December 13, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via OCF@cms.hhs.gov

RE: Oncology Care First Model: Informal Request for Information

Dear Administrator Verma:

The National Association of ACOs (NAACOS) is pleased to submit comments in response to the Informal Request for Information on the new Oncology Care First Model, published online November 1.[1]

NAACOS works to advance population health-focused payment and delivery models and represents hundreds of organizations who serve 12 million beneficiary lives by participating in models in Medicare, Medicaid, and commercial health plans. This includes the Medicare Shared Savings Program (MSSP), Next Generation ACO Model, Medicare Advantage and alternative payment models supported by a myriad of commercial health plans.

ACOs have been instrumental in Medicare's shift to value-based care. The origin of Medicare ACOs dates back to the George W. Bush administration, and now nearly 560 ACOs operate in Medicare, covering nearly 13 million beneficiaries. Population-health model ACOs are a market-based solution to fragmented and costly care that empowers local physicians, hospitals, and other providers to work together and take responsibility for improving quality, enhancing patient experience, and reducing waste. Importantly, the ACO model also maintains patient choice of clinicians.

NAACOS shares with the Centers for Medicare & Medicaid Services (CMS) the goal of moving toward a value-based payment system and the cost reductions and quality improvements it brings. ACOs have for years invested in resources, such as data analytics, information technology, and care coordinators, and worked to change institutional culture to focus on prevention and care coordination so that they can succeed in alternative payment models. Our recommendations reflect our collective desire to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

As envisioned, the Oncology Care First Model would replace the ongoing Oncology Care Model (OCM), which is scheduled to sunset at the end of 2021. Oncology Care First would test prospective payments for managing the care and drug administration along with demanding total-cost-of-care responsibility

[1] https://innovation.cms.gov/Files/x/ocf-informalrfi.pdf

for oncology practices. Its goals are to reduce Medicare spending while improving care quality. NAACOS appreciates that this model would be voluntary and qualifying as an Advanced Alternative Payment Model under the Quality Payment Program.

While NAACOS supports the efforts of CMS and the CMS Innovation Center to introduce value-based payment models, various models overlap with each other and – from time to time – conflict with each other, unfortunately. Practices can participate in both the MSSP and other models. ACO patients can trigger episodes in other bundled payment or disease-specific models. CMS, for example, allows OCM practices to dually participate in MSSP and the Next Generation ACO Model. Performance-based payments are included in MSSP and Next Gen shared savings calculations. If a portion of the discount is paid out as shared savings to an ACO under MSSP or Next Gen, CMS will recoup the portion from OCM participants who are part of that MSSP or NextGen.

The Informal Request for Information asked for no feedback on overlap with other payment models and gave one sentence for a potential policy: *As in OCM, we would develop methodologies to account for overlap and interaction between current or new CMS programs or initiatives and [Oncology Care First] participants, practitioners, and beneficiaries.*

We understand CMS is working on a uniform, agency-wide program overlap policy to replace the model-by-model rules that exist today. NAACOS appreciates that work and offers a simple solution: Test new models on non-ACO patients and let total-cost-of-care models, like ACOs, operate as expected. **Specifically, NAACOS urges CMS to exclude all ACO patients from attribution to any other payment models to reduce duplicative care coordination efforts and create a clear, transparent and understandable policy across all Innovation Center models. Furthermore, models that demand accountability for all of patients' spending should be given priority over disease specific models like Oncology Care First and the forthcoming Comprehensive Kidney Care Contracting Model.** We want providers to participate in multiple models, if they'd like, but also want to give attribution precedence to total-cost-of-care models, since they have the greatest opportunity to control spending and increase quality.

Existing rules create unintended consequences, including increased program complexity and potentially patient confusion resulting from care being handled by multiple programs. Health systems would duplicate resources – meaning waste resources – to manage multiple coordination efforts. NAACOS is concerned CMS has chosen not to prioritize total-cost-of-care models over disease-specific payment programs, including the OCM. This policy has the potential to harm ACOs when savings it produces are not attributed to the ACO.

ACO models have proven to be superior at reducing Medicare spending compared to episodic or disease-specific payment models. The second evaluation of the OCM concluded "overall cost and savings findings do not yet show meaningful impacts, and cost impacts are not large enough to compensate for the financial incentives received by the participating practices." Formal evaluations of the Bundled Payments for Care Improvement revealed Medicare experienced net losses after taking into account reconciliation payments to participants. The formal evaluation for the Comprehensive Care for

Joint Replacement (CJR) model resulted in a mere 0.5 percent savings to Medicare, but those savings couldn't be concluded with statistical certainty. Comprehensive Primary Care Plus had few effects on cost, service use, and quality for Medicare FFS beneficiaries in the first year.

Meanwhile, a growing body of "counterfactual" data, which compares Medicare spending to what spending would be like in the absence of ACOs, shows ACOs are lowering Medicare spending by 1 percent to 2 percent, which translates into tens of billions of dollars of savings when compounded annually. Researchers at Harvard University, the Medicare Payment Advisory Commission, and Dobson DaVanzo & Associates have all done such work. Medicare ACOs in 2018 showed a continuing trend of ACOs saving money compared to the CMS-set benchmarks, generating $1.7 billion compared to their benchmarks and $740 million after accounting for shared savings payments and collecting shared loss payments. CMS acknowledged "spillover" savings in the August 2018 proposed "Pathways to Success" rule, pointing out that ACOs lowered Medicare spending outside the ACO program by $1.8–$4.2 billion in 2016 alone in such ways as lower Medicare Advantage payments.

Furthermore, the Next Generation ACO Model has been praised by the CMS administrator as a shining example of the Innovation Center's work in value-based care for its year-after-year savings. The CMS actuary certified the Pioneer ACO model for expansion in 2015. Most recently, the ACO Investment Model overall reduced spending by 3.5 percent.

To reiterate, NAACOS believes that CMS should exclude ACO-aligned patients from other Innovation Center models to reduce programmatic complexities and overlap, including the reconciliation of payments and savings. NAACOS appreciates CMS's work to introduce new payment models and hopes our recommendations will help all value-based care models, including ACOs, to further reach their goals, which align with CMS's.

Sincerely,

Clif Gaus
President and CEO