December 13, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

Submitted electronically: OCF@cms.hhs.gov

RE: Oncology Care First Model: Informal Request for Information

Dear Administrator Verma:

The American College of Radiology (ACR), representing more than 38,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the Oncology Care First Model: Informal Request for Information.

Proposals

CMS released a Request for Information (RFI) requesting comments on a potential new model for episode-based payments to support high quality oncology care. This potential new model would build on the current Oncology Care Model (OCM) and aims to include a multi-disciplinary approach to treatment of cancer patients. The Oncology Care First (OCF) Model would expand on the OCM by suggesting the inclusion of radiation therapy and possibly imaging and labs in a broader oncology episode-of-care.

The proposed model pays a prospective Monthly Population Payment (MPP) for evaluation and management and drug administrative services to medical oncologists who would be responsible for quality reporting, outcomes and risk. The OCF Performance Based Payment (PBP) episode is triggered at the infusion of chemotherapy and includes six months of care, including all Part A and Part B services, as well as certain Part D expenditures.

ACR Perspective and Comments

The ACR believes that the OCM and OCF Models are medical oncology centric and do not lay the proper groundwork for multi-disciplinary payment nor direct responsibility for the costs and outcome of the patient. Although medical oncologists manage the care and administration of drugs

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for oncology patients, they have little control over other treatments the patient may need (i.e., radiation therapy, interventional radiology and surgery) in a six-month period. Not only would the medical oncologist be held accountable for costs of other therapies of which it would have little control, expansion of the episode-of-care to include them could incentivize underutilization of them for patients in this new model.

A separate Milliman report on the "Cost Drivers of Cancer Care" indicates that radiation therapy is 4 percent of the total cost of cancer care. The OCM Evaluation Performance Period One report indicates that radiation therapy costs, in OCM participating practices, were 3 percent of the total cost of care at the baseline. Subsequent analysis indicates that radiation therapy costs declined to 2.5 percent during the first evaluation period. OCM practices consistently use about 23 percent less radiation therapy than the national baseline to date, which points to selection bias of practices participating in the OCM.

While it is not clear why OCM groups experience a greater decrease in radiation therapy cost per episode during the evaluation period, it is reasonable to believe that those reductions could be due to efforts to meet or beat the OCM target rate by reducing use of radiation therapy services.

Therefore, the ACR believes it is best to keep radiation oncology (RO) services outside the OCF and pay it either as fee-for-service, or in the case of radiation oncology, through the pending RO APM for those in the model.

Furthermore, ***ACR believes that if CMMI decides to implement the OCF as proposed with the inclusion of radiation therapy services, we urge CMS to omit OCF practice data from the trend factor analysis used to annually update the RO Model national case rates.*** In order to establish a clean trend factor for the RO Model, CMS should only include non-RO Model practices that also do not participate in a separate advanced alternative payment model (APM) such as the OCF.

Proposals

CMS proposes that the OCF be considered an advanced alternative payment model (APM) recognized under the Quality Payment Program.

ACR Perspective and Comment

The ACR supports including the OCF two-sided risk tracks in the QPP as qualifying APMs and the one-sided risk track and both of the two-sided risk tracks as MIPS APMs.

Proposals

CMMI specifically requests feedback on whether additional services such as imaging or lab services should be included in the MPP.

ACR Perspective and Comment

The ACR believes that medical oncology practices should refer patients for any imaging to a radiology office or hospital imaging center and pay for them separately under fee-for-services as is current practice. The ACR is concerned that bundling imaging into the OCF episode-of-care would incentivize model participants to seek cost savings by choosing imaging providers based on cost alone. Disregarding quality and safety issues may have deleterious consequences outside of the 6-month accountable window of care. High exposure to radiation, unnecessary contrast exposure, use of low quality equipment, and repeat non-diagnostic scans are a few of the potential pitfalls of choosing an imaging provider solely on cost.

Conclusion

The ACR appreciates the opportunity to comment on the Oncology Care First RFI. In addition to the submission of these comments, **the ACR fully supports the more detailed comments as submitted by the American Society for Radiation Oncology (ASTRO)**. If you have any questions or comments on our letter, please do not hesitate to contact Samantha Porter at (703) 648-0693 or via email at sporter@acr.org, or Pam Kassing at (800) 227-5463 x4544 or via email at pkassing@acr.org.

Respectfully Submitted,

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