May 7, 2019

The Honorable Chuck Grassley  
Chair, Senate Committee on Finance  
U.S. Senate  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member, Senate Committee on Finance  
U.S. Senate  
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden,

The American Society of Clinical Oncology (ASCO) is pleased to submit comments for the Committee’s hearing, “Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead.”

ASCO is the national organization representing more than 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. We are committed to ensuring that evidence-based practices for the treatment of cancer are available to all Americans.

ASCO supported the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a replacement to the flawed Sustainable Growth Rate. Since its enactment, ASCO has educated its members on MACRA and how to make it work for both their practices and the Medicare beneficiaries they serve. We have extensive MACRA-related practice tools, webinars, and other resources readily available for our members on asco.org/MACRA.

We appreciate the Committee’s shared commitment to MACRA’s success, and we offer the following ideas for how Congress and the Centers for Medicare and Medicaid Services (CMS) can strengthen MACRA and the Medicare program.

Encourage the Creation of Value-Based Incentives that Increase Quality and Lower Cost

ASCO members practice in diverse settings, including community-based physician practices, outpatient cancer centers, teaching hospitals, and large cancer treatment centers. Our members participate in a variety of value-based payment models, including the Merit-based Incentive Payment System (MIPS), Alternative Payment Models (APMs) with private payers, the Center for Medicare and Medicaid Innovation (CMMI) sponsored Oncology Care Model (OCM) and other CMMI sponsored models. As strong advocates of high-quality, high-value care, ASCO has supported development of new payment models that include the full scope of services needed by patients facing a cancer diagnosis. We do not agree with piecemeal reforms based on cost alone.
A key component of OCM is the sharing of Medicare claims data, which provides physicians the information necessary to understand the total cost of care borne by Medicare and patients. Analysis of these data has highlighted opportunities to reduce health care costs. We have heard from participating practices that oncology-specific care management payments, such as OCM’s monthly-enhanced oncology service (MEOS) payments, provide funding to support resources such as navigators, triage nurses, and palliative care specialists. This helps to mitigate some of the costs for these previously uncovered services that are critical to quality care in oncology. We note that, for many practices, a large portion of the MEOS payment has been consumed by administrative support needed to comply with required reporting and analysis of data. This has drawn MEOS payments away from the intended patient services support and is an area where ongoing discussion will be important.

Practices participating in APMs continue to undergo transformation. Many have reported hiring clinical and financial navigators to improve coordination of care and proactively manage symptoms that would otherwise lead to acute care admissions or other long-term expenses. Practices have also employed value-based decision support tools, such as treatment and triage pathways.

Overall, participation in these payment models have resulted in reduced admissions, improved end-of-life quality measure performance, and increased patient satisfaction.

**Adopt the Patient-Centered Oncology Payment Model (PCOP)**

Medicare coding and payment for outpatient cancer treatment should be transformed by adopting proposals such as ASCO’s “Patient-Centered Oncology Payment Model” (PCOP) and implementing policies that are consistent with that model. Originally published in 2015, ASCO has recently convened a diverse team of clinicians, payer and employer representatives to update the PCOP model and incorporate learnings from OCM and multiple commercial payer models.

The updated PCOP incorporates a community-centric oncology medical home structure, that encourages a true multi-payer approach. The use of evidence-based clinical treatment pathways is a cornerstone of the PCOP model, along with measurement and rewards for high-quality, high-value care.

A draft of the updated PCOP model has been provided to the CMMI and will be submitted to the Physician-Focused Payment Model Technical Advisory Committee later this year. Should the PTAC recommend acceptance, Congressional support will be imperative for CMMI approval. ASCO is already in discussions with states and local communities who are interested in the PCOP model to advance cancer care for their population.

**Test Multiple Oncology-focused Alternative Payment Models**

ASCO urges Congress to work with CMMI to create and adapt a multi-step process for developing and implementing APMs—one that begins with limited-scale testing and then refinement or expansion of promising APMs over time. ASCO believes that by utilizing small-scale testing of multiple oncology-focused APMs, CMS can highlight potentially successful strategies for the broader community of cancer patients and oncology professionals.

For cancer, ASCO urges Congress and CMS to encourage the approval of multiple APMs because of the varied needs of cancer populations and providers. Oncology practices exist in numerous forms, and a “one size fits all” approach to payment models fails to take advantage of the strength of each of these practice structures. In this context, care should be taken not to disadvantage small and rural practices, which fulfill a crucial role in oncology care. While CMS has taken concrete steps to assist small practices participating in MIPS, such as freely available technical assistance and special considerations related to their scoring in the MIPS.
framework, small and rural practices fared less well under MIPS in the first performance year (2017): while the overall national mean score for a clinician was 74 points, clinicians in small and rural practices had national means of 43 points and 63 points, respectively. CMMI should embrace oncology-focused APMs that differ from the existing OCM, as well as from other existing models that are not specifically focused on cancer.

