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April 15, 2013

Chairman Dave Camp  
Ways and Means Committee  
1102 Longworth House Office Building  
Building  
Washington, DC 20515

Chairman Fred Upton  
Energy and Commerce Committee  
2125 Rayburn House Office  
Washington, DC 20515

**Re: Second Draft of SGR Repeal and Reform Proposal**

Dear Chairman Camp and Chairman Upton:

On behalf of the American Society of Clinical Oncology (ASCO), I am pleased to offer feedback on the second draft of the joint Energy and Commerce Committee and Ways and Means Committee sustainable growth rate (SGR) repeal and reform proposal. ASCO greatly appreciates your continued outreach to stakeholders during your efforts to repeal the SGR and reform Medicare payments for physicians.

ASCO is the world's leading specialty society representing more than 30,000 physicians and other health care professionals who specialize in the treatment of patients with cancer and conduct cancer research. ASCO's core mission is to ensure access to high quality cancer care, and ASCO is a leader in quality measurement and improvement for oncology. Reform of the Medicare program is of particular impact to cancer care as over 60 percent of all cancer diagnoses occur in individuals over 65 years old. We are encouraged by your efforts on SGR reform to this point, as well as your commitment to address the SGR this year.

**General Comments on the Second Draft**

- **Goals of Reform:** ASCO strongly supports the goals of reform outlined in your proposal. Promoting physician leadership in the areas of quality and efficiency measurement, reform of reimbursement models and development of alternative payment models is critical to successful reform.
- **Critical role of specialty societies:** Many national medical specialty societies have mature and robust quality measurement and improvement programs. Specialty societies should continue to be leaders in the development of the quality measures and clinical improvement activities underpinning the update incentive programs (UIPs).

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- ***Ample time for testing:*** The latest iteration of your proposal is consistent with ASCO's guiding principles on payment reform, and we look forward to working with you to advance these principles. It is critical, however, that the concepts and models proposed in this plan are allowed ample time for testing and refinement.

## **Feedback on Specific Questions**

### Phase I:

The reforms outlined in the joint proposal represent a significant shift in practice for many physicians and will require considerable preparation for many. The proposed reforms therefore necessitate a defined period of time for transition, during which practices can adapt and prepare for any incentive programs. In parallel, alternative payment models should be tested and refined during this initial period before they are adopted widely. As you move forward with the development of this plan, we encourage you to build in a sufficient period of time – five years has been proposed by some groups – to allow for these changes in the system to occur.

During this proposed period of stability, it is important that physicians are able to rely on positive updates to help make the investments in infrastructure needed to improve care. ASCO urges you to consider positive updates that, at a minimum, counteract the indiscriminate cut mandated by the sequester as passed in the Budget Control Act.

### Phase II:

A sufficient duration for Phase I will be crucial to ensuring that measures are comprehensive and mature for use during Phase II. The development of such measures involves complex methodological and statistical issues. ASCO supports the Committees' proposal to establish an Expert Panel to assist with these issues, and it is imperative that the Expert Panel is active in providing guidance during Phase I. We urge the Committees to further define the membership and charge of the Expert Panel. Specifically, we strongly recommend a panel of experts nominated by and representing key national medical specialty societies. Among other responsibilities noted in response to specific questions below, we suggest that the Expert Panel should be charged with defining a small number of risk adjustment methodologies that are validated to adjust for patient comorbidity and socioeconomic factors across the majority of conditions.

- ✓ *How should the Secretary address specialties that have not established sufficient quality measures?*

Physicians are more likely to adopt quality measurement programs and clinical improvement activities that are developed and implemented by their professional societies. The Secretary should work with medical specialty societies to ensure sufficient quality measures are developed during the Phase I period to allow for meaningful reporting for every specialty. For those specialty societies that are just starting measure development, or that have limited experience in measure development, the Committees should ensure that the duration of Phase I is adequate to allow these societies to develop and test a sufficient number of quality measures.

Specialty societies may wish to arrange or participate in collaborative measure development initiatives with related disciplines and interested stakeholders. This collaborative development has the potential to fill gaps and augment specialty and/or setting-specific measures with cross-cutting measures.

Specialty societies must be prepared to undertake measure development that includes well-defined, clinically meaningful denominator specifications and exceptions/exclusions criteria when appropriate, to allow for consideration of patient preferences and medical contraindications. As noted above, for some measures, risk adjustment will be required to allow for valid comparison across sites and to avoid unintended consequences. Additionally, these quality measures are intended for use in alternative payment models that will inherently present varying levels of risk of overuse and/or underuse of health care services. As a result, it is crucial that quality measure sets include both measures of underuse and overuse.

