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**BY ELECTRONIC DELIVERY**

**Re: Oncology Care First Model: Informal Request for Information**

Dear Administrator Verma:

The Association of Community Cancer Centers (ACCC) appreciates this opportunity to comment on the Oncology Care First Model (OCF) described in the Informal Request for Information (RFI) published by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI).<sup>1</sup> ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC represents more than 25,000 cancer care professionals from approximately 2,000 hospitals and private practices nationwide, many of which are currently participating in the Oncology Care Model (OCM).

ACCC is deeply committed to promoting patient access to the most effective cancer treatments that are medically necessary given a patient's individualized needs. We further believe that it is vitally important to encourage ongoing innovation in the delivery of cancer care for all Americans.

ACCC especially appreciates the opportunity to comment on CMMI's proposals related to this important Model. Our members are committed to value-based care because we believe this movement holds the promise of delivering higher quality care at a greater value for patients, providers, and the health care system. Our members' years of participating in, leading, and developing value-based payment systems gives ACCC an unusually deep perspective on what has worked and what has not worked in these systems, and we look forward to bringing this experience to the table in collaboration with CMMI.

## **I. ACCC applauds CMMI for making OCF a voluntary Model.**

ACCC and its members have long been at the forefront of the movement toward value-based payment, with many of our members voluntarily participating in CMS-sponsored models like the Oncology Care Model (OCM) and other value-based arrangements with partners across the health care system. ACCC appreciates CMMI's goal of reducing "program expenditures while preserving or enhancing the quality of care for Medicare beneficiaries with cancer or a cancer-related diagnosis."<sup>1</sup>

ACCC appreciates and supports CMMI allowing eligible oncology practices the option to participate in OCF, rather than requiring them to do so. While our members and other cancer care providers have invested the necessary time and resources to prepare for participation in a model like OCM or OCF, other practices are still in the process of doing so. For that reason, we believe voluntary models are more likely to attract participants who are prepared and committed to participate and stand a good chance of performing well and achieving the goals of the model. CMMI should finalize OCF as a voluntary model.

## **II. ACCC is pleased that CMMI is conceptualizing the potential OCF Model as a multi-payer model, similar to OCM.**

CMMI is conceptualizing the potential OCF as a multi-payer Model where commercial payers and state Medicaid agencies would partner with the Innovation Center, aligning their oncology value-based payment models with OCF, promoting consistency across payers.<sup>2</sup>

ACCC applauds this multi-payer model, which is similar to the model used in the OCM. However, as you know, payer participation in the OCM was not as robust as it might have been. As CMMI finalizes the OCF Model, the Center should ensure payers are not disincentivized from participating due to aspects of the Model that a payer might be unable or unwilling to implement in such a short time frame. For example, requiring a prospective payment to replace separate payment for certain core services, as proposed in the RFI, could be a disincentive for other payers to join the OCF Model.

## **III. ACCC urges CMS to make significant changes to the risk tracks for purposes of performance-based payment (PBP) episodes.**

CMMI proposes three risk tracks under the OCF Model for purposes of PBP reconciliation, including a one-sided risk track available for the first two performance periods, and two tracks with two-sided risk. CMMI envisions the first of the two-sided risk tracks as being less aggressive, while the second risk track may be more aggressive. CMMI does not provide many details regarding the two-sided risk tracks but does state it expects to set a discount of 3% to 4% to set OCF targets.<sup>3</sup> This discount is higher than current discounts under OCM two-sided risk tracks, which are set at 2.5% to 2.75%.

Additionally, all physician group practices that participated in OCM would be required to participate in two-sided risk for the full duration of their participation in the OCF Model, while

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<sup>1</sup> Id. at p. 1.

<sup>2</sup> Id. at p. 5.

<sup>3</sup> Id. at p. 10.

participants that did not participate in OCM might be given the option of no downside risk for a limited time.<sup>4</sup>

ACCC strongly encourages CMMI to provide further details on the risk tracks and allow stakeholders to provide more detailed input before finalizing the OCF Model. Without a basic understanding of the proposed discounts from benchmark costs, stop-loss and stop-gain percentages, and other key components for each risk track, it will be difficult for potential participants and others to gauge whether the Model offers a useful and attractive range of options for practices with different levels of experience taking on financial risk for care.

Further, ACCC urges CMMI to allow all physician group practices and hospital outpatient department participants to be in one-sided risk for the full duration of their participation in the OCF Model. ACCC fully supports, and has long been at the forefront, of the movement toward value-based payment. However, ACCC is extremely concerned that both physician practices and hospital outpatient departments may be unwilling to participate in the OCF Model if they are required to participate in two-sided risk.

The challenge of taking two-sided risk is particularly acute at small practices and hospitals that treat a high number of Medicare beneficiaries. ACCC is encouraging CMMI, at a minimum, to allow all participants at least two years in the one-sided risk track under OCF to allow them time to accumulate data and experience in this model before they are required to move to two-sided risk.

Some ACCC members who participated in the OCM report having received no performance-based payments, and the early publicly available results from OCM showed minimal cost savings, which were not large enough to compensate for any financial incentives received by the participating practices. One recent analysis found that about 70% of OCM practices would owe CMS a performance-based payment if they were required to take on two-sided risk under the original OCM methodology,<sup>5</sup> and the RFI envisions that OCF practices would be required to find savings with an even steeper discount rate. To require OCM participants to now go straight into 2-sided risk, particularly without a thorough understanding as to how it would work, is extremely concerning to physician practices. Currently, no physician practices or hospital outpatient departments have the data or experience to understand the extent of their risk exposure in a 2-sided risk model under OCF, or ways to manage that risk. By implementing mandatory 2-sided risk under the OCF Model, CMMI may greatly reduce the number of participants in the OCF, particularly those physician practices without the experience and knowledge garnered from participation in the OCM.

