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Via Electronic Submission

March 1, 2019

The Honorable Lamar Alexander
Chair, Senate Health Education, Labor and Pensions Committee
U.S. Senate
Washington, D.C. 20510

Dear Senator Alexander,

The American Society of Clinical Oncology (ASCO) appreciates your request for information on reducing the cost of health care while improving quality. We are pleased to share our ideas for improving the delivery of cancer care in a way that is cost effective and beneficial for patients, oncology professionals, and payers.

ASCO is the national organization representing over 45,000 physicians and other health care professionals specializing in cancer prevention, diagnosis, and treatment. ASCO members are dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidenced- based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans, including Medicare beneficiaries and Medicaid enrollees.

As you continue to address the growing cost of health care, ASCO respectfully requests Congress and the Administration to work together on the following policy improvements.

Congress Should 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 such as Anthem, Humana, and United HealthCare; as well as the Center for Medicare and Medicaid Innovation (CMMI) sponsored Oncology Care Model (OCM) and other CMMI sponsored models. ASCO supports the idea of high-quality, high-value care, and we have advocated for new payment models which carefully consider the full scope of services provided, rather than arbitrarily reduce payment levels based on cost alone.

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An often-cited example of an oncology alternative payment model is the United HealthCare Episode of Care pilot for breast, lung, and colon cancers (EOC). Started in 2009, the EOC pilot included submission of clinical data, an upfront episodic payment – this amount was in addition to typical reimbursement for outpatient evaluation and management, treatment administration, and drug costs – measurement of drug selection against a practice-selected pathway, and potential shared-savings for practices that are successful in reducing total cost of care for their patients. The initial pilot lasted 3 years and has since been renewed and expanded to additional practices.[1]

The EOC pilot measured actual medical costs against predicted fee-for-service costs. The pilot included data from more than 810 patients and resulted in a savings of $33.4 million -- actual medical costs totaled $64.8 million, compared to predicted costs of $98.1 million. While the total number of patients was not large enough for sufficient analysis of outcomes in breast and colon cancers, there was no significant survival difference within the lung cancer group.[2]

Another oncology model has focused on overall health care costs. 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 this data has highlighted opportunities to reduce health care costs.

For example, 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.

Practices participating in alternative payment models 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.

Congress Should Encourage the Administration to Adopt 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

[1] DOI: 10.1200/JOP.2014.001488 Journal of Oncology Practice 10, no. 5 (September 1 2014) 322-326
[2] DOI: 10.1200/JOP.2014.001488 Journal of Oncology Practice 10, no. 5 (September 1 2014) 322-326

beneficiaries, and would align Medicare policy with ongoing pathway initiatives in use by commercial payers. Monthly supplemental payments would support the necessary infrastructure to enhance care coordination, symptom management and post treatment services. Pathways, along with enhancing care management and triage for patients throughout their treatment, can result in lower costs by avoiding expensive and unplanned interventions.

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

Small-scale Testing of Multiple Oncology-focused Alternative Payment Models

Industries outside of healthcare have approached complex challenges by developing methods for "rapid-prototyping" of new products. 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, the Centers for Medicare and Medicaid Services (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. 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.

Adoption of 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.

Designation of Certain Oncology Practices as Medical Homes and Provision for Expanded Reimbursement for Care Coordination

ASCO believes cost savings can be achieved through improved coordination of care, reduced emergency room visits, decreased hospitalizations, diminished use of low-value procedures and treatments, and increased use of palliative care and hospice services at the end of life. The Oncology Medical Home is a care delivery model that supports the PCOP payment model described above and provides the infrastructure to achieve these cost savings. Payment models such as the Oncology Care Model include medical home features and provide payments to the participating practice for building the infrastructure needed to achieve cost savings.

Reduced Burden of Prior Authorization and Step Therapy

An ASCO survey published in the 2017 *State of Cancer Care in America Report* found that 78 percent of oncology practices cited prior authorization as a significant pressure associated with payers. In a separate survey conducted by the American Medical Association (AMA), medical practices indicated that on average they conducted 31 prior authorization requests per physician weekly. According to the survey, 91 percent of physicians report that prior authorizations result in delays in care, and sometimes lead to serious adverse events.[3] In ASCO's "Policy Statement on the Impact of Utilization Management Policies for Cancer Drug Therapies," we outline several options to reduce the administrative burden of pre-authorizations, such as implementing standardized processes and forms, restricting prior authorization policies to drugs where specific concerns exist, eliminating prior authorization when a proposed treatment is on an accepted pathway, and integrating prior authorization processes into electronic medical records (EMRs), among other proposals.

Additionally, step therapy, or "fail first," is inappropriate in cancer care because of the individualized nature of cancer treatment and the lack of interchangeable clinical options. Step-therapy creates barriers and delays to patient access to cancer care, which can hurt patient outcomes and increase disease progression. It is particularly problematic in cancer where receiving the best drug first is critical and forcing a patient to take an inferior drug first may render the most appropriate drug less effective.

ASCO urges Congress to work with CMS and other payers to streamline the prior authorization process and create a standardized system that reduces burden on oncologists and patients with cancer. Congress should ensure appropriate patient protections are in place around step therapy practices. One important step to accomplish this is passage of the *Restoring the Patient's Voices Act* (H.R. 20177 in the 115th Congress).

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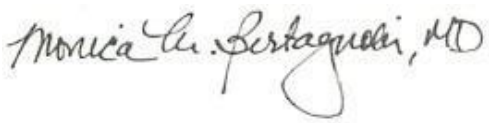
ASCO looks forward to working with you to accomplish these important goals for patients with cancer. For question about this or other issues related to cancer care and research, please reach out to Amanda Schwartz, Amanda.schwartz@asco.org or 571-483-1647.

[3] American Medical Association, 2018 AMA Prior Authorization (PA) Physician Survey, located at: https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf

March 1, 2019

Sincerely,



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