June 2, 2011

Donald Berwick, MD, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC  20201

Re: CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

On behalf of the Community Oncology Alliance (COA), a non-profit organization representing the interests of community oncology practices and their patients, I appreciate the opportunity to comment on the proposed rule for Accountable Care Organizations (ACOs) — CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations (the “Proposed Rule”).

COA acknowledges the need for health care reform. Specifically, we believe that medical care needs to be better coordinated, based on evidence-based guidelines/pathways, and focused on delivering both quality and value. The growing complexity of cancer care requires that oncologists in community-based practices coordinate care with primary care physicians and other specialists. Over the past 40 years, since our country declared the War on Cancer, we have achieved impressive results in evolving the cancer care delivery system from inpatient, hospital-based care to the outpatient, community setting. In the process, we have produced the world’s best cancer care delivery system as documented by 5-year survival rates, as well as a treatment system that is extremely efficient in delivering value to both patients and providers.

The entire oncology provider team is certainly not resting on the accomplishments to date but working hard to further improve cancer care delivery in this country. However, the delivery system is under enormous pressure due to unrealistically low reimbursement from Medicare. Additionally, Medicare has inordinate influence on private insurers to follow the government payment system, which has happened with increasing frequency over the past 7 years. The strains on the system are now very clear. Over the past 3½ years, COA has tracked 199 cancer care facilities that have closed, 369 practices — often accounting for multiple facilities — that are struggling financially, and 315 facilities that have been taken over by hospitals.¹ This recent market consolidation is leading to patient access issues in rural areas and increasing costs for patients and payers (Medicare and private insurers) — and, in the process, endangering the past 40 years of significant successes. If we do not realistically address the failures of the Medicare system in dealing with cancer care the implications will possibly be catastrophic.

¹ Community Oncology Alliance Practice Impact Report (http://www.communityoncology.org/COAStrudies.aspx)
We appreciate and recognize the task of the Centers for Medicare and Medicaid Services (CMS) in operationalizing the ACO concept as outlined in the Patient Protection and Affordable Health Care Act of 2009. Unfortunately, the Proposed Rule published by CMS has totally neglected to address and include cancer care. Not one of the 65 quality measures deals with cancer treatment/care, and it is unclear how oncology practices fit into the ACO framework.

What follows are our general comments on the Proposed Rule — “general” in that we will look to others such as primary care providers, for whom the Proposed Rule is relevant, to provide specific comments on aspects of the rule. Next, because we do not see how the Proposed Rule can be modified to realistically include cancer care, we propose a solution. COA has already submitted that solution to the Center for Medicare and Medicaid Innovation (CMI) but has received no response to date (Patient-Centered Oncology Medical Home Demonstration; submitted by the Community Oncology Alliance to the Center for Medicare and Medicaid Innovation on March 30, 2011). Our solution focuses on specific processes to evolve oncology practices into patient-centered oncology medical homes. This solution is intended to further evolve the cancer care delivery system to optimize both the quality and value of care delivered, based on a model that maximizes care coordination and efficiency — exactly what ACOs are intended to achieve.

Comments

We will look to other parties to comment on the specifics of the Proposed Rule. In general, we believe that the Proposed Rule places inordinate investment pressure on medical providers for an insufficient return that carries a significant amount of risk, regardless of the type of ACO. In effect, CMS is proposing a payment system whereby ACO providers are expected to contribute to a reduction in services, which translates into reduced revenue to providers, and then keep only 50-60% of that revenue in “shared savings.” Compounding the reduction in revenue is the fact that a substantial portion of the shared savings will be held back by CMS. Given the pressures facing oncology practices, as explained earlier, even if there was a place for cancer care in the ACO structure, this scenario would be unworkable for oncology practices. A study by Avalere Health showed that in 2008 Medicare reimbursed only 57% of the cost of infusion room services (not including the cost of the drugs, which are increasingly reimbursed less than cost). It is unrealistic to expect the cancer care delivery system to absorb any further Medicare reimbursement cuts without being dismantled.

The quality measures in the Proposed Rule are primary care-based — not one deals with cancer care — and the measures generally have no direct relationship to cost management in the short term. Successful performance on quality measures may translate to improved cost management and health status over the horizon of a generation, but not within the short 3-year time frame of the contract period specified in the Proposed Rule. We note that Fisher and Wennberg (Ann Intern Med. 2003; 138:273-298) implicate specialty care as drivers of cost differences, yet the proposed rule offers no incentives for specialists (i.e., oncologists) to modify the cost of specialty services. Oncologists could undertake expensive practice redesign to provide and document cost efficient care, yet there are no related quality measures in the Proposed Rule within the oncologist’s control that could assure success in both quality and cost reduction, and in the process create shared savings.

