grant project on oncology payment reform — the COME HOME project. The patient satisfaction tool, available in paper and digital formats, as well as in 5 languages, has been administered over 46,000 times to cancer patients. Furthermore, COA has worked with the Commission on Cancer to develop a comprehensive accreditation program whereby community cancer clinics can apply for and receive recognition as accredited OMHs. This accreditation program, based on the 19 measures of quality and value, was recently launched and completed in a pilot program with 10 community oncology practices.

Results with private payer and Medicare pilots of the OMH model and associated oncology payment reform have been very encouraging in terms of enhancing the measurable quality of care and decreasing the measurable cost of cancer care. These pilots have successfully accomplished some of the key objectives stated by the chronic care working group.

In terms of broadening the oncology payment reform initiative, COA has worked with the bipartisan team of Congresswoman Cathy McMorris Rodgers and Congressman Steve Israel in developing and introducing legislation that creates a demonstration project on oncology payment reform based on the OMH model. I have attached a summary of the *Cancer Care Payment Reform Act of 2015* (H.R. 1934) in the email with this letter. It is interesting that this legislation deals with many of the specific issue areas listed in your request for comment letter of May 22, 2015. The basis for the underlying OMH and oncology payment reform model in H.R. 1934 is successful pilot programs that have been completed by private insurers.

As I related in the introduction to this letter, we welcome the opportunity to discuss the OMH, and associated oncology payment reform, as a proven way of addressing not only the increasing cost of cancer care but also as a model for other areas of medicine in managing chronic diseases. There are many learnings from pilot programs conducted to date. In fact, COA brought together over 120 private payers, oncology providers, and industry to discuss oncology payment reform and learnings to date. I have attached a review of the *Payer Exchange Summit on Oncology Payment Reform* from the fall of 2014 in the email with this letter.

I can be reached at tokon@COAcancer.org and 203-715-0300.

Sincerely,

Ted Okon
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