October 31, 2022

The Honorable Ami Bera, MD
U.S. House of Representatives
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Washington, D.C. 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
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The Honorable Kim Schrier, MD
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The Honorable Michael Burgess, MD
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The Honorable Earl Blumenauer
U.S. House of Representatives
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The Honorable Brad Wenstrup, DPM
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The Honorable Bradley Schneider
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The Honorable Mariannette Miller-Meeks, M.D.
U.S. House of Representatives
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Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks,

On behalf of The US Oncology Network (The Network), which represents more than 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to provide feedback on the current state of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and associated payment mechanisms.

The US Oncology Network is one of the nation's largest and most innovative networks of independent, community-based oncology providers, treating more than 1.2 million cancer patients annually in more than 450 locations across 25 states. The Network unites over 1,400 like-minded physicians around a common vision of expanding patient access to the highest quality, state-of-the-art care close to home and at lower costs for patients and the health care system. The Network has long been an avid proponent of value-based care because it motivates better quality, outcomes, and patient experience at a sustainable cost.

The Network's commitment to the evolution of value-based care is demonstrated by our participation in the Oncology Care Model (OCM), a voluntary demonstration program from the Center for Medicare and Medicaid Innovation (CMMI) running from 2016-2021. The OCM required participating practices to manage all aspects of a cancer patient's care delivery (including prescription drugs and emergency department visits) for a 6-month episode. Over the duration of the 6-year model, Network practices enrolled more than 125,000 unique patients and saved the Medicare program nearly $300 million relative to benchmark prices. These results stemmed from investments in practice transformation that led to a 30% reduction in hospitalizations, a 19% decrease in ED visits, and an 8% increase in hospice stays longer than three days. While the OCM improved the quality of care for patients and resulted in real savings to the Medicare program, opportunities remain to the improve the design of alternative payment models (APM) and increase provider participation.

As we work towards greater participation in APMs, payment stability in the Medicare Physician Fee Schedule (PFS) is critical. Without payment certainty and predictability, independent physician practices will be

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reluctant to take on additional risk. The Network continues to support MACRA's goal of tying payment to quality and is hopeful this goal can still be sought through more predictable payment updates and improved incentives and updates to the Medicare Quality Payment Program. In response to the request for information (RFI),The Network would like to comment on the following areas to assist Congress in its efforts to stabilize the Medicare payment system and increase provider participation in value-based payment models:

Regulatory, Statutory, and Implementation Barriers

The passage of MACRA was well-intentioned as a replacement to the years of threatened payment cuts stemming from the "Sustainable Growth Rate," and we appreciate the extensive work by Congressional Committees to take stakeholder feedback to craft the final policy. The original timeline envisioned by MACRA was to provide steady payment to physicians while ramping up the program (2015-2019), create opportunity for incentive payments through the Merit-Based Incentive Payment System (MIPS) and the APM Qualifying Participant (QP) bonus to increase participation in VBC arrangements and activities (2020-2025), and then transition to a more modest conversation factor after the program was further established (2026 and beyond). It was expected that by payment year 2026 (performance year 2024), enough providers would be participating in and receiving shared savings from APMs that the modest increase would be an appropriate update for future years. However, this timeline was largely based on budget constraints, the ten-year scoring window, and the desire to push providers into APMs quickly.

Unfortunately, the goals of the statute have not been realized on this timeline. Following MACRA passage, as CMS was implementing the policy, the agency set a goal of tying 30% of Medicare payments to quality or value through APMs by 2016 and 50% by 2018;[1] however; only 43% of MIPS eligible clinicians were participating in APMs as of 2020, and CMS estimates that only between 14 -18% of clinicians will receive the 5% Advanced APM bonus for performance year 2022 (payment year 2024).[2] This is in part due to the lack of available models, but also a result of the COVID-19 global pandemic which was hugely disruptive to the medical community. Physician practices face an additional challenge today with historically high inflation rates and rising practice expenses. Given the delayed progress toward this goal, Congress should reconsider this timeline and extend existing incentives to continue encouraging provider participation in APMs.

