December 13, 2019

VIA ELECTRONIC MAIL

Amy Bassano
Acting Director, Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

      Re: Oncology Care First Request for Information

Dear Acting Director Bassano:

The Health Care Transformation Task Force (HCTTF or Task Force) thanks the Centers for Medicare and Medicaid Services for the opportunity to provide our input on the Oncology Care First (OCF) model through this Request for Information (RFI).

The Task Force is an industry consortium representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – all committed to adopting payment reforms that promote a competitive marketplace for value-based health care and allow health care organizations to move from a system that incentivizes volume of services to one that rewards value of care. Our member organizations aspire to have 75 percent of their business in value-based arrangements by the end of 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our members have built, operated, and participated in various alternative payment models, including episodes of care models that engage specialists in practice transformation and the Oncology Care Model (OCM). We believe these models hold great promise for achieving necessary improvements in patient experience, desired outcomes, and reduced health care expenditures. We have also regularly called on CMS to develop additional opportunities for mature organizations to take on more advanced risk and accountability for total cost of care and outcomes for Medicare FFS beneficiaries. Our comments offered herein reflect a desire for continued collaboration to help CMS to best operationalize this alternative payment model (APM).

I. General Feedback

We appreciate that CMS is building upon the lessons learned to date from OCM and is open to additional stakeholder feedback particularly from current OCM practices when considering the designing of the proposed OCF model. In the RFI, CMS states that "though OCM is ongoing, early results suggest that the model is having an increasingly positive impact on acute care utilization and quality of care, including at the end of life." **We encourage CMS to make every effort to make improvements and refinements to existing CMMI models – and to certify and expand those models that are found to successfully improve care and reduce costs – even as second-generation models in the same clinical area enter the design and early testing phase.**

With a multitude of Advanced APMs mid-evaluation, CMS should also design the Oncology Care First model in a way that does not disrupt participation in and evaluation of existing programs already in place. Providers participating in Medicare ACOs, bundled payment initiatives, and other CMMI models have made significant investments in care redesign and infrastructure to improve care and lower costs for Medicare beneficiaries. The policy objective should be to enhance those existing coordinated care models and avoid alternatives that could disrupt participation in those models. The Task Force has previously provided feedback to CMS on the importance of considering model overlap and synchronization. In prior communication with CMS, we outlined five principles for managing model overlap between clinical episode and population-based payment models.[1] The agency could reference these principles and conduct a thorough review of the implications of overlap with other APMs and determine how best to integrate the potential Oncology Care First model with existing models in a way that leverages rather than replaces the growing number of Medicare alternative payment model arrangements that are showing promising results.

II. Responses to RFI Questions

A. *Practice redesign activities*

CMS seeks input on how the potential OCF model could support participants' care transformation, building on lessons learned from the implementation of the practice redesign activities included in OCM. In order to have a health care system that is both person-centered and value-driven, we strongly believe that patient engagement and continuous quality improvement should be at the heart of all delivery policies and practices. **To that end, we support the proposed utilization of electronic patient-reported outcomes to both track and drive performance improvement**. We encourage CMS to undertake an approach to PRO measure deployment that supports the foundational work of data collection and reporting with a progression towards value-based payment for outcomes, rather than incenting outcomes performance within the payment model's early years. CMS should give a firm signal to

---

[1] https://hcttf.org/wp-content/uploads/2018/09/HCTTF-BPCIA-ACO-Model-Synchronization.pdf

participants that payment will ultimately be tied to improved health outcomes, but that interim measures will recognize meaningful progress towards having that capability and making use of outcomes data in care improvement activities. Recognizing that neither NQF nor CMS have identified preferred instruments and ePROs for the Quality Payment Program, we recommend incorporation of PROs which have been broadly tested, including PROMIS-validated instruments that measure Health-Related Quality of Life (with both a physical health and mental health component), pain management and interference with daily activities, and fatigue management and interference. Additionally, the EORTC QLQ-C30 instrument is widely used in Europe and has been recommended by the International Consortium for Health Outcomes Measurement (ICHOM).

