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for

The American Society of Clinical Oncology

before

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"Medicare Physician Payments: Perspectives from Physicians"

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Thank you for the opportunity to participate in this important Roundtable discussion. My name is Barbara McAneny, and I am a medical oncologist practicing in New Mexico. I am here today on behalf of the American Society of Clinical Oncology (ASCO), which supports the Finance Committee's efforts to transform the Medicare payment system in a way that encourages and rewards high-quality, high-value care for individuals with cancer. Chairman Baucus and Ranking Member Hatch, we appreciate your leadership and attention to this issue.

The treatment of cancer is evolving rapidly. Great strides have been made toward more effective treatments and improved quality of life. But along with the promise of today's science have come some of the most significant challenges ever faced by our field in delivering care to our patients. Today, more than 60% of cancer occurs in Medicare beneficiaries. By 2030, due in large part to the aging of our population, that number will grow to 70%. At a time when demand for cancer care is peaking, we anticipate a 30% shortfall in the number of oncologists needed to provide care. Community oncology practices already are struggling to survive.

Clearly, Medicare will continue to be an important partner in overcoming the physical, social and economic burden cancer poses for our patients and our nation. The current fee for service Medicare payment system does not necessarily reward high quality, cost effective care and the annual debate over the sustainable growth rate (SGR) formula has created instability in physician practices—a situation that is eroding what has been a highly effective network of care. Oncologists, like all physicians, hope that Congress can achieve a more rational and sustainable system of payment—and soon. We look forward to working with you toward our vision of a fair and responsible system that rewards evidence-based care and recognizes the many cognitive services, like end of life counseling, that are critical to treating patients with cancer.

As the world's leading specialty society representing over thirty thousand physicians who treat people with cancer and conduct cancer research, ASCO is committed to working with you and other policy makers to ensure oncologists are equipped to provide every cancer patient the highest quality care. We welcome the opportunity to share with you information about ASCO's initiatives to incentivize and enable oncologists to provide high quality, high value care, and I am eager to share my experience as a practicing oncologist. We look forward to working closely with you in the coming weeks and months toward our shared goals.

Below is a summary of my testimony:

Any alternative to the current Medicare payment system should incentivize quality and efficiency. Achieving these important goals depends in large measure on successful establishment of a unified, comprehensive and cancer-focused quality program for Medicare. Already, thousands of oncologists practice in sites participating in ASCO's Quality Oncology

Practice Initiative (QOPI), which promotes quality. I am an active participant in QOPI and have experienced its ability to support meaningful quality improvement in my practice. But regardless of the investment oncologists make in QOPI—and it is significant—we must also report on quality through Medicare's less comprehensive PQRS program. We urge policy makers to capitalize on the considerable progress that has already been made in defining, measuring and supporting the delivery of high-quality, high-value oncology care. We stand ready to work with you toward a more rational payment framework and leveraging QOPI could be an immediate first step toward that end.

Oncology professionals are in the best position to lead transformation of care delivery and payment for oncology and more likely to adopt an oncologist-developed system. The aging of the Medicare population and the complexity of cancer represent unique challenges to the health care system, challenges that are best faced by the people who treat cancer. When engaging in payment reform discussions, we bring: the necessary clinical expertise; unique understanding of the realities of care for the cancer population; and established relationships with important stakeholders like patients and patient advocacy organizations. A reform of the payment system for oncology will be more likely to be embraced if it is done in collaboration and cooperation with the field of oncology.

New oncology care models must be tested through pilot programs and new policies should be transitioned over a reasonable period of time. However well-intentioned and well-planned, any dramatic change in the payment system has the potential for unintended consequences. Preserving continued access to care must be a guiding principle for any transformation of the payment system and can only be achieved through careful testing and measured transitions. Cancer care occurs across a wide range of practice settings and communities. We must take the time to understand how proposed policies affect all settings and the often vulnerable populations they serve. For example, many patients living in rural areas are unable to travel and depend on care close to home. Policies that have the effect of dismantling community care could exaggerate disparities that are already difficult to overcome.

Discussion:

<u>Payment System Reforms Should Build on Investments Already Made by Physician Leaders</u>

The foundation of any payment system should be to incentivize the best quality care. ASCO's quality improvement registry, QOPI, offers providers a way to judge performance against their peers and against established quality benchmarks. It promotes the six aims for high quality care outlined by the Institute of Medicine: safe; timely; effective; efficient; patient-centered;

and equitable. QOPI was designed to be highly adaptable and nimble; the quality measures change based on emerging scientific evidence and clinical guidelines, the program can evolve to meet the needs of insurers, and QOPI can be embedded within any payment system—including Medicare.

The QOPI program is robust. Its more than 100 measures of quality of cancer care have been developed and are maintained by experts in oncology and in the science of quality measurement. QOPI has been widely adopted by the oncology community, with nearly 800 practices nationwide registered. Data from more than 25,000 medical records are submitted to ASCO at each data submission. We are currently planning for integration of patient reported outcomes into ASCO quality programs.