During Phase II and subsequent phases, flexibility must be allowed for additions and changes to quality measures to adapt to evolving science and practice changes. This flexibility is especially critical in the field of oncology, which is constantly changing and moving forward based on new and emerging evidence of optimal treatments and interventions. An oncology quality measure that was appropriate before the introduction of an improved regimen, for example, may quickly become obsolete as physicians move toward the altered regimen in the treatment of their patients.

We agree with the need for annual review of implemented quality measures. ASCO completes such a review currently, and we strongly recommend that measure developers review measures intended for Phase II implementation annually for scientific soundness, refinements based on implementation testing, and ongoing meaningfulness and usefulness. Measure developers and measure implementers should be able to demonstrate robust annual review processes and methodologies; however, it is imperative that the process be under the direct control of those who are developing and implementing the measures for each specialty to ensure efficiency.

✓ *Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?*

ASCO believes it is both appropriate and desirable to reward quality improvement over time as a component of SGR reform. Additional expert guidance will be needed regarding appropriate and meaningful improvement targets, as they will likely differ based on practice baseline and the specific quality measure. For example, improvement expectations for a provider or practice with a baseline performance of 25 percent should be distinct from the provider or practice with a baseline performance of 75 percent. We suggest that the Expert Panel be charged with providing overall guidance regarding rewarding improvement, which can be customized as necessary by measure developers and implementers.

An inherent goal in quality improvement is the improvement in performance of all practices over time. Practices will start at different baselines; therefore, rather than penalizing those practices that begin at lower or higher benchmarks, ASCO believes that all practices or physicians should

also be eligible for incentives. Rather than simplifying the measures, the incentive systems should help promote lower performing practices to achieve excellence over realistic time frames. Exceptions may be necessary for practices or physicians in underserved areas with fewer resources.

ASCO advises extreme caution when developing a program to compare physicians to their peers. As stated in our response to the first iteration of the proposal, we urge you to avoid models in which the financial incentives for high quality care are limited to a certain percentage of participating physicians in a practice area. Incentive systems should encourage all physicians within a particular area of practice to excel under new models in providing high-quality, cost-effective care. Financial incentives would be warranted even – or especially – when a high percentage of physicians in a particular specialty achieve similar high performance under a quality assessment program that promotes the best interests of Medicare beneficiaries and the Medicare program.

- ✓ *Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?*

In our role as the national medical specialty society for oncology, ASCO has developed multiple quality improvement activities for oncology.

In particular, ASCO has developed the Quality Oncology Practice Initiative (QOPI), which is the leading quality measurement and quality assurance program for medical oncologists. Whereas oncology specific measures under other programs, such as PQRS, are very limited, QOPI offers more than 150 quality measures that span multiple diseases and domains of cancer care. QOPI measures evolve rapidly to reflect the pace of science and emerging clinical consensus. Now over ten years old, QOPI provides a model for the type of quality improvement measures and activities that Congress should promote across all medical specialties. Additional information about QOPI is available at: <http://qopi.asco.org>.

ASCO has a comprehensive portfolio of established clinical practice improvement activities in place for oncologists, and these programs continue to expand. They include:

- Quality Oncology Practice Initiative (QOPI): a quality improvement registry for medical oncologists, including more than 150 quality measures organized into disease-specific and domain-focused modules. More than 850 medical oncology practices are registered QOPI participants.
- QOPI Certification Program: a 3-year practice-level certification, based on performance for a subset of QOPI measures and demonstrated compliance with site safety standards. Launched in 2010, the QOPI Certification Program has certified more than 175 practices.
- Learning Collaborative: with support from an Agency for Healthcare Research and Quality grant, ASCO is initiating a virtual learning collaborative focused on practice improvement in complex areas. The initial project will focus on improvement in palliative care services offered in medical oncology practice.

- Quality Training Program: in 2013, ASCO is launching a training program for ASCO members and their practice teams in dissemination and improvement science. The training program combines traditional and experiential learning, with each participating group undertaking a local improvement project.
- Treatment Summaries and Survivorship Care Plans: standard definitions and templates for documentation of cancer treatments provided and evidence-based survivorship care, intended to enhance care coordination. A Health Level 7 (HL7) interoperability standard is under ballot.

These programs represent ASCO's already well-established clinical improvement activities. Additional programs being developed by ASCO include: expanded practice improvement programs designed to meet requirements for Continuing Medical Education (CME) and Maintenance of Certification (MOC); collection and integration of patient-reported outcomes into quality measurement and quality reporting; and development of CancerLinQ™, a rapid learning system designed to draw insight from the vast, untapped pool of data on “real world” patients. ASCO recently announced its prototype for CancerLinQ™, the society's multi-phase initiative to develop a rapid learning system in cancer care.<sup>1</sup>

As the above clearly illustrates, oncology has in place numerous clinical practice improvement activities to define, measure, and support the delivery of cancer care.