QP Thresholds

Under MACRA, providers that participate in an Advanced APM and achieve QP status are exempt from MIPS and eligible to receive additional financial incentives; however, providers are continuing to face challenges meeting the existing criteria to achieve QP certification and the thresholds are set to increase in 2023. Currently, the threshold score for an APM entity is calculated in one of two ways, either the payment amount method or patient count method. The threshold score using the payment count method is calculated by dividing: (1) the aggregate of payments for Medicare Part B covered professional services furnished by the APM entity group to attributed beneficiaries during the QP performance period; by (2) aggregate of payments for Medicare Part B covered professional services furnished by the APM entity group to all attribution-eligible beneficiaries during the QP performance period. The threshold score using the patient count method is calculated by dividing: (1) the number of attributed beneficiaries to whom the APM entity group furnishes Medicare Part B covered professional services; by (2) the number of attribution-eligible beneficiaries to whom the APM entity group furnishes Medicare Part B covered professional services.

The current threshold for full QP status is 50% of payments or 35% of patients; this will increase to 75% of payments or 50% of patients for performance years beginning with 2023. The current threshold for partial QP status is 40% of payments or 25% of patients; this will increase to 50% of payments or 35% of patients for performance years beginning with 2023. Achieving partial QP status gives practices the option to choose whether or not to participate in MIPS, but they are not eligible for the additional financial incentive.

[1] https://www.nejm.org/doi/full/10.1056/nejmp1500445
[2] https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_Physician_FINAL_SEC.pdf

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Importantly, the ability to meet the QP threshold can be limited by the design of the APM and may be beyond the control of the provider. For example, providers often see Medicare patients that are not in an APM because APM eligibility is based on patients actively receiving certain treatment. Relatedly, CMS recently announced the Enhancing Oncology Model (EOM), which builds on the OCM and is set to begin on July 1, 2023. While we are encouraged by what is known so far about the new model, The Network is concerned about the ability of future EOM practices to achieve the QP threshold. According to CMS, the average payment threshold score in OCM was 53% (just barely meeting the current 50% threshold), and the average patient threshold score was 21% (far below the current 35% threshold). Compared to the OCM, EOM will only enroll patients who are receiving systemic chemotherapy for 1 of 7 types of cancers, inevitably reducing the number of episodes and payments. This will make the existing targets more challenging to achieve and the higher thresholds more daunting.

Advanced APM Inventive Payment

Additionally, after performance year 2022 (payment year 2024), there is no further statutory authority for the 5% Advanced APM incentive payment. In performance year 2023 (payment year 2025), the statute does not provide an incentive for eligible clinicians who become QPs. Beginning in performance year 2024 (payment year 2026), the update to the conversion factor for QP-eligible clinicians is 0.75%, and the update to the general conversion factor is 0.25%.

The EOM will require participating practices to accept 2-sided risk on Day 1 and will also reduce the upfront payment amount to fund enhanced services. In summary, practices are being asked to do more with less at the same time that the reward for participating is lower, given the sunsetting 5% Advanced APM bonus and the much lower 0.75% Medicare payment adjustment. These factors may act as a deterrent to participation, especially for practices who did not participate in OCM and have not made the initial investments in software or staffing that are necessary for successful participation in a model like the EOM. The Network urges Congress to extend the existing QP threshold scores and the 5% Advanced APM bonus to continue incentivizing participation in Advanced APMs.

Increasing Provider Participation in Value-Based Payment Models

Independent practices are under considerable financial and administrative strain today. According to an April 2022 report by the Physicians Advocacy Institute and Avalere, over 52% of physicians were employed by hospitals in January 2022.[3] This finding mirrors the American Medical Association's 2020 Physician Private Practice Benchmark Survey,[4] which found 49.1% of patient care physicians worked in private practice, the first time the share of physicians in private practices has dropped below 50% since the AMA analysis began in 2012. Many physician practices, particularly those in rural areas, may be enthusiastic about the premise of value-based care but simply lack the resources to pursue it. Therefore, it is critical that APMs are designed with enough flexibility to allow participation from all providers that comprise our healthcare delivery system. In addition to the statutory changes discussed above, Congress should encourage CMS to consider the following when designing new APMs:

First, introduction and testing of new APMs must be voluntary. The OCM was a voluntary model yet still experienced robust patient and provider enrollment and produced meaningful results. CMMI has proposed mandatory models, such as the Medicare Part B Drug Demo, the International Pricing Index, the Most Favored Nation Model, and the Radiation Oncology (RO) Model, but they were met with strong stakeholder pushback due to their punitive nature and CMMI ultimately did not finalize them. A voluntary model can be phased-in and iterative to allow more sophisticated practices to test the model before expanding it to practices that may have less resources.