#### **IV. ACCC urges CMMI to structure the prospective payment for care management and certain other services as a supplemental payment.**

CMMI is proposing to structure the OCF Model similar to the OCM, with prospective payment for care management and certain other services, plus retrospective adjustments to Part A and B payments based on performance against a target or benchmark cost. However, the prospective payment would not be a supplemental payment, but instead would amount to a capitated payment for the covered services, a Monthly Population Payment (MPP), which would include payment for evaluation and

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<sup>4</sup> Id. at p. 10.

<sup>5</sup> Avalere, More than Half of All OCM Providers Could Owe CMS Money if Required to Join in 2-Sided Risk Model (May 21, 2019), available at <https://avalere.com/press-releases/more-than-half-of-all-ocm-providers-could-owe-cms-money-if-required-to-join-in-2-sided-risk-model>.

management (E&M) services, drug administration services, and enhanced care coordination services (eg. having 24/7 patient access) required under the OCF Model.<sup>6</sup> CMMI also has suggested that lab services, imaging services, and the 6 percent add-on for drug payments could be included in the MPP.

ACCC strongly urges CMMI not to implement the MPP as a capitated payment replacing separate payment for certain services. Instead, CMMI should maintain the Medicare fee-for-service payments as structured in the OCM and finalize the MPP as a supplemental payment for additional care coordination services only. ACCC is concerned that the level of payment resulting from the new structure would have a significant negative impact on hospitals and physician practices participating in the OCF Model. With enhanced care coordination services required under the OCF Model, and the potential inclusion of lab services and the 6 percent add-on for drug payments, as well as uncertainty regarding the level of reimbursement under the new structure, participants in the OCF Model may expose themselves to significant financial losses. We are especially concerned about this uncertainty given that CMMI has released so few details about the Model's methodology, which forces prospective practices to guess whether the capitated payment will be sufficient to cover the cost of providing both the core services now reimbursed separately and the supplemental services required to perform well in the Model.

Replacing the supplemental care coordination payment with a capitated payment for core physician services also risks undermining the care coordination benefits of a prospective population-based payment. With a regular infusion of funds based on the expected number and complexity of Model-eligible patients, a practice can make investments in staffing, technology, and practice transformation that are not just helpful but necessary to strong performance under a Model like OCF. If CMMI instead requires practices to use those same funds to pay for core services like evaluation and management visits and drug administration, practices will have less incentive (or ability) to make those investments. If that happens, the Model is less likely to produce the same transformations in oncology care that we have begun to see under OCM.

**V. ACCC urges CMMI to provide additional detail about the methodology for the novel therapy adjustment and to ensure that the final adjustment adequately accounts for the cost of innovative and often life-saving new therapies.**

ACCC applauds CMMI's proposal to include a novel therapy adjustment in the OCF Model. We believe it is critical that the Model not create a disincentive for participating practices to use new drugs. New therapies may be the best available treatment for a particular patient and, in many cases, may offer the patient a dramatic improvement in the chances of treatment response, remission, or even cure. If the OCF Model methodology does not include an appropriately structured adjustment to the benchmark and/or target cost for an episode to account for the use of innovative therapies, practices will have a strong disincentive to use them, and patients may suffer.

We are concerned, however, that CMMI proposes to apply the novel therapy adjustment only if an OCF practice has a higher proportion of expenditures for newly FDA-approved therapies than non-OCF practices. This is how the adjustment was structured under OCM, and ACCC has heard from a wide range of our participating members that the novel therapy adjustment under OCM is vastly insufficient to cover the actual costs of new therapies. OCF practices should not be forced to make the same choice between performing well under the Model and using the most appropriate and beneficial treatment for a patient. Instead, we encourage CMMI to structure the adjustment in a manner that

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<sup>6</sup> Id. at p. 6.

accounts for the actual cost of individual new therapies, as CMS does in other prospective payment systems. Alternatively, CMMI could simply remove the cost of eligible novel therapies from the calculation of actual episode costs, until those costs can be adequately incorporated into the benchmark costs.

**VI. ACCC strongly recommends that CMMI provide additional details and opportunity to comment on OCF before finalizing the new Model.**

ACCC greatly appreciates the opportunity to comment on the OCF Model. However, the RFI lacks many of the details necessary to implement the Model. ACCC understands that CMMI plans to incorporate stakeholder input from both written comments as well as the Public Listening Session held on November 4, 2019.

However, ACCC strongly recommends that CMMI provide an additional opportunity for public comment once it incorporates feedback received from interested stakeholders, to ensure alignment with stakeholder interests and participation by physician group practices and hospital outpatient departments. OCM practices, which include many of our members, have much to share with CMMI about what has worked and what needs improvement from that model, and we believe the OCF Model will benefit significantly from giving these experienced practices (and other stakeholders) an opportunity to review and engage with CMMI on a more detailed methodology.

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ACCC greatly appreciates CMMI seeking public input on the proposed OCF Model. ACCC reiterates our commitment to promoting access to effective cancer treatments for all Medicare beneficiaries who need them, including through carefully structured value-based payment models. We hope CMS will consider our comments above and make appropriate changes to the proposed OCF Model to ensure that it offers a real opportunity to promote and test innovative approaches to delivering cancer care.

If you have any questions about our comment letter or would like to discuss our comment in further detail, please contact Christian Downs, ACCC's Executive Director, at [cdowns@acc-cancer.org](mailto:cdowns@acc-cancer.org) or 301-984-9496.

Respectfully submitted,



Ali McBride PharmD, MS, BCOP  
President, Association of Community Cancer Centers