

115TH CONGRESS
2D SESSION

H. R. 5160

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

MARCH 5, 2018

Mr. DESAULNIER (for himself and Mr. POE of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Cancer Care Planning and Communications Act of
6 2018”.

7 (b) FINDINGS.—Congress makes the following find-
8 ings:

1 (1) Cancer care in the United States is often
2 described as the best in the world because patients
3 have access to many treatment options, including
4 cutting-edge therapies that save lives and improve
5 the quality of life.

6 (2) Access to the best treatment options is not
7 equal across all populations and in all communities.
8 The 1999 Institute of Medicine report entitled “The
9 Unequal Burden of Cancer” found that low-income
10 people often lack access to adequate cancer care and
11 that ethnic minorities have not benefitted fully from
12 cancer treatment advances.

13 (3) In addition, despite access to high-quality
14 treatment options for many, individuals with cancer
15 often do not have access to a cancer care system
16 that incorporates shared decision-making and the co-
17 ordination of all elements of care.

18 (4) Cancer survivors often experience the
19 under-diagnosis and under-treatment of the symp-
20 toms of cancer and side effects of cancer treatment,
21 a problem that begins at the time of diagnosis and
22 may become more severe with disease progression
23 and at the end of life. The failure to treat the symp-
24 toms, side effects, and late effects of cancer and can-
25 cer treatment may have a serious adverse impact on

1 the health, survival, well-being, and quality of life of
2 cancer survivors.

3 (5) Individuals with cancer often do not partici-
4 pate in a shared decision-making process that con-
5 siders all treatment options and do not benefit from
6 coordination of all elements of active treatment and
7 palliative care.

8 (6) Quality cancer care should incorporate ac-
9 cess to psychosocial services and management of the
10 symptoms of cancer and the symptoms of cancer
11 treatment, including pain, nausea, vomiting, fatigue,
12 and depression.

13 (7) Quality cancer care should include a means
14 for engaging cancer survivors in a shared decision-
15 making process that produces a comprehensive care
16 summary and a plan for follow-up care after primary
17 treatment to ensure that cancer survivors have ac-
18 cess to follow-up monitoring and treatment of pos-
19 sible late effects of cancer and cancer treatment, in-
20 cluding appropriate psychosocial services.

21 (8) The Institute of Medicine report entitled
22 “Ensuring Quality Cancer Care” described the ele-
23 ments of quality care for an individual with cancer
24 to include—

1 (A) the development of initial treatment
2 recommendations by an experienced health care
3 provider;

4 (B) the development of a plan for the
5 course of treatment of the individual and com-
6 munication of the plan to the individual;

7 (C) access to the resources necessary to
8 implement the course of treatment;

9 (D) access to high-quality clinical trials;

10 (E) a mechanism to coordinate services for
11 the treatment of the individual; and

12 (F) psychosocial support services and com-
13 passionate care for the individual.

14 (9) In its report “From Cancer Patient to Can-
15 cer Survivor: Lost in Transition”, the Institute of
16 Medicine recommended that individuals with cancer
17 completing primary treatment be provided a com-
18 prehensive summary of their care along with a fol-
19 low-up survivorship plan of treatment.

20 (10) In “Cancer Care for the Whole Patient”,
21 the Institute of Medicine stated that the develop-
22 ment of a plan that includes biomedical and psycho-
23 social care should be a standard for quality cancer
24 care in any quality measurement system.

1 (11) The Commission on Cancer has encour-
2 aged survivorship care planning by making the de-
3 velopment of such plans for patients one of the
4 standards of accreditation for cancer care providers,
5 but cancer care professionals report difficulties com-
6 pleting the plans.

7 (12) Because more than half of all cancer diag-
8 noses occur among elderly Medicare beneficiaries,
9 addressing cancer care inadequacies through Medi-
10 care reforms will provide benefits to millions of
11 Americans. Providing Medicare beneficiaries more
12 routine access to cancer care plans and survivorship
13 care plans is a key to shared decisionmaking and
14 better coordination of care.

15 (13) Important payment and delivery reforms
16 that incorporate cancer care planning and coordina-
17 tion are already being tested in the Medicare pro-
18 gram; the Oncology Care Model has been imple-
19 mented in a number of oncology practices, and addi-
20 tional models that will include care planning have
21 been proposed.

22 (14) The alternative payment models, including
23 the Oncology Care Model, provide access to cancer
24 care planning for Medicare beneficiaries who receive
25 their cancer care in practices that are part of the

1 Oncology Care Model. Other Medicare beneficiaries
2 who are not enrolled in these delivery demonstra-
3 tions may not have access to a cancer care plan or
4 appropriate care coordination.

5 (15) The failure to provide a cancer care plan
6 to patients in many care settings relates in part to
7 inadequate Medicare payment for such planning and
8 coordination services.

9 (16) Changes in Medicare payment for cancer
10 care planning and coordination will support shared
11 decisionmaking that reviews all treatment options
12 and will contribute to improved care for individuals
13 with cancer from the time of diagnosis through the
14 end of the life. Medicare payment for cancer care
15 planning may begin a reform process that helps us
16 realize the well-planned and well-coordinated cancer
17 care that has been recommended by the Institute of
18 Medicine/National Academy of Medicine and that is
19 preferred by cancer patients across the Nation.