The success of QOPI has led to demand from oncologists to continually raise the bar on quality measurement and improvement programs at ASCO. In 2010, ASCO launched the QOPI Certification Program, which offers a formal, three-year certification for oncology practices that satisfy quality measure scoring thresholds and pass a rigorous site visit assessing safety of chemotherapy administration. Since January of 2011, more than 120 oncology practices, including mine, have achieved certification. We have also tested alternate registry models, such as our recent breast cancer registry pilot. Oncologists and team members at 20 diverse practice sites submitted data on every breast cancer patient treated, and facilitated the collection of clinician and patient survey data. The breast cancer registry system reinforced data entry by generating real-time clinical treatment plan and summary documents for patients and other health care providers. These summary documents can be time-intensive to populate during routine clinical care, but are highly valued and were specifically requested in an Institute of Medicine report. The physician-patient and provider-to-provider communication enhanced through the ASCO breast cancer registry pilot are core elements of many pilot projects supported by CMMI and are essential to coordinating high quality, cost effective care.

Our experience with QOPI also has positioned ASCO as a leader in measure development for oncology. We have partnered with other national organizations (such as the AMA Physician Consortium for Performance Improvement, American Society for Radiation Oncology, and the National Comprehensive Cancer Network) to develop measures intended for use in accountability programs, including pay for performance. ASCO is actively involved in promoting cancer measures for endorsement by the National Quality Forum (NQF). We are in the process of testing electronic data submission to QOPI via electronic health records. QOPI has been acknowledged by private payers as a valuable program and many recognize QOPI participation through means such as quality designations in provider directories, reduced prior authorization requirements, and payment incentives.

A Medicare payment system that truly rewards quality and efficiency must be nimble enough to reflect rapidly changing science and practice standards. It requires a robust infrastructure, including measure development and a system for detailed clinical data submission, reporting and analysis. ASCO—like many specialty societies—has invested heavily in its quality measurement and improvement programs and is well on the way to building the next generation. The depth of disease specific expertise and investment is not one CMS is likely to duplicate—nor should it. We urge policy makers to take advantage of the work that is already being done in oncology in the area of quality measurement and improvement.

We consistently hear from oncologists that it is challenging to participate in the multiple Medicare programs intended to promote quality and adoption of HIT. These programs include the Physician Quality Reporting System (PQRS), e-Prescribing (eRx) Program, EHR Incentive Program, and Quality Resource Use Reports (QRURs) on which the new value-based modifier will be based. While ASCO strongly supports the goals of these initiatives, we have shared with CMS that these programs are often duplicative and subject to unrealistic timelines. The use of QOPI could serve as a central program to replace or streamline most of the existing CMS reporting requirements, save significant resources, and provide much more granular and meaningful information beyond what can be achieved with CMS-directed programs.

Long term, ASCO envisions a true rapid learning system, furthering our need to ensure that the right care is provided at the right time in the right setting for every patient. Within a rapid learning health care system, health information technology is leveraged to allow routinely collected, real-time clinical data to drive the process of scientific discovery, which becomes a natural outgrowth of patient care. A rapid learning system will promote evidence-based oncology practice, even as scientific discovery continues to reveal that "common cancers" actually comprise numerous distinct subtypes with unique treatment recommendations. By harnessing the power of electronic records, we can deliver decision support tools to oncologists, receive data about treatments and outcomes, analyze data to create better treatment recommendations, and modify the guidance based on resulting clinical insights. The oncology care system learns as part of ordinary practice and engages in rapid-cycle improvement. A rapid learning system will reduce unnecessary variation in care. Value will be maximized. Resources will be used far more optimally. Savings should be calculated and shared with the participants. ASCO is currently working to make such a system a reality in cancer care.

<u>Physicians are best able to lead a transformation of the delivery of care and payment system, and more likely to adopt a physician-led effort.</u>

ASCO recognizes that the current fee–for-service model of payment does not reward judicious use of resources, and we have been working with our expert volunteers to develop feasible alternatives for cancer. New models are just that: new. They are untested. Much is at stake for our patients, and it is critical that oncology providers, working with a diverse team of stakeholders including patients, take the lead in testing and assessing their sustainability and their impact on quality and access to care. Many oncologists are already exploring or participating in demonstrations through Medicare or private payers to test alternative payment models, and we believe the following models may have promise:

Patient-Centered Medical Homes (PCMHs): ASCO has a strong history of working with other groups to help frame and define the concept of a medical home within oncology. Often when patients are diagnosed with cancer, their oncologist becomes the "primary" physician during the time they are under active treatment—and frequently for sustained periods following active treatment and transition to survivorship. These patients usually require ongoing care for pre-existing medical conditions, whether from their primary care physician or other specialists. Coordination of this care is critical in order to ensure patient safety, the highest quality treatment, and patient satisfaction with and engagement in their care.