[3] http://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21
[4] https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf

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Second, stakeholder engagement and physician-buy in must remain a cornerstone of any transition to new payment models. Two-way dialogue and transparency between CMS and interested practices is crucial to model success. This includes transparency into model payment methodology. If providers are able to fully understand a model's impact on their practice's financials and benefit to patient care, they are more likely to embrace the model. The high level of provider enrollment in the OCM also reflects the collaborative approach that CMMI took in developing and implementing the model, during which CMMI addressed stakeholder questions and concerns.

Third, practice transformation takes time and resources. Our experience in standing up VBC models in both Medicare and commercial plans has taught us that there is typically significant upfront and ongoing financial investment required. In the OCM, CMS provided a monthly enhanced oncology services (MEOS) payment on a per-member basis that was instrumental in helping practices make that investment. For example, participating practices used the MEOS payment to invest in services like patient navigation, afterhours access, social work, psychosocial/ mental health, telehealth, palliative care, advance care planning, and nutrition, which, in turn, improved the patient experience and reduced costs by mitigating clinical deterioration and hospitalization. Many of these services are typically not reimbursed otherwise, making it difficult for practices to offer them. While a MEOS-type payment is a critical component of any model that requires practices to offer entirely new services with new staffing, it is especially key for attracting the participation of small and community-based practices that can also help meet health equity goals. In contrast, models proposed by CMS (such as the RO Model) that were mandatory and would have required immediate cuts while increasing provider burden received significant stakeholder pushback.

In addition to financial investment, the OCM demanded a fundamental shift in the delivery of patient care, including the scope and coordination of the care team. Because of this, we did not begin to see meaningful changes in key OCM metrics across The Network until PP3. For example, we saw a 7% reduction in hospitalizations from PP1 to PP3, and a 30% reduction in hospitalizations by PP10. As practices gained more experience in OCM, they were better able to control for costs, which is likely common for many alternative payment models. Therefore, it is important that CMMI assess a model's performance based on the full length of the model, rather than interim evaluation reports.

In summary, The Network believes that with properly-designed APMs backed by stakeholder support, more and more clinicians will embrace risk-based models in which providers share in the costs or savings to the Medicare program based on actual outcomes.

Recommendations to Improve MIPS and APM Programs

Improved Access to Timely Data

The Network believes CMS should offer timelier access to comprehensive claims data for VBC participants to help them more easily monitor their performance and take corrective action. The availability of participant data is immensely valuable in improving model performance, physician satisfaction, and ultimately patient outcomes. Timelier access to data/ feedback reports would allow us to see trends that are fresh and give the provider and care team the ability to course-correct and implement changes that can have measurable, more immediate impacts to patient care. For example, in the OCM, feedback reports and raw claims data were not available for 6 months or longer; official results were not available until 20 months after the start of a Performance Period. If data were available sooner, we could identify patients that are at risk for readmission and more quickly test new ideas by seeing near term outcomes.

Reporting Requirements and Provider Burden

We appreciate Congress' and CMS' recognition of the growing burdens on providers. We encourage further consideration of the administrative and reporting burdens in Medicare VBC programs to help practices focus on transformation and delivering care for patients. The OCM, for example, required participating practices to submit significant amounts of clinical, staging and quality data on an ongoing basis requiring extensive

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technology, tools, and practice staff time to capture and collate. We recognize the need for the data, but we believe there may be a more innovative way in which the data could be accumulated by Medicare with less burden on practices. In a similar vein, if clinical or sociodemographic data submission is required for APM participation, it should be used to inform program performance or stratify patients to assess the impact of social drivers of health.

The Network encourages the alignment of measure selection and measure specifications across reporting programs, federal and state agencies, and the private sector. Better harmonization of quality measures across VBC programs would also help align expectations, workflow, and performance. Additionally, we believe there are opportunities to prioritize high-impact and outcomes-geared measures to bring more value to the patients we serve.

MIPS Value Pathways
CMS has expressed their belief that MIPS Value Pathways (MVPs) will serve as a steppingstone for practices to engage in APMs. In order for MVPs to serve as a bridge towards APM participation, it is critical that the quality measures and improvement activities align between the specialty MVPs and corresponding APMs established by CMMI. Practices are hesitant to engage in risk-bearing APMs without experience executing quality improvement initiatives, similar to those defined by the MIPS Improvement Activities and APM enhanced services. MVPs could serve as a steppingstone if the quality measures and improvement activities align with those of a similar APM. Moreover, in order to encourage clinician and practice adoption of MVPs, CMS should consider additional incentives for clinicians, such as bonus points for participation, a lower performance threshold to avoid a downward adjustment or guaranteed held harmless from downward adjustment. Without sufficient participation during the transition phase when MVPs are optional, CMS will not gain a sense of impact for clinicians to participate and receive meaningful feedback from participants on how MVPs may encourage/ discourage future participation in APMs.