**Exclude Medicare Drug Cost from Resource Use in Cancer Care**

ASCO has urged CMS to exclude all Medicare Part B and D drug costs from the assessment of cost performance and refrain from increasing the weight of cost performance category in the MIPS scoring methodology until it implements a cost measurement methodology that fairly and accurately assesses resource use in cancer care.

The current cost measurement methodologies are inadequate for measuring cost performance for oncology focused providers and practices due to several unique characteristics of cancer care. Cancer is a complex disease state with multiple forms. Treatment decisions are highly dependent upon a patient’s unique medical characteristics, including their cancer morphology, cancer stage, genetic characteristics, mutation status, comorbidities and preferences. Individual physicians often specialize in treating specific types of cancer that may be especially complex or expensive to treat. Protecting the most vulnerable Medicare beneficiaries will require CMS to account for these considerations without threatening the viability of subspecialties that focus on treating certain cancers.

**Promote Interoperability**

Interoperability and the free exchange of health care information are core components to realizing the potential of a value-based health care system.

ASCO commends CMS for reforming the Promoting Interoperability (PI) performance category measures to emphasize the exchange of health information, but we remain concerned that the scoring for this category remains essentially “all or nothing,” which places a heavy penalty on practices which fail to meet one of the criteria. We understand that CMS is exploring potential options to move toward more customized scoring of this category through incentives for innovative use of HIT, and ASCO would be eager to discuss our ideas for how this could be accomplished with CMS.

Despite our many steps forward in this area, oncology practitioners are still plagued by a lack of interoperability between different types of electronic medical records (EMRs) in addition to a lack of interoperability between EMRs and other forms of health information technology including electronic systems such as registries, genomic testing laboratories, and hospital laboratory information systems. These types of technology hold great promise for improving and enhancing patient care, especially in the realm of care coordination and quality improvement. To further enhance healthcare quality, we should move with urgency towards realizing the vision of seamlessly integrated health information, easily and securely accessible to all patients.

A basic need in the field of oncology is a common, shared set of data elements used to exchange information between providers and patients. Under our CancerLinQ (CLQ®) subsidiary, ASCO is currently developing a set of “Minimal Common Oncology Data Elements” (mCODE™), an effort designed to result in a parsimonious set of consensus-developed oncology data elements necessary for critical information exchange between EHRs, for clinical care, quality reporting, and other use cases. This set of oncology data elements is envisioned by ASCO to form the basis of an initial parsimonious set of necessary data that should populate all electronic health records (EHRs) serving patients with cancer. Adoption of these data elements, which are being developed by experts in the fields of oncology and informatics, would greatly streamline the exchange of
basic needed data necessary for oncologists. The National Cancer Institute (NCI) is engaged with this project, and we look forward to collaborating with agencies such as ONC wherever possible to encourage consideration and adoption of these elements when they are finalized. We have previously provided ONC with our description of this work and will continue to keep the agency abreast of our efforts; we are currently engaged in a pilot project with a large healthcare system as proof of concept in anticipation of wider adoption of these oncology data elements, which we believe would streamline communication between care providers and positively impact patient care.

Encourage Adoption of High-Quality Clinical Pathways
ASCO strongly supports the utilization of high-quality value-based oncology clinical pathways. As health care payment models continue to advance, private insurers have already embraced the use of oncology clinical pathways that incorporate both evolving scientific evidence and considerations of cost and value. We have encouraged the Medicare program to adopt high-quality value-based pathways as a mechanism to assure high-quality and high-value care for the Medicare population.

Clinical pathways are regularly updated treatment protocols that map care based on current scientific evidence. When used appropriately, high-quality pathways can reduce unwarranted variations in care and focus resources on the most appropriate and valuable therapies while still allowing for justifiable individualized decision-making. Placing adherence to clinical pathways at the center of an oncology-based care model can improve quality, efficiency, and value of medical oncology services for Medicare beneficiaries, and would align Medicare policy with ongoing pathway initiatives in use by commercial payers.

ASCO has done extensive work examining pathways in oncology and has developed robust criteria for the development and implementation of pathway programs. ASCO has used these criteria to assess clinical pathway vendors. For more information on clinical pathways please visit: https://www.asco.org/practice-guidelines/cancer-care-initiatives/clinical-pathways.

Improve Access to Claims Data
MACRA required CMS to make its data easier to access, especially for the purpose of linking clinical registries to CMS claims data. CMS is using its existing ResDAC process instead, which is cumbersome, time consuming to navigate, and strictly limits use of the data. CMS should allow much easier access to its data, as intended by Congress in the MACRA legislation. Congress should work with CMS to ensure these changes are made.

Thank you for your commitment to improving the Medicare program. If you have questions on any issue involving the care of individuals with cancer or would like to be directed to ASCO’s thoughts on a specific issue related to drug pricing, please contact Jennifer Brunelle at jennifer.brunelle@asco.org.

Sincerely,

Monica M. Bertagnolli, MD, FACS, FASCO
President, American Society of Clinical Oncology