A PCMH model has potential to provide real savings to both payers and patients. Such models emphasize consistent coordination of care, aggressive symptom management, increased access to qualified professionals via a system of telephone triage or electronic means, and increased patient engagement in care decisions. They focus on avoiding emergency room visits, decreasing hospital admissions, and allowing less costly interventions when symptoms are addressed immediately. The PCMH model can result in significant savings, but its robust implementation can require significant investment by practices, including expanded health IT (EHRs, tools for patients), additional staffing for after-hours care and aggressive symptom management, focused telephone triage by trained clinical providers, and enhanced patient treatment plans and summaries. Practices have spent millions on EHRs alone, only to be left disappointed—and out of pocket—when these technologies do not adequately meet the special needs for oncologic record keeping and decision support. Demonstrations of the PCMH model in oncology are called for, but they should involve "shared savings" between practices and payers, similar to the existing Medicare Shared Savings Program.

CMS has other projects underway in which the agency has in advance provided to practices or institutions a certain percentage of anticipated savings; we believe such a model is worth considering in the context of an oncology PCMH.

Case Management Fees. In oncology, much of the cognitive work and the services that go into the management of patients are under-recognized and under-valued. Development of treatment plans and summaries—especially for complex and serious diseases such as cancer—takes time and requires experienced medical decision-making. As mentioned above, coordination of patient care among multiple physicians and disciplines is important to optimizing cancer treatment outcomes and patient satisfaction. In many circumstances, Medicare does not recognize (and hence does not reimburse) important services and activities that do not necessitate face-to-face time with the patient. A case management fee—tied to the appropriate quality indicators—could be tested in certain areas of oncology. We expand on this idea below.

Mixed models: Some models blend a case management fee, clinical care pathways, and quality incentives. In such models, physicians agree to follow predetermined treatment protocols (pathways) and are reimbursed at invoice cost for the drugs that are used. They receive a case management fee and must meet certain quality objectives. Positive updates to payments are based on meeting progressively more numerous and/or rigorous quality measures; savings are anticipated as a result of the slower growth in management fees compared to the higher expected growth in drug costs.

Bundling: ASCO earlier approached CMS with a potential demonstration project that would consist of a bundled payment, including a case management fee, for certain groups of patients with colon cancer. We would be pleased to revisit this project as we believe it could be expanded to include elements of a PCMH, along with quality measurement. Piloting such a project is critical for "proof of concept," and necessary to point the field to other pilots that could be developed, tested and—if successful—adopted more widely. We believe that this project would lead to savings first, as discussed above, due to the slower growth in management fees compared to more rapid growth in drug costs; second, depending on the menu of PCMH options included, we would expect savings from decreased emergency room use and/or decreased hospitalization rates.

For any model that contains bundled payments, episode-of-care payments, flat management fees or any other similar arrangement, it is crucial that quality of care is measured and monitored, in order to give physicians the continuous opportunity to improve practice quality and efficiencies and to ensure patient satisfaction with care.

<u>Any new payment model for oncology must be tested to avoid unintended consequences.</u>

Emerging science holds great promise for new and more effective therapies, but cancer is still an extremely complex and costly disease. It occurs largely in our most vulnerable citizens—the elderly. Advancing untested models of care could jeopardize not only quality and access to care, but further erode the increasingly fragile system that delivers care today. We urge policy makers to allow for demonstrations of promising payment systems, taking time to understand their impact and consequences.

I am a recent recipient of a grant by the Centers for Medicare and Medicaid Innovation (CMMI). Through this grant seven community oncology practices across the United States will conduct a three-year test of a medical home model of care delivery for patients with breast, lung, or colorectal cancer. Through comprehensive outpatient oncology care, including patient education, team care, medication management, and 24/7 practice access and inpatient care coordination, the medical home model will improve the timeliness and appropriateness of care, reduce unnecessary testing, and reduce avoidable emergency room visits and hospitalizations. We will explore the potential for broader application in oncology over the next three years, understanding its advantages, limitations and ability to produce savings. This deliberate and thoughtful approach—this same level of examination—should be applied to any potential model of reform before national implementation. We are prepared to partner with the Administration in that effort.

In addition to the issues we are focusing on today, there are many difficult challenges that will require ongoing collaboration among Congress, ASCO and other stakeholders. These issues include the current crisis involving shortages of clinically important oncology drugs and the anticipated future shortage of medical oncologists. We look forward to working with you as you engage in this difficult task of implementing payment reform and working to address the additional challenges that we face. Please do not hesitate to contact Shelagh Foster at shelagh.foster@asco.org or 571-483-1612 with any questions or follow up. The health care system is at a critical point and together we can transform oncology for our patients.