

December 12, 2019

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

Re: Oncology Care First Model; Request for Information

Dear Acting Director Bassano:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to respond to the Center for Medicare and Medicaid Innovation (CMMI) Request for Information on the Oncology Care First (OCF) model. It is critically important for CMMI to make better payment models available for cancer care as oncologists have cited numerous barriers to providing high quality patient care in the regular Medicare physician payment system. For example, because fee-for-service payments are chiefly tied to face-to-face services and administration of cancer therapies, it is difficult for oncology practices to support teamwork and collaboration with other physicians, nurse care managers, after-hours access to help prevent emergency department visits, education and counseling on patient self-management and nutrition, comprehensive diagnostic work-ups, patient-physician shared decision making about treatment plans, support for cancer survivorship, as well as helping patients access nonmedical services like financial and transportation help that patients may need in order to adhere to treatment plans for their cancer.

OCF is very similar to the current Oncology Care Model (OCM). Although participants in OCM have been able to improve care using the Monthly Enhanced Oncology Services (MEOS) payments for non-face-to-face services and support staff provided in OCM, they have also identified several areas where improvements are needed, for example:

- MEOS payments are limited to patients who are undergoing treatment;
- Financial risk rules can penalize physicians for costs outside their control, such as increases in drug prices and treatments for chronic and acute care needs that are unrelated to patients' cancer;
- Lack of adequate risk adjustment hurts practices that treat a higher proportion of patients with complex conditions, poor functional status, and/or lack of caregiver support at home;
- Electronic health record systems must be customized for use in reporting on CMMI measures;
- Practices are required to report quality measures that are not useful in improving the quality of patient care; and
- Attribution methods fail to accurately identify the patients whose care oncology practices are managing.

These problems have been repeatedly cited by OCM participating practices and were reinforced at the November 4<sup>th</sup> listening session on the OCF model. The AMA is concerned that the plans for the OCF model do not address the limitations of OCM. Instead of implementing OCF as currently outlined, the AMA recommends that CMMI adopt the approach used in the Making Accountable Sustainable Oncology Networks (MASON) model, which was recommended to the Department of Health and Human Services (HHS) by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). In his response to the MASON recommendation, HHS Secretary Azar said that HHS “values transparent payment determined by successful episodes of care rather than discrete services,” and noted that the virtual accounts in MASON “are intended to empower patients and providers to collaboratively manage costs.” Finally, the Secretary noted that the differences between OCM and MASON “may be design features other OCM participants would appreciate.”

The MASON model has been designed to include the positive aspects of the other CMMI-supported oncology models, including the oncology medical home and OCM, while also incorporating important refinements that will address the limitations of current oncology payment models, thereby more effectively improving the quality and affordability of cancer care in the United States. The model would provide support for comprehensive diagnostic and treatment planning services for new cancer patients, as well as survivorship services for patients following treatment, that are not available in OCM. Participating practices would be accountable for the aspects of Medicare spending they can control, but they would be protected from financial losses due to fluctuations in drug prices and due to the higher costs of treating patients with greater needs. Patients will benefit greatly from the intensive care coordination and reliance on evidence-based clinical pathways.

The AMA views the MASON model as having five major advantages over the currently outlined OCF model. Each of these five improvements is described below, and the AMA strongly recommends that CMMI incorporate these same provisions into its next medical oncology model.

## **1. Financial Accountability**

In contrast to OCF, which proposes to put participants at financial risk for all of the services their patients receive for all of their health care needs, MASON would only hold participating practices accountable for the cost of cancer treatment and related complications. This is an important difference. A patient with cancer who had difficult-to-control hypertension before she developed cancer, for example, could experience a fall requiring an emergency department visit and a hospital admission because her cardiologist made a change in her hypertension medication; this would be undesirable, but it would be unrelated to the cancer treatment and outside the control of her oncologist. Unrelated health problems would be especially difficult for an oncology practice to manage if the patient’s other physicians are not part of the same group or health system as the oncologist. But even if all the patient’s physicians are in the same group, only the oncologists are being paid differently under OCF, so there is no payment to support better care for the patient’s other conditions. Financial accountability under MASON is focused on cancer-related services, which is what oncologists can influence. There are many opportunities for reducing avoidable spending on cancer-related services, so MASON can successfully achieve significant savings with this revised focus.

