The US Oncology Network

December 13, 2019

VIA EMAIL SUBMISSION TO OCF@cms.hhs.gov

Amy Bassano
Acting Director
Center for Medicare and Medicaid Innovation
2810 Lord Baltimore Drive, Suite 130, Windsor Mill, MD 21244

**RE: Informal Request for Information on the Oncology Care First Model**

Dear Director Bassano:

On behalf of The US Oncology Network, which represents over 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to provide feedback on the informal Request for Information (RFI) on the proposed Oncology Care First (OCF) Model. 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 995,000 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, most cost-effective, integrated cancer care to help patients on their cancer journey.

The Network is committed to value-based care models that lead to improved patient care, better quality, and cost savings. In fact, we are proud to support more than 900 physicians participating in the current Oncology Care Model (OCM). In the first 40 months of the OCM, Network providers enrolled more than 83,000 unique patients, which is a testament to the cooperative approach the Center for Medicare and Medicaid Innovation (CMMI) took in developing and implementing the voluntary model, including addressing many stakeholder questions and concerns throughout the process.

Due to the focus on practice transformation and investments made by The Network's OCM practices, patient care has been enhanced. For example, Medicare patients in the OCM receive comprehensive care management and treatment plans, assistance from navigators and social workers, advance care planning, survivorship advice, information on estimated total out-of-pocket costs and enhanced, formalized, team care. **These reforms and investments have reduced hospital admissions by 7 percent and expensive emergency room visits by 4 percent; they have also led to a 5 percent increase in hospice stays longer than 3 days.** A key component of The Network's success in the OCM is adherence to oncology evidence-based Value Pathways, which has been proven to lower the overall cost of care with equal or better outcomes.[1] Collectively, Network practices alone have realized more than $80 million in savings for Medicare through participation in the OCM while being able to appropriately manage all aspects of care delivery, including drug utilization.

While the OCM has resulted in real practice transformation and savings to the Medicare program, opportunities remain to improve upon the OCM's design in order to increase participation in the OCF model. Based on our experience in the OCM and participation in the public listening session on this RFI, The Network believes the following recommendations are critical for CMMI to address as the OCF model moves forward:

[1] Neubauer MA, Hoverman JR, Kolodziej M, et al. (2010) Cost effectiveness of evidence-based treatment guidelines for the treatment of non–small-cell lung cancer in the community setting. J Oncol Pract 6:12–18. http://m.jop.ascopubs.org/content/6/1/12.abstract

- Provide greater transparency into the calculation of the OCF baseline, benchmark, and trend factor;
- Improve transparency in the Monthly Population Payment (MPP) methodology and provide practices an estimate of the MPP prior to application;
- Provide more data on a real-time basis to improve both patient care and physician satisfaction with the model;
- Allow all participating practices to start with one-sided risk and continue through at least two full performance periods before deciding whether to continue as two-sided;
- Allow OCF practices who are participating in two-sided risk the ability to opt out of other CMMI demonstration models if there is a clear conflict in model scope; and
- Allow for another opportunity for stakeholder feedback after more details of the OCF model have been released.

To facilitate your review, we have broken-out our comments into the following sections:

**Baseline, Benchmark, and Total Cost Performance Transparency**

The RFI indicates the OCF Model will build and improve upon features in the current OCM. However, the RFI is too short on detail to fully and accurately assess how, or if, problems with benchmarking in the OCM will be addressed. For example, in the OCM, it is not apparent what drives results by practice nor why results have been inconsistent over the various performance periods; therefore, it is critical that practices have the ability to understand how they will be baselined for the OCF and how benchmarks for the OCF will be established. A corollary concern, since many practices have participated in the OCM, is how the benchmarking will account for current performance. For the OCF to be successful, it is imperative that the model not penalize well-performing practices and not over-incentivize costly practices. For these reasons, we also request deeper visibility on key factors (i.e. hospitalizations, emergency department usage, hospice, drug utilization) in how other practices are performing both inside and outside of the OCF.

Additionally, we note that CMMI is considering calculating the trend factor separately for each cancer type assuming sufficient volume. We believe benchmark prices and trend factors should be calculated separately for each cancer type, and we encourage CMMI to include this distinction in the model going forward. Risk adjustment is critical to determining the benchmark, and there are opportunities for improvement in the OCF. For example, in the OCM the radiation adjustment is approximately 60%. For episodes with lower benchmark prices, this is a relatively small adjustment, while it is significantly larger for relatively expensive episodes. In this particular example, we have found that radiation therapy is more of an additive cost than a multiplicative cost. Similarly, CMMI is also proposing to set benchmark prices using clinical data submitted by physician group practice (PGP) participants. We agree with CMMI that clinical and staging data should be used in the risk adjustment model. As an example, breast cancer patients who are HER2+ are going to receive Herceptin, which is a very expensive but clinically appropriate drug. Practices should not be penalized if they have more HER2+ breast cancer patients relative to the average.

Further, we support CMMI's proposal to remove low-risk cancers out of total cost of care responsibility. Often, non-oncology providers are meeting the needs of these patients, and oncologists have less oversight of these populations, resulting in less opportunities for savings and greater risk due to non-cancer driven outliers. That said, we encourage CMMI to provide additional information that will enable a better understanding of the total cost of care, including drugs based on individual disease categories versus overall costs. As we have noted throughout the OCM, when new core drugs without generic equivalents come to market that must be used to provide standard of care, they almost always drive total expenditures above the benchmark. While we appreciate that CMMI, through the Novel Therapy adjustment and applying the trend factor on a disease

category basis, might see these as responsive to the introduction of new, high cost drugs, this should be modeled for two performance periods from the OCM time frame to provide more visibility on the impact to total cost performance. In doing so, it is critical to understand the basis of any non-OCM comparator group data that might be used.

**Overall, The Network believes greater transparency into the calculation of the OCF baseline, benchmark, and trend factor is critical for a practice to successfully participate in the new model.**

**Monthly Population Payment (MPP) Transparency**

One of the strengths of the OCM is that it remains voluntary in nature and still produces very robust participation. The OCM's monthly enhanced oncology services (MEOS) payment was instrumental in solidifying this support by helping practices make the investments necessary for participation and success in the model. Rather than continuing to provide a MEOS payment, CMMI is proposing an MPP, which would apply to a broader set of patients and services. The Network supports CMMI's proposal to include a broader set of patients in the OCF, including beneficiaries who are receiving hormonal therapy only and those who are under active surveillance but not receiving chemotherapy. We are also pleased to see the inclusion of the enhanced services component within the MPP which will help support continued access to navigation, social work, psychosocial/mental health, telehealth, palliative care, advance care planning, and nutrition. These enhanced services provided in the OCM have improved the patient experience and reduced costs by mitigating clinical deterioration and hospitalization. We encourage CMMI to ensure the low risk MPPs sufficiently cover enhanced services for the lower risk patient population.

The proposed MPP would also include evaluation and management (E/M) visits. From our experience in the OCM, we know the MEOS payment helps deliver the enhanced services critical to OCM success. We also know that more frequent and timely visits often reduce costly ER and hospital visits and therefore have some concern that the inclusion of E/M visits within the OCF could theoretically penalize a practice for seeing patients more often. **Therefore, we believe it is critical that any changes to the MPP not discourage frequent visits, education, treatment planning and advance care planning visits.**

CMMI also seeks comment on the inclusion of additional services in the MPP, such as imaging or lab services, and potentially others not listed in the RFI. The Network urges caution on the inclusion of services that are completed outside of the practice. Oncologists have less control over these types of services and their costs and including them in the MPP would increase the administrative burden. We are also aware that CMMI is considering other items and services, alluded to in the open forum, for inclusion in the MPP, and again express caution about proceeding in this direction. Given the breadth of our experience in the OCM, we offer to be a resource as CMMI continues to design the MPP.

While there are similarities to the MEOS payments, the proposed MPP is considerably different and carries financial risk. Hence, it is all the more critical that practices (both PGP and HOPD-based) understand their exposure under the OCF. **The Network strongly encourages CMMI to provide comprehensive MPP modeling and data transparency. This information should be made available on a per practice basis to allow practices to forecast their financials—both revenue and costs— that would be encompassed within the MPP compared to the experience in the OCM. Having this data in advance is crucial for robust and early participation in the OCF Model.** Practices must understand their financial risk for transitioning from fee for service to a partial capitated rate to ensure that payment covers costs. Practices will have a reduced incentive to join this model unless full transparency is provided.

Finally, while the proposed structure of the MPP eliminates the need to prospectively enroll and bill patients for the MEOS payment, it does add some burden to the revenue cycle process that we believe should be reflected in the calculation of the MPP. For example, while the RFI points out that beneficiary coinsurance continues to apply, there needs to be specific attention to how to handle capitated MPP payments in tandem with patient responsibility and secondary payers. Specifically, the OCF is limited to fee-for-service beneficiaries, many of whom use supplemental (Medigap) insurance to cover their coinsurance costs, so there needs to be a means of coordinating separate payer systems—both for beneficiaries and practices. The capitated nature of the proposed MPP also requires a practice to bill E/Ms for attribution and other charges, write-off charges and then reconcile them against the MPP payments.

**Improved Access to Timely Data and Results**

**During the OCF listening session, CMMI noted it is working to provide more data on a real-time basis; The Network strongly encourages this endeavor, as providing more timely data will improve both patient care and physician satisfaction with the model.** One important tool that participants across CMMI initiatives have employed in practice transformation is access to claims data—as is certainly the case in the OCM. Still, the lag in receipt of data has been limiting. Timelier, or monthly, access to claims data would make data more actionable, enabling providers to improve quality and cost in real-time. We believe if monthly data were available, we would be able to see trends that are fresh and actionable by provider and care team. For example, we could identify patients that are at risk for readmission and more quickly test new ideas by seeing near term outcomes.

Beyond claims data, practices would be better able to engage with patients that are in the hospital and their care teams by knowing from the payer that a patient has been admitted. For example, Cigna provides this information daily, allowing practices to expedite patient discharge and follow up in real time. While we recognize that there will always be some lag in data reporting, we also request that assigned and attributed patient lists be provided in a timely manner, at least monthly, to ensure accurate patient identification, MPP billing and reconciliation, and quality measurement for beneficiary-only measures.

**Performance-Based Payment (PBP) Risk Tracks**

The RFI briefly describes three risk tracks: a one-sided, upside-only track and two tracks with two-sided risk, one more robust than the other. We fully understand CMMI's commitment to two-sided risk and ask that CMMI continue the open dialogue that it has initiated with stakeholders. In particular, we urge CMMI to provide greater detail on the two tiers for two-sided risk and allow sufficient time for modeling of both options. We would also suggest that by its very nature, the MPP as proposed in the OCF, creates sufficient financial risk that should satisfy CMMI's financial risk threshold such that even the one-sided track should qualify as an advanced alternative payment model. We look forward to remaining an engaged resource as CMMI continues to design these risk tracks.

Additionally, CMMI proposes to allow PGPs that have not participated in the OCM to participate, for a limited time, in the one-sided track. While the RFI does not quantify the levels of risk, **The Network urges CMMI to allow all participating PGPs to start as one-sided and continue through at least two full performance periods before deciding whether to continue as two-sided or withdraw.** Even if a practice has been successful in OCM, it cannot be assured that they will be able to succeed in the OCF under a new baseline, benchmark, trend factors, and MPP. Creating a smooth glide path, starting with one-sided risk for those who opt to use it, will encourage participation and could lead to two-sided risk being considered by more practices compared to an immediate two-sided structure. We've seen this approach to providing additional time to gain experience in other models and would appreciate CMMI's consideration of doing the same in the OCF.

**Quality Performance**

We generally agree with CMMI's proposal to continue to use the quality metrics that are currently in use in the OCM. An exception would be with the current process measures around pain and depression. Both are important but should be substituted for outcome-based measures similar to the Quality Clinical Data Registry (QCDR) measure for Pain Improvement, if possible, at a cancer-specific level. We also recommend removing the timing restrictions around which visits count for depression screens. This was a legacy PQRS/MIPS measure that was intended for general practitioners who see their patients infrequently, perhaps once a year during a preventive care visit where the encounter code makes sense. We also encourage CMS to better harmonize measures across CMS Quality Payment Programs to ensure alignment in expectations, workflow and performance across measures. One example of this are pain measures, which currently vary across programs with elevated pain being >0 for one program and >3 for another; CMS should adopt one consistent pain level that represents elevated pain and triggers the need for a pain plan.