- ✓ *Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?*

ASCO strongly supports allowing providers to choose whether the assessment of their quality performance occurs at the individual or group practice level, as this flexibility will help address technical issues (such as providing options for assuring an adequate number of patient events) and also enhance quality improvement potential overall.

We believe that it is the responsibility of the specialty societies to develop and select a diversity of measures in such a way that the denominators used for interpreting the quality measures are generally valid and reliable across practices in the specialty. To ensure protection for small practices, it is logical to employ analytic rules that prevent measures with denominators below a certain threshold to be applied to these small practices (some small practices might be otherwise disadvantaged by their size alone). We suggest that a threshold number, or an analytic rule, be established by the Expert Panel.

In the area of oncology, state chapters within our specialty society have achieved success in establishing collaborative improvement networks to facilitate and promote participation in our national quality assurance program, QOPI, among oncology practices of all sizes.

### Phase III:

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<sup>1</sup> Additional information on ASCO's CancerLinQ initiative is available at: <http://ascoaction.asco.org/Home/tabid/41/articleType/ArticleView/articleId/322/ASCO-Begins-First-Phase-of-CancerLinQ-the-Development-of-a-Prototype-of-a-Breast-Cancer-Specific-Rapid-Learning-System.aspx>.

- ✓ *How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?*

ASCO urges caution over speed in refining these complex methodologies that carry a great deal of risk if not implemented properly. Efficiency is difficult to measure and may be measured differently by specialty, or even within specialties. For example, in the treatment of cancer, consideration must be given to differences in practice setting when determining efficiency metrics.

- ✓ *Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?*

Yes, otherwise there is a risk of sacrificing quality for efficiency in resource utilization or of underutilization. High quality care must always trump efficiency. High quality care at a low cost equals value; low quality care at a low cost has no value at all.

#### Alternative Payment Model (APM) Adoption:

- ✓ *What do you believe will be necessary to support provider participation in new payment models?*

As recognized in your proposal, stability is a key component in encouraging providers to consider new payment models. Continual uncertainty around both Medicare reimbursement policies and the details of program administration discourage physicians from participating in the testing of, or investing in, the necessary infrastructure for such new models.

Involvement of the national medical specialty societies in the development and testing of models will go a long way toward building the trust necessary for physicians to make these important transitions. Any new models must be extensively field tested to understand the impact on patient care, the feasibility and the ability to achieve the goals of quality improvement and cost reduction. Models that succeed in demonstrating improved value (increased quality/decreased cost) must have a detailed methodology published so that others can implement these successful programs efficiently and successfully. Published data on the resources necessary and the costs of implementing an alternative payment model (APM) should be easily available, and successful pioneers in APM development could participate in formal or informal programs where they would function as mentors for other practices seeking to institute these reforms.

- ✓ *What is a reasonable time frame for CMS to approve and adopt APMs?*

ASCO recommends allowing 3-5 years for the testing of models and for the evolution of necessary quality metrics and analytics. The overall progress can be expedited by testing the new models in parallel with all phases of the proposals.

- ✓ *Should providers be able to participate in more than one payment model?*

ASCO believes that physician practices and individual physicians should be able to participate in more than one payment model.

Current Law Improvement:

- ✓ *What improvements upon current law do you believe will be required to support alternative payment model adoption?*

ASCO strongly supports the goals of federal programs to promote health information technology (HIT) adoption and quality improvement, but the current patchwork of requirements for the numerous federal programs overlap and lead to confusion for physicians. The EHR meaningful use incentive program, PQRS, and eRx incentive program have similar requirements in many areas, and their competing reporting timelines has led to complex and burdensome reporting for all providers. While Congress and some federal agencies have made progress on streamlining these programs, ASCO urges policymakers to harmonize these programs, slow the pace of regulatory development with the EHR meaningful use program, and, in general, to be cautious about and fully analyze the effects of any further policy in health IT.

- ✓ *What improvements upon current law will help ease the administrative burden upon medical providers and allow more time care for Medicare beneficiaries?*

Although electronic health records (EHR) show much promise in reforming the system, numerous burdens must be eased to take full advantage of the potential of EHRs. EHRs should be required to have standard reporting capabilities so that practices can automatically transmit data to data registries and other quality monitoring organizations.

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Thank you again for the opportunity to provide ASCO's input and for your commitment to repealing and replacing the SGR this year. ASCO stands ready to work with you toward a more stable, rational and sustainable system that ensures access for Medicare beneficiaries with cancer. If you have any questions or would like to request assistance from ASCO on any issue involving the care of individuals with cancer, please do not hesitate to contact Shelagh Foster at 571-483-1612 or [shelagh.foster@asco.org](mailto:shelagh.foster@asco.org).

Sincerely,



Sandra M. Swain, MD, FACP  
President, American Society of Clinical Oncology