There are also serious concerns about the high level of financial risk required in the OCF model as proposed. Most of the spending for care of cancer patients is for the cost of drugs, not for the

oncology practice's staff, so requiring a practice to pay for even a small percentage of the total cost of care could eliminate all of the revenue the practice receives for its own services. One listening session participant noted that these risk levels would be "practice ending" if they were imposed. New CMMI models should improve patient access to high quality cancer care, not threaten to reduce access through risk requirements that are too steep for most practices to manage.

## **2. Drug Prices and Clinical Pathways**

Oncologists cannot control drug prices. Sometimes they can choose a lower cost drug that is equally effective, or avoid using an expensive drug, but often there is only one choice to achieve the best outcome. By placing oncologists at risk for drug costs, OCF would be encouraging practices to undertreat patients. The limited quality measures in OCF would not prevent this undertreatment because they do not assess whether the patient's treatment follows evidence-based clinical pathways. In contrast, MASON holds practices accountable for following recommended clinical pathways, which is the only appropriate way to ensure that patients' treatment plans are based on their needs and that they do not get inappropriate drugs or services. Unlike OCM, MASON does not reward practices for using lower-cost drugs that are not evidence-based. The National Comprehensive Cancer Network, American Society of Clinical Oncologists, and other participants in the November listening session all advocated for using performance measures based on clinical pathways, as MASON does.

It is also important to recognize that it is not just new drugs and drug price increases that affect drug costs. Evidence in cancer care is changing rapidly. If new evidence indicates that an existing expensive drug works best for specific patients, then oncologists need to treat their patients with that drug even if it increases spending. Often the evidence is very specific; for example, patients who have been on chemotherapy previously generally have fewer treatment choices than those getting their first line of therapy. For small practices, these factors are unlikely to "average out."

## **3. Risk Adjustment**

MASON uses data and clinical pathways to very precisely define target costs for delivering high quality patient-centered care based on the current patient's needs, not the historical costs for other patients. OCF only adjusts its target prices based on the type of cancer and whether the patient is receiving chemotherapy, hormonal therapy, or nothing. Many listening session participants noted that this approach would not take into account the effects of stage of cancer, subtype of cancer, the toxicity and complexity of the chemotherapy, and the patient's functional status and caregiver support, all of which have a huge impact on the services that patients need and cancer care costs. For example, higher-toxicity chemotherapy requires closer patient monitoring, potentially more supportive drugs (like drugs to prevent infection and anti-emetics), and a higher frequency of interventions to avoid emergency visits. These differences have equal or greater effects on practice costs and Medicare spending than the type of cancer.

The PTAC commended MASON's granular and flexible approach, using payment levels specific to the patient's health conditions, the appropriate evidence-based treatment pathway, and other factors likely to affect utilization and spending.

#### 4. Quality Measures

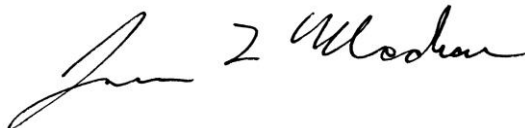
CMS proposes to use the same quality measures in OCF as it is using in OCM. As noted above, these measures do not assess whether individual patients are getting evidence-based treatment for the particular cancer that they have. Moreover, practices receive the same payments for individual patients regardless of the quality of care delivered to them, as long as quality is good “on average.” In MASON, payments are partially withheld and can only be provided to the practice if it follows specific evidence-based clinical guidelines for each of its patients or documents patient-specific reasons for deviation.

#### 5. Predicting Future Costs Based on Outdated Treatment Patterns

The design of OCF assumes that the types of patients a practice treated in the past and the types of treatments and other services they received can be used to predict cancer treatment spending at a practice in the future, but CMS has provided no evidence demonstrating this is true. It is now widely recognized that two groups of patients with the same general type of cancer can differ dramatically in the specific molecular subtypes of cancer, and consequently the appropriate treatments for the two groups will also be different. The model CMS uses to predict spending does not adjust for this; as a result, an oncology practice that happened to have patients who were less-expensive-than-average to treat during the baseline period could be assigned a target that is far less than the cost of treating the patients they have during a performance year, and vice versa. Physician practices do not have the financial reserves to handle these dramatic variations in spending and the associated potential for large random penalties and bonuses, and the practice could be forced to close long before the variations “average out.” MASON would include the cost of reinsurance in the payments and set payment amounts based on the actual characteristics of the practice’s current patients.

To summarize, the AMA strongly encourages CMMI to design future oncology payment models to incorporate the key elements of the MASON model, rather than continuing to use the problematic elements of the current OCM model. Thank you for the opportunity to respond to this Request for Information and for considering our recommendations. If you have any questions, please contact Margaret Garikes, Vice President, Federal Affairs, at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org) or 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD