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February 18, 2020

Jeffrey Bailet, MD
Chair, Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health & Human Services
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to offer our strong support for the Patient-Centered Oncology Payment (PCOP) proposal from the American Society of Clinical Oncology (ASCO). It is critically important for well-designed physician-focused payment models to be developed and implemented for cancer care. Oncologists have cited numerous barriers to providing high-quality patient care under the existing Medicare physician payment system. Although the Oncology Care Model has helped to overcome some of these barriers, the PCOP proposal represents a significant advance from this current Medicare model, and it also offers several advantages over the plans announced to date for the successor to the Oncology Care Model, called Oncology Care First.

Medicare fee-for-service payments are chiefly tied to face-to-face patient encounters and administration of cancer therapies. This payment structure makes it extremely difficult for oncology practices to support teamwork and collaboration with other physicians, nurse care managers, after-hours access to help prevent emergency department visits and hospital admissions, education and counseling on patient self-management and nutrition, comprehensive diagnostic work-ups, patient-physician shared decision making about treatment plans, and support for cancer survivorship. It is also difficult for practices to help patients access nonmedical services like financial and transportation assistance that patients may need in order to adhere to treatment plans for their cancer.

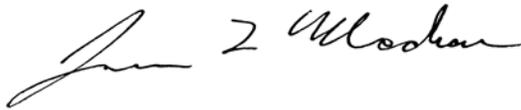
The ASCO PCOP proposal would address all of these barriers. Unlike the monthly payments available to participants in the Oncology Care Model, PCOP would also support comprehensive diagnostic work-ups and development of treatment plans before patients begin treatment with chemotherapy, as well as active monitoring during months when patients are not receiving cancer treatment. In addition, practices would receive needed support for patients who need effective survivorship care and end-of-life care. PCOP also places major emphasis on quality of care by measuring adherence to evidence-based treatment pathways and patient satisfaction with their cancer care. By integrating patient access to clinical trials into the payment model design, the PCOP proposal helps to ensure that patients will be able to take advantage of the latest research and advances in cancer treatment.

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Another major advance in PCOP is its approach to participation by entire communities, instead of limiting participation to select health plans or practices. By forming community-wide oncology steering committees, sharing clinical research information across communities, and having community case conferences, the ASCO PCOP model will ensure that high-quality care is equitably available to all patients with cancer, and not limited to a single hospital, health system or insurance plan. This approach will facilitate true team-based care across all health professionals involved in the patient's care, all sites of care, and all types of care, including support services and community resources.

The AMA strongly urges the PTAC to recommend the PCOP proposal to the Secretary of Health and Human Services for implementation. Thank you for considering our views.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD

February 18, 2020

Jeffrey Bailet, MD
Chairman
Physician Focused Payment Model Technical Advisory Committee
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet and Members of the PTAC,

The American Society for Radiation Oncology (ASTRO) is pleased to submit comments on the Patient-Centered Oncology Payment (PCOP) model proposed by the American Society of Clinical Oncology (ASCO). While we appreciate efforts to establish value-based payment methodologies for cancer care, we strongly disagree with the establishment of a total cost of care model that includes radiation therapy services. Radiation therapy is a distinct form of cancer treatment that should be paid through the forthcoming Centers for Medicare and Medicaid Services (CMS) Radiation Oncology Alternative Payment Model (RO Model), with reforms suggested by the radiation oncology community, or at existing Fee-for-Services rates.

ASTRO members are medical professionals, practicing at community hospitals, academic medical centers, and freestanding cancer treatment centers in the United States and around the globe, and who make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams often include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers, and treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy.

Multi-disciplinary Cancer Care

The proposed PCOP model seeks to establish community-based medical homes for patients seeking cancer treatment. According to the proposal, the model will achieve this goal through the application of standardized quality metrics, established treatment pathways and care guidelines, and a multi-pronged payment methodology.