Without specific quality measures related to cancer care, oncology practices participating in ACOs will face enormous pressures from ACO governance to simply reduce the costs of

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2 Providing High Quality Care in Community Oncology Practices / An Assessment of Infusion Services and Their Associated Costs, Avalere Health, February 2010 (http://www.communityoncology.org/COAStudies.aspx)
cancer care, which will likely translate into inferior care for seniors covered by Medicare. As a result, cancer care faces the same problems encountered by HMOs 20 years ago — this will simply be about cost reductions; ignoring the impact on quality cancer care delivery.

There is a serious risk that cost containment arising from shared savings could evolve into the withholding of cancer care for patients with advanced disease. Primary care physicians would have an incentive to begin making judgments about the “worth” of advanced cancer care, even though they have no expertise in patient outcomes involving newer therapies; especially as more expensive drugs are introduced that have been approved by Medicare for payment based on the agency’s own review.

Solutions

The Patient Protection and Affordable Health Care Act of 2009 (H.R. 3590; “ACA”) established the CMI. Pursuant to Section 3021 (Part III) of H.R. 3590, one of the specified demonstration projects is as follows:

‘’(xii) Aligning nationally recognized, evidence based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.”

In meeting with Dr. Richard Gilfillan, Acting Director of the CMI, COA was challenged to be more “aggressive” with this oncology-specific demonstration project. As a result, COA incorporated elements of the demonstration project that were included in health care reform law into a more comprehensive project around the Patient-Centered Oncology Medical Home (the “Oncology Medical Home”). This more comprehensive approach involves “harder” endpoints dealing with enhanced quality and lower costs of care, especially in terms of reducing hospitalizations and decreasing emergency room utilization.

The model that forms the basis for this demonstration project is based on real-world experience, not concept. Dr. John Sprandio, MD, has developed an oncology-specific medical home model by re-engineering clinical and operational processes in his community oncology practice, Consultants in Medical Oncology and Hematology (CMOH) in Drexel Hill, Pennsylvania. CMOH has been recognized as a level III medical home by the National Committee for Quality Assurance (NCQA).

The Oncology Medical Home model developed at CMOH is straightforward. At the time of the diagnosis of cancer, the practice assumes the primary responsibility for the coordination of all related services for patients requiring evaluation and active treatment of their oncologic and hematologic conditions. Responsibility of care delivery continues through all necessary therapy — including surgery, radiation, and chemotherapy — and extends into the survivorship phase of care. The practice does not assume the management of non-oncologic medical issues from the patient's primary care physician, necessitating the maintenance of an intense level of communication between the practice and the primary care team. The Oncology Medical Home model of care provides a framework for defining and refining the concepts of quality and value in cancer care. The inherent data collection and evaluation cycle fuels continuous process improvement within the practice.

CMOH has seen positive results with the Oncology Medical Home model since 2005. To cite just a few notable examples:
• **Triage ER Referrals**
  The percentage of incoming clinical calls resulting in ER referrals decreased by more than 50% over a 5-year period.

• **Chemotherapy Patient ER Utilization**
  ER referrals for patients actively on treatment progressively decreased since 2004. The current practice average is <1.0 emergency room visit per patient per year (commercial, Medicare, and Medicaid populations included). This compares favorably to emergency room utilization rates of 2.0 per patient per year, reported in a large, commercially insured population. Overall, the practice documented a 65% reduction in ER visits per chemotherapy patient per year since 2004.

• **Admission Data**
  As Oncology Medical Home services were expanded across the practice, a 16% reduction in overall hospital admissions in FY 2009 and a 9.7% reduction in FY 2010 have been documented.

The care of cancer patients in the Oncology Medical Home model creates savings after initial start-up costs are recouped; however, the majority of savings will be realized in decreasing inpatient hospitalizations, decreasing emergency room visits, and elimination of duplicative imaging and laboratory services. Unlike the ACO model that is defined by a payment model (i.e., shared savings), with little if any direction on processes to achieve those savings while increasing quality, the Oncology Medical Home model is defined by the processes to achieve increased quality, efficiency, and value. COA has proposed as part of the demonstration project the testing of several payment models, including shared savings, episode-of-care, and per beneficiary payment.

Given the unique and complex nature of cancer care, coupled with the fact that cancer care was left out of the ACO concept, we believe that the Oncology Medical Home is a more realistic way of achieving the underlying ACO goals — care coordination, increased quality, and cost savings. In essence, we are focused on enhancing our own “home” as the first step to enhancing the medical “neighborhood.”

We would like to meet with you, Dr. Gilfillan, and staff at CMS to discuss ways of strengthening and preserving our country’s cancer care delivery system. Additionally, not only are we in active discussions with private payers, but we are also piloting novel payment programs. We believe that for oncology we have a way of fixing the broken sustainable growth rate (SGR) formula in implementing the Oncology Medical Home model. The time to act is now because already the demand for cancer care is starting to outstrip the supply of oncologists in a system that is under enormous pressure. I look forward to your response.

Sincerely,

[Handwritten Signature]

David Eagle, MD
President

CC: Kathleen Sebelius, HHS Secretary
Richard Gilfillan, MD, Acting Director of the CMI

Community Oncology Alliance