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Via Electronic Submission

January 14, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Re: CMS-2408-P Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

Dear Administrator Verma:

The American Society of Clinical Oncology is pleased to offer these comments in response to the proposed rule on Medicaid and Children's Health Insurance Plan Managed Care.

ASCO is the national organization representing more than 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. ASCO members are also 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 Medicaid enrollees.

We appreciate the opportunity to comment on the proposed rule and its implications for cancer care providers and patients. ASCO has worked diligently to ensure that patients have access to high-quality and high-value cancer care. In 2014, ASCO published a Policy Statement on Medicaid Reform that details our positions to ensure access to high-quality and high-value cancer care for all Medicaid enrollees.[i] The principles presented in that statement inform our comments today.

We urge CMS to ensure that all Medicaid enrollees have access to basic elements of health coverage that are critically essential to the modern treatment of cancer.

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CMS should enact network adequacy standards that are appropriate for ensuring that Medicaid Managed Care enrollees who are cancer patients or cancer survivors are able to access high quality cancer care in a timely fashion.

ASCO supports the proposed change to allow states to define which provider types to include in access standards for specialist providers. However, cancer patients and survivors are a particularly vulnerable subset of the Medicaid population who require timely access to cancer specialists, facilities, and supportive care. In the 2016 final rule, CMS updated the Medicare Managed Care (MMC) network adequacy standards to decrease variability in network adequacy standards across all states. It is imperative that federal standards create a regulatory floor that is robust enough to support the medical needs of all MMC enrollees independent of their state of residence. As written, the proposed changes could allow elimination of minimum requirements, which has the potential to erode access for patients with cancer.

Striking a balance between creating a meaningful national standard and recognizing local challenges is a difficult task. Our membership includes medical oncology practices in every state and across a wide range of settings, including urban, rural and underserved areas. Recognizing that states need flexibility to establish standards that are specific to the needs of their populations (even diverse populations within their states), ASCO supports network adequacy standards that promote access based on specific patient needs, availability of care and providers, and appropriate utilization of services. We believe the proposed framework can be strengthened to better assure cancer patients and survivors have meaningful access to medically necessary cancer care services in a timely fashion.

One specific area in need of refinement relates to time and distance for certain provider types and specialties. The CMS approach that predicates network adequacy standards for specialists and facilities on time and distance is susceptible to manipulation. A general time and distance standard ensures there are providers within a locality, but fails to account for several important factors like subspecialty expertise, and more importantly the capacity of network providers to accept new patients. These concerns are important to patients with cancer because the treatment of cancer is often time sensitive, complex, labor-intensive and costly. These characteristics result in greater susceptibility of vulnerable patients to discriminatory practices in provider network construction. CMS previously recognized that cancer patients face challenges in accessing oncology providers in the Federally Facilitated Marketplace for the purchase of qualified health plans. In its 2016 Call Letter for the Federally Facilitated Marketplace, CMS stated that it would apply special scrutiny to the availability of oncology services given the historical challenges in ensuring adequate oncology access.[ii] We commend CMS for taking these actions in the context of the exchanges, and we urge CMS to create similar protections under MMC by mandating oncology-specific protections given the vulnerability of this patient population.

Additionally, as stated in our June 2018 response to the proposed rule entitled “Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold” ASCO encourages CMS to continue to require states to assess Medicaid access to ensure that Medicaid beneficiaries who

are cancer patients or cancer survivors are able to access high quality cancer care in a timely fashion.

CMS should continue to allow pass through payments to facilitate and encourage the transition of health care purchasing from models based on volume to models based on value.

The proposed rule recognizes the need for continued innovation and reform of health care delivery systems from rewarding volume to rewarding the value of care provided. We applaud the flexibility given to states to allow value-based payment arrangements in MMC contracts.

ASCO is an enthusiastic supporter of value-based purchasing and has developed a patient-centered proposal that would fundamentally restructure the delivery of cancer care in the United States. ASCO's *Patient-Centered Oncology Payment* proposal is designed to better align payments with the services that patients require, simultaneously improving patient treatment and reducing spending. CMS should continue to advance such innovation beyond its current investment in the Oncology Care Model. We would be happy to meet with CMS to discuss our concepts for payment reform for cancer services that can be applied to MMC or other health insurance markets.

CMS should ensure that quality measures relating to cancer care focus on the specifics of cancer treatment, are meaningful to patients and relevant in all oncology disciplines or specialties. Alignment of measures across all payors including Medicaid managed care plans and the Medicare program would reduce the burden associated with quality reporting and facilitate delivery of high-quality, high-value care.

ASCO supports the identification of a uniform set of quality measures for use across managed care plans for inclusion in the state's Quality Reporting System (QRS). We support the goal of eliminating duplication, overlap and inadvertent variances among related measures. However, we believe the core measures should be developed by or in close collaboration with cancer care experts.

Achieving meaningful quality improvement in cancer care will require a measure set that is specifically tailored to the unique characteristics of patients with specific clinical attributes and cancer diagnoses.

Current quality measures and payment programs rely too heavily on documenting irrelevant tasks, increasing administrative burden on physicians, and reducing time focused on the patient. Aside from these difficulties, there is little to no evidence that such task-oriented measures improve patient care. For more than a decade, ASCO has offered to its members the Quality Oncology Practice Initiative (QOPI®), a comprehensive quality program that includes robust, oncologist-developed quality measures, which allows providers to report clinically relevant quality measures for cancer care that promote value and protect patients during cancer treatment.[2]

(Separately, ASCO also maintains both a QCDR and qualified registry that are currently accepted by CMS for use in the Quality Payment Program.)

Creation of new measures that are meaningful and reflective of modern oncology practice requires standard documentation of essential data elements. For example, the documentation of treatment intent, performance status and communication of treatment plan/summary are building blocks for the development of meaningful measures focused on the patient experience. However, current limitations of such cancer measures in federal programs have hindered the ability of oncologists to report on these important aspects of cancer treatment.

Additionally, performance measurement is effective only to the extent there is rapid feedback to support performance improvement. Currently, reporting and the receipt of performance feedback is slow and cumbersome, and the retrieval of key clinical data elements for quality reporting and other activities depends on interoperability of EHRs. Enhanced interoperability of health information channels would support efficient reporting, analysis—and insight—of clinical experiences and patient outcomes. Both the Administration and Congress have signaled that EHR interoperability—and the creation of rapid learning systems—is a priority and we are anxious to work with you in furthering this critical goal.

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Thank you for the opportunity to provide comments on new policies for the regulation of Medicaid Managed Care. Please contact Sybil Green at Sybil.Green@asco.org or 571-483-1620 with any questions.

Sincerely,

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

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[i] American Society of Clinical Oncology. American Society of Clinical Oncology policy statement on Medicaid reform. Journal of Clinical Oncology. 2014;32:4162-4167.

[ii] Center for Consumer Information and Insurance Oversight, Final 2016 Letter to Issuers in the Federally Facilitated Marketplaces 23 *available at* http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf