



Oncology Nursing Society

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Seema Verma, MPH
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201
Submitted electronically via OCF@cms.hhs.gov

RE: **Informal RFI on the Oncology Care First (OCF) Model**

Dear Administrator Verma:

The Oncology Nursing Society (ONS) appreciates the opportunity to provide our perspective on a potential Oncology Care First (OCF) Model that aims to improve health outcomes and quality of care for Medicare beneficiaries with cancer.

Overview/Model Goals

Oncology nurses play a critical role in improving patient experiences and outcomes by identifying and eliminating waste and inefficiencies and actively improving systems of cancer care delivery. Anecdotal information from practices participating in the Oncology Care Model (OCM) illustrate that most efficiencies and improvements, especially those having the greatest influence on patient outcomes, are the result of significant nursing involvement in workflow changes. For example, improving triage workflow for patients seeking counsel after appointments, increasing proactive assessment of treatment-related side effects, identifying patients most likely to seek emergency care and restructuring their follow-up to be more anticipatory, and adjusting provider visit and treatment scheduling for more efficient use of human resources and physical space. ***These efforts should be recognized, reimbursed and appropriately attributed to the professionals driving the improvements.***

In addition, ***we urge improved transparency on how “cost of care” is determined, especially given the shortfalls noted by many practices participating in the OCM.*** In the RFI, CMS explains that “[t]otal cost of care accountability for Medicare costs, including drug costs, incurred during a six-month episode of care triggered by a Medicare beneficiary’s receipt of a Part B or D chemotherapy drug, with the opportunity to achieve a performance-based payment (PBP) or owe a repayment to CMS (PBP recoupment), depending on quality performance and costs relative to benchmark and target amounts.” However, we are eager to better understand all costs that will be accounted for during the episode, including any exclusions. This is important considering the model, much to our disappointment, continues to see cancer in isolation of other patient comorbidities. These comorbid conditions are the reality of our patient populations; they influence patient goals, cost of care and the ability to include non-oncology care providers to ensure optimal patient outcomes. ***We urge CMS to provide details about the way it will incorporate and account for comorbid conditions as part of the model.***

Similarly, we note that the OCM was implemented as many newer treatments were being approved, and the pace of new approvals has escalated, most having side effects without a 20+ year track record to best determine/estimate cost of care. Newer agents require inclusion of other non-oncology specialists to determine optimal adverse event management, which will increase the cost of care. **We urge CMS to ensure these and other costs are appropriately and adequately accounted for.**

Potential Model Design Elements

In addition, and with respect to the Potential Model Design Elements, CMS notes that “PGP participants would include Medicare-enrolled PGPs that are identified by a TIN and composed of one or more physicians and non-physician practitioners [emphasis added] who treat Medicare beneficiaries receiving chemotherapy or chemotherapy-related services for a cancer diagnosis and who have reassigned to the PGP the right to receive Medicare payments.” To ensure that oncology advanced practice registered nurses (APRNs) are appropriately distinguished for these purposes, **we urge CMS to develop specialty designation codes that APRNs can self-select upon enrollment in the Medicare program.** As we’ve shared in prior comments, the lack of specialty designation for oncology APRNs limits the availability of objective Medicare claims, quality and resource use, and other administrative data, thus preventing public and private stakeholders from conducting important analysis on the impact of oncology nurses on cancer care in the Medicare program. Robust analysis and evaluations, including comparisons to other provider types, is essential for oncology nurses to continue raising the bar and improving cancer care and patient outcomes.

Quality Strategy

With respect to the noted Quality Strategy, we note that requirements for data analysis and application of learnings from the analysis, plus inclusion of electronic patient-reported outcomes (ePROs) or PROs, will significantly increase the burden faced by many practices, whether with human resources and appropriate skill sets and/or with the need to enhance informatics programming/resources to facilitate inclusion of data analysis/implementation of learnings and ePROs/PROs. We urge CMS to ensure reimbursements account for these costs, and that practices have access to technical assistance.

Other Key Considerations

We note that CMS does not discuss how behavioral and mental health will be included in the model. ONS believes that incorporation of intensive psychological patient assessment and management into routine cancer care is paramount. **We urge CMS to ensure that mental healthcare providers are included in the model and can work in direct collaboration with the patient's oncology team and primary physician.** ONS has established [resources](#) that may be of utility in this regard.

In addition, CMS should ensure that other key elements associated with quality cancer care, such as dietician and nutrition services, are included in the model payment.

We also encourage CMS to consider ways that the oncology models can “drop-in” to other alternative payment models, including Medicare Accountable Care Organizations (ACOs), without disadvantaging the participants in either the ACO or the OCM/OCF with respect to setting benchmarks and/or the availability of shared savings.

Finally, we are deeply concerned about “financial toxicity.” As the agency is aware, Medicare does not cover all costs associated with quality cancer care; supplemental insurance is required and often comes with significant co-pays/out-of-pocket expenses. While oncology practices may help to reduce the cost

of cancer care in key areas, it will not be to the point of lessening financial toxicity for our patients. We urge CMS to consider this aspect as it finalizes the OCF model.

We appreciate the opportunity to comment on this proposed model. If you have any questions about our comments, please contact Valerie Adelson, ONS Director of Government Affairs, at vadelson@ons.org.

Sincerely,

The Oncology Nursing Society

About ONS

The Oncology Nursing Society (ONS) is a professional organization of over 39,000 registered nurses and other healthcare providers dedicated to excellence in patient care, education, research, and administration in oncology nursing. ONS members are a diverse group of professionals who represent a variety of professional roles, practice settings, and subspecialty practice areas. Oncology nurses are leaders in the healthcare arena, committed to continuous learning and leading the transformation of cancer care by advocating for high-quality care for people with cancer.