August 27, 2020

The Honorable Brad Smith
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation
2810 Lord Baltimore Drive, Suite 130
Windsor Mill, MD 21244

Dear Director Smith:

On behalf of The US Oncology Network, which represents over 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, we write to share about our experience as the largest collective participant in the Oncology Care Model (OCM) being tested by the Centers for Medicare and Medicaid's (CMS) Center for Medicare and Medicaid Innovation (CMMI).

The US Oncology Network ("The Network") is one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 1,000,000 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.

We are committed to working with the Centers for Medicare & Medicaid Services (CMS) to enhance the delivery of cancer care and protect patient access to high-quality, affordable care in the most efficient manner. This commitment is demonstrated by The Network's 14 practices and more than 900 physicians participating in the OCM. **Since the model was launched in 2016, we have enrolled more than 95,000 patients and saved the Medicare program more than $92 million** relative to benchmark prices. Prior to the emergence of the COVID-19 pandemic, 80 percent of our practices participating in the OCM were pursuing two-sided risk.

We have made significant investments in value-based care and practice transformation and believe that The Network's experience in the OCM indicates promising results. In light of the recently released OCM annual evaluation report, The Network would like to highlight our experience to date, particularly as some of our results diverge from the findings and trends identified in the report. In contrast to the report, our interpretation of OCM data among Network practices points to remarkable model success in driving practice change, improving patient care, and lowering costs. The Network appreciates CMS' commitment to stakeholder input and encourages the agency to consider our perspective as it contemplates OCM improvements and determines the design of future oncology models, such as the Oncology Care First (OCF) Model.

Annual OCM Evaluation Report

In July 2020, CMS released the Third Annual Evaluation Report and agency perspective on the OCM, focused on Performance Periods (PP) 1-3 of the 6-year program. This report concluded that total episode payment (TEP) savings from high-risk cancer bundles largely offset TEP cost increases from low-risk cancer bundles, yielding a non-statistically significant $145 average TEP savings across all bundles before considering Monthly Enhanced Oncology Services (MEOS) and Performance-Based Payment (PBP) incentives. With MEOS and PBP included, the report estimated net Medicare losses of $89 million for PP1 and $65 million for PP2. Additional findings suggest the first three Performance Periods of OCM had no impact on hospitalizations, minimal impact on emergency department (ED) visits, and no impact on hospice utilization.

The availability of real-time OCM participant data is immensely valuable in improving model performance, physician satisfaction, and ultimately patient outcomes. To this end, The Network appreciates the timely dissemination of Performance Period data by CMMI, which allows us to nimbly analyze performance and gain more insight into the benefits of the OCM. As mentioned, the scope of the July 2020 report was limited to PP1-PP3 (PP1-PP2 in the case of MEOS/PBP data), which ended in calendar year 2017.

While this information is helpful to us, our Network data through PP5 offers additional insight into the program we would like to share. Based on this information, we believe it would be short-sighted to draw long-term conclusions on the success of the OCM or design future oncology care models based on the most recent evaluation report alone.

In our view, the most recent evaluation report has not had the opportunity to analyze enough Performance Period data to capture positive trends within the OCM experience. The shift to value-based care, and specifically episode-based cancer care, takes time. The OCM demanded fundamental practice transformation, including new financial and infrastructure investments, along with a significant shift in the delivery of patient care, including the scope and coordination of the care team. Because of this, across The Network we did not begin to see meaningful changes in key OCM metrics until PP3. If our results are transferable to OCM practices as a whole, future evaluations will reflect a marked shift beginning in PP3.

The Network's OCM Experience

The OCM evaluation report compared participating model practices against a non-participating control group. The Network does not have access to the requisite control group information but can compare our practices with the findings reported model-wide. While it is unclear what may be driving The Network's differences, our analysis suggests OCM results are trending in the right direction. The following chart compares our findings against all OCM participants over the PP1-PP3 period as referenced in the most recent annual evaluation report.

Key OCM Findings PP1-PP3: All Practices vs. The US Oncology Network Practices

All OCM Practices (PP1-PP3)	***Network OCM Practices (PP1-PP3)***
• $154 million in total *losses* to CMS after MEOS/PBP[1]	• $231,000 in total *savings* to CMS after MEOS/PBP[1]
• No significant impact on hospitalizations or emergency department (ED) visits	• Hospitalization reduction of 6%, ED visit reduction of 5% relative to PP1
• No substantive impact on quality or utilization, including advance care planning	• Increased hospice utilization by 7% (within >3 days of death) relative to PP1
• Reduction in high-risk total episode payments of $430/episode; increase in low-risk total episode payments of $130/episode[2]	• Reduction in high-risk total episode payments of $1,782/episode; increase in low-risk total episode payments of $632/episode[2]
• Average $145/episode savings[2]	• Average of $1,065/episode savings[2]

[1]Data for PP1-PP2 only
[2]Before MEOS

In nearly all of the findings above, The Network's OCM-participating practices outperformed the all-practice average. On non-financial measures where the evaluation report indicated no statistically significant change, The Network reported notable progress (reduced hospitalizations and ED visits, and increased enrollment in hospice, which indicates improved care planning with patients and their families). On financial measures, The Network calculated $1.4 million in net savings to Medicare after MEOS/PBP and a $920 increase in per episode savings relative to the all-practice average. We do calculate a higher average cost/episode for low-risk episodes relative to all OCM practices. One contributing factor of this disparity is the categorization of some low-risk breast, prostate, and bladder cancers, which were risk-adjusted beginning in PP3. While The Network's low-risk episode costs have been trending downward since PP3, as CMMI suggested in its informal request for information on the OCF Model, we support the removal of low-risk cancers from total cost of care responsibility and the benchmarking of prices and trend factors by cancer type.

The Network's findings suggest OCM practices improved model performance beginning in PP3. This is true of both low-risk and high-risk episodes as practices were better able to control for costs as they gained more experience in the model. This suggests that the transition to the OCM takes time as practices smooth out workflows and implement new team-based care delivery strategies.

Since The Network has OCM practice data through PP5, we next crosswalk that information with the PP1-PP3 data summarized in the chart above. This indicates some important trends over time.

Key OCM Findings: All Practices (PP1-PP3) vs. The US Oncology Network Practices (PP1-PP5)

All OCM Practices (PP1-PP3)	Network OCM Practices (PP1-PP5)[1]
• $154 million in total *losses* to CMS after MEOS/PBP[2]	• $78 million in total *savings* to CMS after MEOS/PBP
• No significant impact on hospitalizations or emergency department (ED) visits	• Hospitalization reduction of 7%, ED visit reduction of 4% relative to PP1
• No substantive impact on quality or utilization, including advance care planning	• Increased hospice utilization by 5% (within >3 days of death) relative to PP1
• Reduction in high-risk total episode payments of $430/episode; increase in low-risk total episode payments of $130/episode[3]	• Reduction in high-risk total episode payments of $2,384/episode; increase in low-risk total episode payments of $629/episode[3]
• Average $145/episode savings[3]	• Average of $1,427/episode savings[3]

[1]Results may change after PP4 & PP5 true-ups

[2]Data for PP1 & PP2 only

[3]Before MEOS

While there was little additional change in the non-financial measures tracked through PP5, The Network significantly increased net savings to Medicare after MEOS/PBP through this period. Additionally, Network practices grew per-episode savings by $362/episode from the savings calculated over the PP1-PP3 period. This amount is $1,282 more than the average episode savings among all OCM participants in the first three Performance Periods. Most of this change is driven by cost reductions in high-risk episodes, as the reduction in low-risk episode costs was largely unchanged.

These results largely focus on the areas in which The Network experience differed from the conclusions made in the most recent OCM evaluation report. However, The Network echoes other positive OCM report findings, including the increased use of cost-effective biosimilars and the high clinician and patient satisfaction scores. Overall, The Network's OCM-participating practices believe this model is proving its quality, care coordination, and cost-saving goals in the delivery of cancer care.

Implications for Future Oncology Models

The Network appreciates CMMI's stakeholder outreach and engagement in the development of the OCF Model and/or additional future oncology models. We also understand the evaluation reports must be considered as part of the design and development process. While we have submitted comments on the informal OCF Model request for information, we also found it necessary to share our experience in the OCM relative to the findings in the most recent evaluation report. It is our hope that the agency will consider this information and further research what may be driving The Network's success in the OCM so that such factors can be preserved and strengthened.

We are committed to the OCM and its success because we believe the model, although not perfect, was designed to address legitimate ways to improve cancer care, improve the patient experience, and reduce costs when possible. Looking forward, we believe the introduction and testing of new APMs must be voluntary with sufficient flexibility to support the providers that undergird our healthcare delivery system. These models are often layered on top of ever-changing and confusing regulatory and administrative burdens that distract from direct patient care. That is why stakeholder engagement must remain a cornerstone of any transition to new payment models. 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.

In our pursuit of value-based community cancer care, we think deeply about the challenges facing our practices and our patients. Even with the help of evidence-based treatment pathways that clarify standards of care, our clinicians still face complex, daily choices that impact patient lives. These decisions affect the value of care, not just the utilization and cost of care. However, under episode-based payments like those in the OCM, we must recognize the real levers available to clinicians. The OCM's payment structure is inclusive of drug costs – an input oncology practices have little control over. In fact, the most recent OCM evaluation report indicated that more than half of average OCM episode payments under Medicare Part B were attributable to chemotherapy costs. As CMMI contemplates changes to the OCM and/or design parameters of any future oncology care model, The Network would urge the agency to realistically consider the controls available to oncologists in the delivery of cancer care.

Conclusion

Since the launch of the OCM in 2016, The US Oncology Network has experienced significant practice transformation, improved care coordination and patient outcomes, and saved the Medicare program more than $92 million relative to benchmark prices. Our most recent performance data suggests these results are only trending better. While the first few OCM Performance Periods signaled a slow start, this is attributable to the transitional requirements of the model's design (i.e. expanded care team, modified workflows, patient navigation) that are common to the beginning of most alternative payment models. We hope that any future changes to the OCM will be based on the most recent program performance data available. If our results are any indication, we believe the OCM to be an undeniable success.

Thank you for the opportunity to share our views on the OCM and the importance of delivering high-quality, affordable cancer care to Medicare beneficiaries. We welcome the opportunity to discuss the issues outlined above and any other issues impacting community cancer care with you and 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,

Marcus Neubauer, MD
Chief Medical Officer
The US Oncology Network

CC: The Honorable Alex Azar, Secretary, U.S. Department of Health and Human Services
The Honorable Seema Verma, Administrator, Centers for Medicare and Medicaid Services