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House Energy & Commerce Committee
Subcommittee on Health

Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

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The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in connection with the hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms.**"** ASCO is grateful to the Energy & Commerce Committee, particularly to this subcommittee, for their work to develop MACRA. We provided extensive feedback to you during development of the legislation, which we publically supported and promoted.

The collaborative environment you created resulted in overwhelming bipartisan support in both the House and Senate. As a part of the provider community, we appreciate this important step toward a more rational payment system and feel ownership over this as well. ASCO will continue to work with you and CMS to ensure this legislation works for oncology providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is entirely consistent with ASCO's mission and work. For more than a decade, we have been focused on delivery of high quality, high value care for every patient with cancer. Our longstanding performance measurement system, QOPI, is a qualified clinical data registry, which has a high degree of support and participation among our members. It is even beginning to penetrate international practices. We also are well on the path to building a rapid learning system for oncology, called CancerLinQ, which we believe will revolutionize cancer care. We are hopeful that these important systems can thrive under MACRA.

We support MACRA's emphasis on value over volume. ASCO is very focused on the cost of cancer care and what it means for patients with cancer. We have developed a wide range of education and related tools that support and encourage patient-physician conversations about the cost of their care. We also have a robust portfolio of clinical guidance for physicians, including a value framework designed to inform and support shared decision-making and the selection of high value care options.

ASCO's Alternative Payment Model

ASCO is encouraged by MACRA's strong emphasis on alternative payment models, and particularly the acceptance of those developed by physicians. ASCO has been developing and refining

an APM for oncology since 2010. Our model, the Patient Centered Oncology Payment Model (PCOP), would fundamentally restructure the way cancer care is paid for and better align those payments with the patient services that are critical to delivering quality care.

PCOP was developed by a dedicated group of ASCO volunteers, who met every other week for two years. The group included medical oncologists from diverse practice settings, seasoned practice administrators, and experts in physician payment and business analysis. In addition to the input from outside experts in clinical and economic aspects of cancer care, ASCO used data from sources such as the National Practice Benchmark for Oncology and interviews with a representative sample of oncology practices to estimate the amount of time and money oncology practices are currently spending to deliver services to oncology patients—services that are not adequately supported by existing fee-for-service payments for office visits and medication administration.

Our PCOP model would also test many of the policy alternatives that have gained visibility recently, including bundled payments and episode-based reimbursement. ASCO has estimated that PCOP would increase or keep whole payments for oncology practices, while still yielding savings to the Medicare program. These savings arise through better matching of payments with actual care delivery that enables practices to organize care in a way that helps patients avoid expensive hospitalizations and unnecessary tests and treatments.

We believe that PCOP will qualify as an APM under MACRA because it meets the stated criteria in the law: includes quality measurement, more than nominal financial risk, requires the use of certified EHRs, and includes financial incentives. CMMI has its own model for oncology, the Oncology Care Model, which some have argued should suffice for oncology. We disagree and don't believe that is consistent with your intent when you developed and passed MACRA.

ASCO is grateful for the path outlined in MACRA for physician developed APMs. We are aware the Physician Focused Payment Model Technical Advisory Committee (the TAC) is just forming, but are hopeful it provides—as you intended—a meaningful opportunity for review and approval of high quality APMs like ASCO's PCOP. If this path does not work as intended, we hope that Congress will intervene.

Preparing Our Members for MACRA

ASCO is utilizing all the communications vehicles we have available to educate and inform our members about MACRA, and prepare them for implementation. We have a group of volunteers and leaders who meet every other week to assist our members in planning for MACRA. Through these efforts, we hope that oncologists can be among the best prepared specialists in the nation. While our hopes remain high that multiple APMs will be available for oncology, we know that many, if not most, of our US members will be in the Merit Based Incentive Payment System (MIPS). To that end, we are encouraging participation in Meaningful Use, Physician Quality Reporting System, and ASCO's own Qualified Clinical Data Registry. We are also ensuring that our physicians understand the relatively new Physician Value-Based Payment Modifier (VBM) given its significance for Resource Use, Clinical Practice Improvement Activity and measure development.

To help educate our members, we've held full day seminars at our office in Alexandria, VA, nationwide webinars, presentations at state society meetings, and presented at ASCO's annual meeting.

This allows all of our members to have an opportunity to receive training on MACRA implementation. We have recruited a dedicated Task Force of ASCO's highest committee leadership to work on implementation and view it from broad perspectives. Additionally, we've conducted practice readiness assessments at individual sites to help practices understand what steps they will need to take ahead of MACRA implementation.

When appropriate, we will share APM information and help prepare membership for participation in all APMs available in oncology.

Engaging with CMS to Make MACRA Work for Oncology

ASCO has provided feedback to CMS on a number of aspects of implementation of specific importance to oncology. Although we support the transition to value-based payment, we remain concerned that the MIPS methodology for measuring resource utilization could unfairly penalize oncologists who provide care that is medically necessary, but also high cost. These are costs that are completely outside of their control. Currently, CMS assesses resource use through the Value-Based Payment Modifier (VBM), which provides too blunt an instrument to protect and promote quality in oncology. To be successful in implementing MACRA, policymakers must learn from and avoid the mistakes made in implementing the VBM.

The treatment of cancer is both clinically complex and highly specialized, creating many factors that must be considered to accurately evaluate medical oncology resource use in a way that protects the interests of patients. There are more than 120 different types of cancer (and through advances in molecular diagnostics, this list is growing), and the most appropriate treatment option for a particular patient often involves the administration of a multi-drug regimen. In a growing number of instances, the selection of the most appropriate anticancer drug for an individual patient is based on molecular factors that predict superior outcomes using increasingly expensive targeted agents that lack equivalent alternatives. In these ever more common scenarios, the medical oncologist is left with little flexibility to reduce drug utilization costs by selecting lower cost alternatives. It is counterproductive to assess a provider's resource use based on Part B or Part D drug expenditures that are outside of their control in this way.

Congress and CMS must not assume that variations in resource needs among patients and medical oncology providers will "average out" over time. It is increasingly common for medical oncologists even in the community setting to specialize in treating particular types or sub-types of cancer. There are some physicians and many oncology practices that specialize in treating the most complex—and often most costly—oncology patients. In some of those instances, there will be significant differences in resource consumption compared with other providers. We are especially concerned that if resource use measurement does not account for these clinical differences, CMS may inadvertently unfairly penalize practices and create access barriers for patients with complex and molecularly unique forms of cancer. Congress and CMS should take this situation into consideration for

any process used to measure resource use in oncology and should not implement such a process until there is confidence the methodology will adequately protect quality and access to care for patients with these complex illnesses.

Given the factors described above, and because drug pricing is entirely outside of the control of treating physicians, ASCO recommends that Congress and CMS adopt a more nuanced approach for oncology than simply comparing aggregate drug costs under Medicare Part B and Part D. Congress and CMS should exclude the use of raw drug expenditures in resource use determinations. Instead, CMS should assess drug resource use by evaluating adherence to evidence-based, value-based medical decision-making. ASCO endorses the use of high-quality clinical pathways in oncology as a mechanism to assess the provision of such care.

Appropriately designed clinical oncology pathways are detailed, evidence-based treatment protocols for delivering quality cancer care for specific patient presentations, including type and stage of disease. Clinical oncology pathways are a tool that can be used to appropriately align incentives for cancer patients and providers for resource use assessment in cancer care. Oncology pathways are being used by an increasing number of private payers to ensure evidence-based, value-based care for cancer patients. Used in this way, clinical oncology pathways can enable oncologists, payers, and patients to provide assurances that patients are receiving clinically appropriate therapies without unnecessary costs, including drugs. Oncology pathways balance the considerations of clinical efficacy, safety, toxicities, cost, and scientific advances, including the growing personalization of therapy based on molecular diagnostics.[1] Simply put, clinical pathways help to ensure that the right patient gets the right care at the right time. Since compliance with appropriately designed oncology pathways define optimal care, medically appropriate concordance with pathway programs that have been developed and peer-reviewed by oncologists should be considered a major quality indicator.

In addition to drug costs, ASCO has serious concerns that CMS is failing to implement adequate risk adjustment to assess resource use in a way that fairly addresses differences in resource use among oncologists. Cancer care is incredibly complex and growing more so with each passing year, and the costs of cancer care are highly variable depending on a patient's diagnosis, cancer stage, molecular markers, geographic access to care, comorbidities and other clinical factors. In light of these complexities, it is imperative that CMS develop a risk adjustment methodology that will be specifically used to address cancer care. Traditional administrative claims data alone are insufficient to provide a desirable risk-adjustment methodology. Without the clinical information routinely collected in a Pathway Program, risk adjustment for outcomes or costs will be impossible.

[1] Zon RT, Frame JN, Neuss MN, Page RD, Wollins DS, Stranne SK, Bosserman LD. American Society of Clinical Oncology policy statement on clinical pathways in oncology. Journal of Oncology Practice. 2016 [epub ahead of print].

We urge Congress to provide oversight in this area to ensure that medical oncologists are not subject to unfair resource use measurement due to the clinical complexity of the patient populations they serve.

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Thank you for your leadership on passage and continued oversight to ensure successful implementation of MACRA. We look forward to continued work with you and your staff's to ensure that Medicare beneficiaries have access to oncology services moving forward. Please contact Amanda Schwartz at Amanda.Schwartz@asco.org with any questions.