20 **SEC. 2. COVERAGE OF CANCER CARE PLANNING AND CO-**
21 **ORDINATION SERVICES.**

22 (a) IN GENERAL.—Section 1861 of the Social Secu-
23 rity Act (42 U.S.C. 1395x) is amended—

24 (1) in subsection (s)(2)—

1 (A) by striking “and” at the end of sub-
2 paragraph (FF);

3 (B) by adding “and” at the end of sub-
4 paragraph (GG); and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(HH) cancer care planning and coordination
8 services (as defined in subsection (jjj))”; and

9 (2) by adding at the end the following new sub-
10 section:

11 “Cancer Care Planning and Coordination Services

12 “(jjj)(1) The term ‘cancer care planning and coordi-
13 nation services’ means—

14 “(A) with respect to an individual who is diag-
15 nosed with cancer, the development of a treatment
16 plan by a physician, nurse practitioner, or physician
17 assistant that—

18 “(i) includes an assessment of the individ-
19 ual’s diagnosis, health status, treatment needs,
20 functional status, pain control, and psychosocial
21 needs;

22 “(ii) engages the individual in a shared de-
23 cision-making process that reviews all treatment
24 options;

1 “(iii) details, to the greatest extent prac-
2 ticable all aspects of the care to be provided to
3 the individual with respect to the treatment of
4 such cancer, including any curative treatment,
5 comprehensive symptom management, and pal-
6 liative care;

7 “(iv) is furnished in person, in written
8 form, to the individual within a period specified
9 by the Secretary that is as soon as practicable
10 after the date on which the individual is so di-
11 agnosed;

12 “(v) is furnished, to the greatest extent
13 practicable, in a form that appropriately takes
14 into account cultural and linguistic needs of the
15 individual in order to make the plan accessible
16 to the individual; and

17 “(vi) is in accordance with standards de-
18 termined by the Secretary to be appropriate;

19 “(B) with respect to an individual for whom a
20 treatment plan has been developed under subpara-
21 graph (A), the revision of such treatment plan as
22 necessary to account for any substantial change in
23 the condition of the individual, recurrence of disease,
24 changes in the individual’s treatment preferences, or
25 significant revision of the elements of curative care

1 or symptom management for the individual, if such
2 revision—

3 “(i) is in accordance with clauses (i), (ii),
4 (iv) and (v) of such subparagraph; and

5 “(ii) is furnished in written form to the in-
6 dividual within a period specified by the Sec-
7 retary that is as soon as practicable after the
8 date of such revision;

9 “(C) with respect to an individual who has com-
10 pleted the primary treatment for cancer, as defined
11 by the Secretary, the development of a follow-up sur-
12 vivorship care plan that—

13 “(i) includes an assessment of the individ-
14 ual’s diagnosis, health status, treatment needs,
15 functional status, pain control, and psychosocial
16 needs;

17 “(ii) engages the individual in a shared de-
18 cision-making process that reviews all survivor-
19 ship care options;

20 “(iii) describes the elements of the primary
21 treatment, including symptom management and
22 palliative care, furnished to such individual;

23 “(iv) provides recommendations for the
24 subsequent care of the individual with respect
25 to the cancer involved;

1 “(v) is furnished, in person, in written
2 form, to the individual within a period specified
3 by the Secretary that is as soon as practicable
4 after the completion of such primary treatment;

5 “(vi) is furnished, to the greatest extent
6 practicable, in a form that appropriately takes
7 into account cultural and linguistic needs of the
8 individual in order to make the plan accessible
9 to the individual; and

10 “(vii) is in accordance with standards de-
11 termined by the Secretary to be appropriate;
12 and

13 “(D) with respect to an individual for whom a
14 follow-up cancer care plan has been developed under
15 subparagraph (C), the revision of such plan as nec-
16 essary to account for any substantial change in the
17 condition of the individual, diagnosis of a second
18 cancer, change in the individual’s preference for sur-
19 vivorship care, or significant revision of the plan for
20 follow-up care, if such revision—

21 “(i) is in accordance with clauses (i), (ii),
22 (iii), (v), and (vi) of such subparagraph; and

23 “(ii) is furnished in written form to the in-
24 dividual within a period specified by the Sec-

1 retary that is as soon as practicable after the
2 date of such revision.

3 “(2) The Secretary shall establish standards to carry
4 out paragraph (1) in consultation with appropriate organi-
5 zations representing suppliers and providers of services re-
6 lated to cancer treatment and organizations representing
7 survivors of cancer. Such standards shall include stand-
8 ards for determining the need and frequency for revisions
9 of the treatment plans and follow-up survivorship care
10 plans based on changes in the condition of the individual
11 or elements and intent of treatment and standards for the
12 communication of the plan to the individual.

13 “(3) In this subsection, the term ‘shared decision-
14 making process’ means, with respect to an individual, a
15 process in which the individual and the individual’s health
16 care providers consider the individual’s diagnosis, treat-
17 ment options, the medical evidence related to treatment
18 options, the risks and benefits of all treatment options,
19 and the individual’s preferences regarding treatment, and
20 then jointly develop and implement a treatment plan.”.

21 (b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—

22 (1) IN GENERAL.—Section 1848(j)(3) of the
23 Social Security Act (42 U.S.C. 1395w-4(j)(3)) is
24 amended by inserting “(HH),” after “health risk as-
25 sessment),”.

1 (2) INITIAL RATES.—Unless the Secretary of
2 Health and Human Services otherwise provides, the
3 payment rate specified under the physician fee
4 schedule under the amendment made by paragraph
5 (1) for cancer care planning and coordination serv-
6 ices shall be the same payment rate as provided for
7 transitional care management services (as defined in
8 CPT code 99496).

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to services furnished on or after
11 the first day of the first calendar year that begins after
12 the date of the enactment of this Act.

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