The proposal asserts that the model is a multi-stakeholder initiative requiring significant collaboration with the intention that it be implemented by a community of payers, practices and community stakeholders within defined geographies. Despite the multi-stakeholder intent of the PCOP model and its inclusion of radiation therapy, ASTRO was not engaged in the development of this model. PCOP sets forth a common framework that each community can modify to ensure

that the selection of quality metrics and clinical pathways are in alignment with community health needs.

ASTRO appreciates the community-based approach that ASCO has taken with the development of the PCOP model; however, we are concerned that insufficient consideration has been given to the importance of multi-disciplinary cancer care, which frequently involves radiation therapy and surgery, in addition to chemotherapy. In many cases, chemotherapy may be given prior to radiation therapy or surgery, and often chemotherapy and radiation therapy are given together. Each of these approaches are often delivered with a curative intent and require a team-based approach to oncology care, where no one member of the team is the lead, but rather each member manages the complexities of cancer care associated with his/her area of expertise.

One of the tenets of value-based care is the development of alternative payment models that allow physicians to manage the costs that they can control. The PCOP model states that “Drugs and biological treatments represent the greatest component of oncology treatment costs, followed by surgery and radiation therapy.” An [ASCO study](#) of the 2013 Medicare population found that of the \$27.9 billion spent on cancer treatment, drugs expenditures accounted for almost a third of cancer costs and radiation therapy only accounted for 7 percent of expenditures¹. The Oncology Care Model (OCM) launched in 2016 also demonstrates the disparity between drug and radiation therapy expenditures. According to the first evaluation report, combined Part D and Part B drug spend drove 56 percent of the costs associated with the delivery of cancer care. Radiation oncology expenditures paled in comparison at 2.5-3 percent of expenditures.

The cost of drugs and biological treatments has grown to occupy the overwhelming majority of cancer-related expenses. In 2017, the cost of cancer drugs reached nearly \$50 billion, with over 75 percent of the growth from the use of cancer drugs launched within the last five years.² The President’s Cancer Panel has issued a call to action regarding the dramatic rise in drug prices, expressing concern that continued growth is straining patient, health system, and society resources. The report further urges the Administration to address the significant burden of drug costs on patients that are resulting in out-of-pocket spending that can be in the hundreds, or even thousands of dollars a month for patients under active treatment.³

It is not clear whether this model will have any impact on the costs of drugs and biological treatments themselves, which would seem to be the area in which there would be the greatest opportunity for savings. Furthermore, the PCOP model is focused on the work of the medical

¹ Verdon, Daniel R., “ASCO: Study examines Medicare expenditures for cancer treatments.” Medical Economics. June 3, 2019, Accessed 02/13/20 <https://www.medicaleconomics.com/news/asco-study-examines-medicare-expenditures-cancer-treatments>. Accessed 02/13/20

² The IQVIA Institute for Human Data Science. “Global Oncology Trends 2018.” May 2018. Accessed 02-13-20 https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/global-oncology-trends-2018.pdf?_=1581616509073

³ President’s Cancer Panel, “Promoting Value, Affordability, and Innovation in Cancer Drug Treatment: A Report to the President of the United States.” March 2018. Accessed 02/13/20 <https://prescancerpanel.cancer.gov/report/drugvalue/>

oncologist and does not refer to radiation oncology services, other than those associated with the total cost of care. Given the desire to focus on reducing the costs associated with drugs and biological treatments and the fact that medical oncologists do not have control over or expertise in radiation therapy treatment planning, delivery or management, ASTRO strongly recommends that the model be modified to only encompass the medical oncology component of cancer care. We believe this is particularly important given the significant cost associated with cancer drugs, as cited above.

Thank you for the opportunity to comment on the PCOP proposal. Should you have any questions or require additional information, please contact Anne Hubbard, Director of Health Policy at 703-839-7394 or Anne.Hubbard@ASTRO.org.

Sincerely,

A handwritten signature in cursive script that reads "Laura Thevenot".

Laura I. Thevenot
Chief Executive Officer