The US Oncology Network worked closely with the American Society of Clinical Oncology (ASCO) and CMS to develop an oncology-specific MVP that focuses on measures that are meaningful to the oncology clinicians and that aligns with various VBC programs; these recommendations were included in the CY2023 MPFS proposed rule for the Advancing Cancer Care MVP. The measures in this oncology-specific MVP prioritize critical components in care for cancer patients, such as shared decision making, pain assessment and management, and advance care planning, that should lead to better outcomes and alignment. That said, The Network does not support CMS' proposal to sunset traditional MIPS in favor of the newly created MVPs in 2028. There is no statutory requirement for MVPs, and CMS should not implement MVPs until there has been successful uptake and use of MVPs by clinicians. Only by examining clinicians' use of MVPs can CMS make an informed proposal on the eventual sunsetting of traditional MIPS.

Measuring Cost in MIPS
Clinician performance in MIPS is measured across four areas: quality, improvement activities, promoting interoperability, and cost. A clinician's payment is based on their scores in the cost and quality categories, and the weighting of the cost category has been phased-in as clinicians have gained experience in the program. In 2018, cost metrics represented 10% of the total score, while quality metrics represented 50%; as of 2022, the cost and quality categories each represent 30% of the total score. A recent publication in the Journal of Clinical Oncology[5] examined the implications of the updated MIPS scoring on reimbursements for oncologists and other providers participating in MIPS and found that the "federally mandated reweighting of MIPS cost metrics will result in a disproportionate increase in oncologists receiving negative payment adjustments." Cancer is more common in the Medicare population and cancer patients are more complex than the average Medicare patient, yet the cost of treatment is disproportionately high in oncology and there are, realistically, few levers available to oncologists in the delivery of cancer care. Therefore, there is a need to better measure cost in MIPS to account for specialties like oncology to ensure fairness across areas of healthcare that inherently have higher risk patients with great complexity and cost.

[5] https://ascopubs.org/doi/abs/10.1200/JCO.2022.40.28_suppl.006?af=R

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Site Neutral Payments
The Network believes there is further opportunity to improve value across the Medicare system while stemming the tide of consolidation. Over the past two decades, the disparity in reimbursement between the physician office setting and the hospital outpatient department (HOPD) setting has increased, creating incentives for hospitals to acquire physician practices. As a result, care is shifting towards the more expensive HOPD setting. According to the Medicare Payment Advisory Commission June 2022 Report to Congress, "payment differences across settings encourage arrangements among providers—such as the consolidation of physician practices with hospitals—that result in care being billed at the payment rates of the provider with the highest rates, increasing program and beneficiary spending without meaningful changes in patient care. From 2015 to 2019, for example, the volume of chemotherapy administration in freestanding clinician offices, the setting for which payment rates are generally lowest, fell 5.4%, while the volume in HOPDs, the setting for which payment rates are generally highest, climbed 27.8%." This trend is only growing and will lead to further consolidation in community oncology. In 2022, reimbursement for drug administration services is 138% higher in the HOPD setting and reimbursement for radiation oncology services is 36% higher in the HOPD setting.

CMMI is tasked with developing and evaluating APMs which test new healthcare payment and service delivery approaches and reward model participants for effectively delivering value-based care. The Network believes that APMs present an opportunity to test site neutral payments to address this site-of-service payment differential and provide higher value to patients and the Medicare program by paying the same amount for the same service regardless of the setting in which the service is provided. While The Network had numerous concerns with the RO Model, we applaud CMMI for incorporating site neutral payments into that model and encourage CMMI to include site neutral payments in other models that cover both the physician office and the HOPD setting.

Conclusion

Thank you for the opportunity to comment as Congress considers ways to improve Medicare payment and further the transition to value-based care. We welcome the opportunity to discuss the issues outlined above and any other issues impacting community cancer care with you or your staff. Should you have any questions, please contact Ben Jones, Vice President of Government Relations and Public Policy, at Ben.Jones@usoncology.com.

Sincerely,

Ben Jones
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The US Oncology Network

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