

December 13, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Oncology Care First Model: Informal Request for Information (November 1, 2019)

Dear Administrator Verma:

The National Navigation Roundtable (NNRT) appreciates the opportunity to comment on the informal request for information (RFI) regarding a potential Oncology Care First (OCF) model. The NNRT is a national coalition of public, private, and voluntary organizations whose mission is to advance navigation efforts that eliminate barriers to quality cancer care, reduce disparities in health outcomes and foster ongoing health equity. The NNRT focuses on navigation through the cancer lens and across the cancer continuum (from prevention to survivorship).

NNRT commends CMS and the Innovation Center for its emphasis on improving the quality of care for Medicare beneficiaries with cancer while at the same time reducing program spending. This emphasis is clear in the implementation of CMS' current Oncology Care Model (OCM). In particular, we have supported the inclusion of patient navigation as an enhanced service in the OCM, and continue to support its inclusion in the proposed new OCF model.

The patient navigation model has demonstrated its value for providing care for vulnerable populations, including patients with low income, low educational attainment, high comorbidities and multiple barriers to receipt of high-quality care due to social determinants of health. For individuals with chronic conditions like cancer, trying to coordinate services while juggling treatment and employment and/or family obligations adds an additional layer of stress that can negatively impact the outcome of their care. Evidence continues to build that patient navigation leads to better outcomes for patients, system efficiencies, and a significant return-on-investment. Navigated patients are: more likely to initiate treatment within 30-60 days from diagnosis,^{1,2} have increased adherence to recommended cancer screening^{3,4,5} and cancer care,⁶ increased smoking cessation,⁷ improved quality of life⁸ and increased patient satisfaction.⁹ Studies have also shown that patient navigation decreases hospital readmission among older high risk, safety-net patients;¹⁰ and decreases emergency department and admissions among patients with advanced cancer.¹¹

The evidence on the effectiveness and efficacy of patient navigation clearly demonstrates that this model of care meets the aims of the CMS Innovation Center to achieve better care for patients while reducing costs. The National Cancer Institute's Patient Navigation Research Program has published over 50 peer-reviewed articles demonstrating the benefit of patient navigation towards increasing quality of care for cancer patients during both the diagnostic and treatment phases of care. Specifically, the trial demonstrated that vulnerable populations were more likely to benefit from the intervention, as defined by minority racial and ethnic status, low income, and low educational attainment, housing instability. Additionally, the University of Alabama at Birmingham CMI patient navigation program has demonstrated in an urban and rural Medicare population, the ability of the patient navigation model to improve

quality of care during active cancer treatment and in end of life care and reduce costs related to unnecessary emergency room visits and hospital readmissions.

For all these reasons, we believe that for patients, the requirement to provide patient navigation is one of the most impactful elements of the current model, and would continue in impact in the new model. We agree with CMS' statement that these activities "continue to be critical for high-quality care," and its wish to "continue supporting and building on the practice transformation work from OCM participants." We strongly encourage CMS to continue to include these requirements in the OCF model – but we also encourage CMS to consider ways to use this requirement to build on the successes of OCM, instead of just carrying over the same requirement.

The evaluation of the OCM for performance period one¹² – the only evaluative information available currently – showed that OCM practices are incorporating patient navigation services. However, provision of specific services like arrangements for transportation or language translation is not universal; and some OCM practices do not employ dedicated navigators. The report also notes that some practices "rely at least in part on nurse navigators at an affiliated or neighboring hospital where the patient had initial surgery."¹³ The report authors also state that "two independent practices increased their patient navigation/care coordination staff for OCM,"¹⁴ implying that other OCM practices did *not* increase their patient navigation staff for the model. While these results show some promising steps to improving patient outcomes through patient navigation, NNRT hopes they can be improved upon in future evaluations and models.