We also support CMMI's proposal to apply achievement of quality performance not only to PBP upside payment but also to apply higher quality performance to reduce downside recoupment. We further suggest refining the existing Patient Experience survey to be less burdensome for patients by making the questions more targeted, reducing its length. CMMI could provide this survey to a larger patient population on a more frequent basis.

**Care Transformation**

CMMI proposes to carry over the six participant redesign activities from the OCM. We believe these have been valuable and agree with this approach. However, it is imperative that enhanced services funding remains sufficient enough to support these valuable and necessary activities.

CMMI also proposes to gradually implement a seventh redesign activity: electronic patient-reported outcomes (ePROs). Several Network practices are already implementing ePROs and while we are encouraged by CMMI's progressive thinking in this arena, we note that it remains a significant investment for practices. Implementation should not be rushed, and patient education and engagement is key for uptake. We ask CMMI to maintain an open dialogue with practices and vendors on what is reasonable regarding the adoption timeline and cost. We agree that gradual implementation may be appropriate; prioritizing implementation for certain types of patients before more widespread adoption may help reduce clinician burden. Integration of ePROs from applications where patients complete them to the electronic medical records where they will be utilized by clinicians for integration into the patients' care is also a critical part of the workflow and essential to the successful use of ePROs.

We recommend that there be some support either in the enhanced services add-on or elsewhere to implement the ePRO platform. Given that some practices have already started to invest in this technology, we also request clarity on what would be required to meet the ePRO requirement from a solution standpoint (e.g. smartphone app, on person device, etc.) and what information is necessary to be captured (e.g. pain, distress, fatigue, medication adherence, side effects, etc.). Finally, we encourage CMMI to reexamine what quality measures should be in scope as ePROs are introduced as well as provide greater clarity on how, as more data is captured, it will be used and aligned with quality measures.

**Reducing Administrative Burden**

The Network appreciates CMMI's efforts, through its Patients over Paperwork initiative, to reduce physician burden. In this context, we see opportunities to reduce administrative burden for practices participating in the OCF. **First, we ask that only clinical and staging data *that is relevant to the model* be required for reporting.**

For example, CMMI should only require reporting of cancer types that impact the payment model and benchmarking. This should also apply to any ongoing clinical and staging data that is required for patients that carry over to a subsequent episode, barring some significant change or difference that might influence the model. For instance, currently in the OCM, CMMI requires current clinical status to be updated at least once per episode. This information isn't utilized for the model, not even for the upcoming PP7 Metastatic Adjustment, and it is the most time-consuming part of the data submission requirement.

Second, the MPP as proposed creates a higher burden on the revenue cycle of a practice due to having to adjudicate and reconcile the payment after it has been made. This will require modifications to revenue cycle platforms and payment methodologies. We encourage CMMI to ensure reconciliations are frequent and predictable for reserving against recoupment.

**Interaction with Other CMMI Models**

As CMMI has alluded to on many occasions, there may be situations in which the OCF participants' care of patients overlaps with other CMMI models. While the OCF is voluntary, other recently-proposed models are mandatory. We caution CMMI that participating in multiple conflicting models may increase practice burden and could impact access to care – or come at the expense of quality. As CMMI develops new models, ensuring practices maintain the ability to manage patient work flow and point of care decisions will help ensure model success. We also encourage CMMI to take practices' investment in the OCF into consideration to minimize disruption and practice burden, as well as to protect the integrity of demonstration results. **The Network encourages CMMI to allow OCF practices who are participating in two-sided risk the ability to opt out of other CMMI demonstration models if there is a clear conflict in model scope.**

**Timing**

The last performance period for the OCM is currently scheduled to run through December 31, 2020. In order to minimize disruption during the transition, we ask CMMI to provide a final rule or other guidance, practice applications, and MPP details by July 2020. Practices could then be ready to start the OCF by January 2021. If this timeline is not possible, CMMI should consider extending the OCM for 2021 and start the OCF in January 2022. In this vein, **we strongly reiterate our recommendation that CMMI allow for another opportunity for stakeholder feedback after more details of the OCF model have been released.**

**Conclusion**

On behalf of The US Oncology Network, thank you for the continued opportunity to provide feedback on new oncology care models to improve patient care and advance innovation in the delivery of cancer care. We welcome the opportunity to discuss the issues outlined above 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,

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Chief Medical Officer
The US Oncology Network