CMS should provide more flexibility around provision of required care transformation activities to better meet patient needs and practice structure, while rewarding adherence to evidence-based clinical pathways. **Specifically, CMS should consider allowing physician group practices to split TINs for purposes of assigning providers to participate in the model.** Current participants in OCM note a potential challenge with providing the Enhanced Services to all beneficiaries, including implementation of a documented care plan covering all 13 components within the Institute of Medicine's Care Management Plan for every patient that would be assigned to the OCF practice for the Monthly Population Payment as described in the RFI. CMS proposes the population of assigned beneficiaries for the purposes of calculating the OCF participant's MPP would be broadly defined as all Medicare FFS beneficiaries who receive an E&M service at the OCF PGP with a cancer or cancer-related diagnosis designated on the Medicare claim. For larger practices that share the same TIN, this presents a challenge if a patient with a cancer, or cancer-related, diagnosis receives an unrelated E&M service from a provider billing under the same TIN.

B. *Payment methodology*

CMS solicits feedback on the potential payment methodology, including the structure and design of the monthly population payment (MPP) and the performance-based payment (PBP). The proposed model would differ from OCM by converting reimbursement for E&M services and drug administration into a prospective MPP as well as expanding the PBP portion to include accountability for the beneficiaries' total cost of care, not just the cost of episode-related utilization. The RFI describes a proposed grouping concept for OCF participation that would include both physician group practices (PGPs) and hospital outpatient departments (HOPDs) that provide oncology care. The MPP would include a Management Component (Enhanced Services, E&Ms) and an Administration Component (drug administration services, E&M payments to HOPDs where applicable). CMS states that, for the portion of the PGP participant's assigned population (if any) that receives chemotherapy in an HOPD, the PGP would receive the Management Component of the MPP and the HOPD would receive the Administration Component of the MPP.

The Task Force recommends that CMS acknowledge early adopters who have taken on the important work of value transformation voluntarily. While we are supportive of bringing in new participants, recalculating the baseline for OCM participants could have the effect of disproportionately disadvantaging current OCM practices that have successfully achieved shared savings. We encourage CMS to consider a more equitable policy that recognizes the investment made by early adopters and provides exceptions to the OCF baseline calculation for OCM practices with a track record of high performance under the prior model.

While we are generally supportive of the payment framework, it is difficult to provide specific feedback without more detail about the financial methodology used to establish the MPP amount and the episode pricing methodology. It is unclear, for instance, how CMS will ensure that the pricing accounts for variation both across cancer types and within cancer types (*e.g.*, subtype and progression). Additionally, we are concerned that the proposed OCF model does not sufficiently recognize the multi-disciplinary approach to cancer care that often involves a radiation oncologist and a surgical oncologist, in addition to a medical oncologist. **We recommend CMS have educational opportunities, such as webinars, outlining the payment structure in detail and offer additional opportunities for public comment once more detail on the pricing methodology is made available.**

C. Risk arrangements

CMS encourages feedback on the conceptualized risk arrangements, including how a downside risk arrangement might be best constructed in terms of the level of risk. The proposed model would include three risk tracks for the purposes of PBP reconciliation, including one upside-only track and two tracks with two-sided upside and downside financial risk. We commend CMS for designing both two-sided risk tracks to qualify as Advanced APMs.

Task Force members report that there is significant volatility in the current 6-month episodes/performance periods in OCM, in part due to low episode volume, which has made it difficult to manage risk in the model. Furthermore, OCM practices do not receive feedback from CMS about their PBP performance and reconciliation payments for up to 18 months following an episode, creating a significant time lag that can impact the practice's ability to manage performance and risk. **The additional progression to risk with total cost of care accountability and the new prospective MPP component are enough of a departure from the existing OCM framework that we encourage CMS to allow for all prospective participants to start in the upside-only track for at least three 6-month episode/performance periods before moving to the two-sided risk tracks.** CMS proposes to shorten the reconciliation period for OCF months to 12 months, so this approach would allow practices to experience at least one financial reconciliation before moving to risk. The new model should include this glidepath to risk in order to allow practices adequate time to understand the new payment model, learn how to manage performance risk, and ultimately minimize participant attrition.

CMS could also allow practices to select their scope of financial risk under the model by segmenting the total costs of cancer care and accepting downside risk for some components and upside risk for others (*e.g.*, upside-only risk for Part D costs), instead of a binary option of risk or no-risk for the total cost of care. We support the proposed option for practices to pool risk that was available to OCM practices, and recommend CMS also add a convener role option, as in the Bundled Payments for Care Improvement initiative, which would apply to the program with partnering practices and help them to implement the program and pool risk.

D. Payer partners

Alignment among public and private payers is critical. Common accountability targets, metrics, and incentives across payers are necessary for expedited transformation, and will allow for meaningful comparability and true best practice identification. CMS should work closely with payer partners – including commercial payers, state Medicaid agencies, and those payers currently participating in OCM – to develop shared expectations for multi-payer alignment with the goal of reducing administrative burden on providers to participate. Specifically, CMS should provide clarifying detail about the proposed mechanisms for alignment with other payers (i.*e.*, through a Memorandum of Understanding), and offer additional opportunities for public comment.

*****

The HCTTF is eager to work with CMS to achieve sustainable change in value-based care, which requires alignment between the private and public sectors and engagement with specialty care providers. Please contact HCTTF's Senior Director Clare Pierce-Wrobel (clare.wrobel@hcttf.org or 202.774.1565) with any questions about or follow up to this letter.

Angela Meoli
Senior Vice President, Network Strategy &
Provider Experience
Aetna, A CVS Health Company

Shawn Martin
Senior Vice President, Advocacy, Practice
Advancement and Policy
American Academy of Family Physicians

Stuart Levine, MD
Chief Medical and Innovation Officer
agilon health

Hoangmai Pham, MD
Vice President, Provider Alignment Solutions
Anthem, Inc.

Sean Cavanaugh
Chief Administrative Officer
Aledade, Inc.

Jordan Hall
Executive Vice President, Accountable Care
Operations
ApolloMed

David Terry
Founder & Chief Executive Officer
Archway Health

Peter Leibold
Chief Advocacy Officer
Ascension

Marci Sindell
Chief Marketing Officer and SVP, External
Affairs
Atrius Health

Jamie Colbert, MD
Senior Medical Director, Delivery System
Innovation and Analytics
Blue Cross Blue Shield of Massachusetts

Todd Van Tol
Senior Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Rahul Rajkumar, MD
Senior Vice President and Chief Medical
Officer
Blue Cross Blue Shield of North Carolina

Ann T. Burnett
Vice President
Provider Network Innovations &
Partnerships Blue Cross Blue Shield of South
Carolina

Gaurov Dayal, MD
Executive Vice President, Chief of Strategy &
Growth
ChenMed

Jean Drouin, MD
Founder and Chief Executive Officer
Clarify Health

Adam Myers, MD
Chief of Population Health and Chair of
Cleveland Clinic Community Care
Cleveland Clinic

Susan Sherry
Deputy Director
Community Catalyst

Shelly Schlenker
Vice President of Public Policy, Advocacy &
Government Relations
Dignity Health

Ross Friedberg
Chief Legal & Business Affairs Officer
Doctor On Demand

Mark McClellan, MD, PhD
Director
Duke Margolis Center for Health Policy

David Klementz
Chief Strategy and Development Officer
Encompass Health

Chris Dawe
Senior Vice President
Evolent Health

Frederick Isasi
Executive Director
Families USA

Sarah Samis
Vice President, Care Delivery and Payment
Transformation
Geisinger

Richard Lipeles
Chief Operating Officer
Heritage Provider Network

Jim Sinkoff
Deputy Executive Officer and Chief Financial
Officer
HRH Care Community Health

Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

Mary Giliberti
Executive Vice President of Policy
Mental Health America

Leonardo Cuello
Director
National Health Law Program

Erin Mackay
Associate Director, Health Information
Technology
National Partnership for Women & Families

Bill Kramer
Executive Director for National Health Policy
Pacific Business Group on Health

Michael Esters
Chief Population Health Officer
Partners HealthCare

Blair Childs
Senior Vice President, Public Affairs
Premier

Faith Cristol
Senior Vice President, Government Affairs
Remedy

Jordan Asher, MD
Senior Vice President and Chief Physician
Executive
Sentara Healthcare

Emily Brower
SVP Clinical Integration & Physician Services
Trinity Health

Mary Beth Kuderik
Chief Strategy & Financial Officer
UAW Retiree Medical Benefits Trust

J.D Fischer
Program Specialist
Washington State Heath Care Authority