While we recognize the importance of OCF PGP participants having flexibility in implementing the patient navigation requirement, we encourage CMS to make the following changes to the requirement and its implementation:

- Provide more comprehensive information about patient navigation to PGP applicants and eventual participants. The RFI links to the description of an inactive National Cancer Institute demonstration project¹⁵ to define "core functions of patient navigation" – and does not make clear which elements of this web page, if any, are actually required. We urge CMS to instead refer applicants and eventual model participants to an evidence-based, consensus document that delineates the roles of various patient navigator types, and to list the patient navigation services it expects PGP participants to provide to patients. These would include a process to identify patients in need of navigation, identifying logistic barriers or social needs (social determinants of health), support patients in addressing social barriers, and tracking patients through their recommended care.^{16,17,18,19}
- PGP participants would still have the flexibility to determine how they will provide these services to their patients, but this would ensure that patients have access to a basic minimum of services.
- Encourage PGP participants to designate patient navigators on staff and identify appropriate community partners to assist with services and resources beyond the scope of the enhanced services offered. This will allow for greater integration of navigation processes into PGP participant workflows. CMS could continue to give PGP participants the flexibility to determine which types of staff they designate as navigators, and whether to have staff devoted full-time to this function, or to have part of multiple staff-persons' time designated towards patient navigation.
- More closely evaluate how PGP participants are implementing the patient navigation requirement. We encourage CMS to hold practices accountable for this requirement through its evaluation process, including requiring practices to document and report on at least an annual basis: 1) the structure of their navigation program – to include who is providing navigation (including titles and qualifications), 2) what services are provided to patients, 3) how many patients are receiving navigation services. This will not only hold practices accountable for this requirement, but also provide valuable information to the public and to other practices

who want to incorporate patient navigation. We also encourage CMS to explore in its future evaluations of the model how PGP participants are using the Monthly Population Payments to improve the quality of cancer care.

- Work with patient navigation stakeholders to provide PGP participants with ongoing resources to improve the quality of navigation services offered. Provide a mechanism (such as a listserv or discussion forum) which allows patient navigators working in or with PGP participants to contact one another to share lessons learned and gain insights on a daily basis. We also urge CMS to provide ongoing avenues or a repository for professional development to PGP participants to build on or improve the quality of navigation services offered. The leadership of NNRT would be happy to discuss further opportunities like this with CMS.

NNRT appreciates the opportunity to offer comments on the informal RFI for the Oncology Care First Model. We support improving the delivery of care for cancer patients and look forward to working with CMS on the model. We urge you to actively engage cancer patient advocates in the final design and implementation of the OCF model to help ensure its success. Please feel free to contact Jennifer Hoque at Jennifer.Hoque@cancer.org with any questions about our comments, or to schedule a discussion with the experts or leadership of the National Navigation Roundtable.

Sincerely,



Tracy Battaglia, MD, MPH
Chair, National Navigation Roundtable



Andrea Dwyer
Vice Chair, National Navigation Roundtable

¹ Freund et al., “Impact of Patient Navigation on Timely Cancer Care: The Patient Navigation Research Program.” *Journal of the National Cancer Institute* 106, no. 6 (June 2014): dju115, <https://doi.org/10.1093/jnci/dju115>.

² Ramirez et al., “Reducing Time-to-Treatment in Underserved Latinas with Breast Cancer: The Six Cities Study.” *Cancer* 120, no. 5 (March 1, 2014): 752–60, <https://doi.org/10.1002/cncr.28450>.

³ Nasar U Ahmed et al., “Randomized Controlled Trial of Mammography Intervention in Insured Very Low-Income Women.” *Cancer Epidemiology, Biomarkers & Prevention: A Publication of the American Association for Cancer Research*, Cosponsored by the American Society of Preventive Oncology 19, no. 7 (July 2010): 1790–98, <https://doi.org/10.1158/1055-9965.EPI-10-0141>.

⁴ Taylor et al., “A Randomized Controlled Trial of Interventions to Promote Cervical Cancer Screening among Chinese Women in North America.”

⁵ Karen E Lasser et al., “Colorectal Cancer Screening among Ethnically Diverse, Low-Income Patients: A Randomized Controlled Trial.” *Archives of Internal Medicine* 171, no. 10 (May 23, 2011): 906–12, <https://doi.org/10.1001/archinternmed.2011.201>.

⁶ Naomi Y Ko et al., “Can Patient Navigation Improve Receipt of Recommended Breast Cancer Care? Evidence from the National Patient Navigation Research Program.” *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology* 32, no. 25 (September 1, 2014): 2758–64, <https://doi.org/10.1200/JCO.2014.28.25>.

⁷ Karen E. Lasser et al., “Effect of Patient Navigation and Financial Incentives on Smoking Cessation Among Primary Care Patients at an Urban Safety-Net Hospital,” *JAMA Internal Medicine* 177, no. 12 (December 1, 2017): 1798, <https://doi.org/10.1001/jamainternmed.2017.4372>.

⁸ Janine Giese-Davis et al., “Peer-Counseling for Women Newly Diagnosed with Breast Cancer: A Randomized Community/Research Collaboration Trial.” *Cancer* 122, no. 15 (August 1, 2016): 2408–17, <https://doi.org/10.1002/cncr.30036>.

⁹ Pascal Jean-Pierre et al., “Satisfaction with Cancer Care among Underserved Racial-Ethnic Minorities and Lower-Income Patients Receiving Patient Navigation,” *Cancer* 122, no. 7 (April 1, 2016): 1060–67, <https://doi.org/10.1002/cncr.29902>.

¹⁰ Richard B Balaban et al., “A Patient Navigator Intervention to Reduce Hospital Readmissions among High-Risk Safety-Net Patients: A Randomized Controlled Trial,” *Journal of General Internal Medicine* 30, no. 7 (July 2015): 907–15, <https://doi.org/10.1007/s11606-015-3185-x>.

¹¹ Kvale EA Rocque GB, Williams CP, Jones MI, Kenzik KM, Williams GR, AzueroA, Jackson BE, Halilova KI, Meneses K, Taylor RA, Partridge E, Pisu M, “Healthcare Utilization, Medicare Spending, and Sources of Patient Distress Identified during Implementation of a Lay Navigation Program for Older Patients with Breast Cancer,” *Breast Cancer Res Treat* 167, no. 1 (2018): 215–23, <https://doi.org/10.1007/s10549-017-4498-8>.

¹² Abt Associates. Evaluation of the Oncology Care Model: Performance Period One. December 2018. <https://innovation.cms.gov/Files/reports/ocm-secondannualeval-pp1.pdf>

¹³ Ibid. See pg. 63.

¹⁴ Ibid. See pg. 63.

¹⁵ <https://www.cancer.gov/about-nci/organization/crhd/disparities-research/pnpr#PNRP-Overview>

¹⁶ Freund K, Haas J, Lemon S, et al. Standardized Activities for Lay Patient Navigators in Breast Cancer Care: Recommendations from a city-wide implementation study. *Cancer*. 2019 [ahead of print]. NIHMS1042680.

¹⁷ Willis A., et al. Development of a Framework for Patient Navigation: Delineating Roles Across Navigator Types. *Journal of Oncology Navigation & Survivorship*. December 2013 Vol 4, No 6. <http://www.jons-online.com/issues/2013/december-2013-vol-4-no-6?view=article&artid=1249:development-of-a-framework-for-patient-navigation-delineating-roles-across-navigator-types>

¹⁸ Academy of Oncology Nurse & Patient Navigators. Standardized Evidence-Based Oncology Navigation Metrics for All Models: A Powerful Tool in Assessing the Value and Impact of Navigation Programs. *Journal of Oncology Navigation & Survivorship* May 2017. Vol 8, No 5. <http://www.jons-online.com/issues/2017/may-2017-vol-9-no-5/1623-value-impact-of-navigation-programs>

¹⁹ Strusowski, Tricia and Johnston, Danelle. AONN+ Evidence-Based Oncology Navigation Metrics Crosswalk with National Oncology Standards and Indicators. *Journal of Oncology Navigation & Survivorship* June 2018. Vol 9, No 6. <http://www.jons-online.com/issues/2018/june-2018-vol-9-no-6/1852-aonn-evidence-based-oncology-navigation-metrics-crosswalk-with-national-jons-oncology-standards-and-indicators>