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**VIA ELECTRONIC MAIL**

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

Re: Oncology Care First Request for Information

Dear Acting Director Bassano:

Thank you for the opportunity to provide input on the proposed oncology payment model, tentatively labelled Oncology Care First. The Pacific Business Group on Health (PBGH) is a purchaser coalition representing 40 public and private organizations that collectively spend \$100 billion each year purchasing health care services for more than 12 million Americans. Our members share a passionate belief in the possibility of transforming the health care system to be accountable for health outcomes, patient experience, and spending, and in which consumers are motivated to make the best choices for their individual health needs and providers are motivated to offer high quality, efficient and appropriate care.

Value-based payment will only work if it reflects improvements in patient outcomes. Federal programs like the Quality Payment Program cannot continue to rely on highly technical clinical or process measures that fail to signal improvements in value. We are encouraged by CMMI continuing to propose innovative payment models that are keyed to measured improvements in patient health outcomes. Even as large employers, we look to CMS to provide national leadership that ensures that all providers commit to and build the capability to collect and use outcome measures. CMS should exert its national leadership to drive an expedient and systematic, multi-year process.

PBGH has had a long history of advancing quality measurement and public performance accountability, from publishing commercial plan and medical group patient experience and clinical quality results to developing the predecessor patient experience surveys that were the basis for CG-CAHPS. More recently, we have led pilots to collect and report patient-reported outcomes (PROs), and have been steeped in multi-stakeholder and provider collaborations to standardize data collection, spread best practices in use of PROs for patient care and inform treatment decision support. We are also proud to be a recipient of a CMS Cooperative Agreement to test and develop PRO-based performance measures in oncology care for use in MACRA. In this capacity, we have been working closely with the Michigan Quality Oncology Consortium and many of the leading hospitals that make up the Alliance of Dedicated Cancer Centers. In this role, we have found enthusiastic support for capturing patient-generated information in managing the course of curative treatment for cancer. Through enhanced intake information forms within electronic medical records as well as mobile applications, a diverse group of

providers representing both community-based oncologists, large group practices and academic-centers are working collaboratively to integrate PRO surveys into routine workflows in the care setting and as part of follow-up care.

In this comment letter, we outline a staged measure adoption process that can be implemented within the design of a new oncology payment model and which will help oncology practices shift to outcomes-based purchasing, payment, and contracting. This process entails:

- Sequencing measures used for oncology payment incentives to encourage continually increasing capabilities for collection of ePROs
- Assuring that providers understand and use ePROs in patient care
- Building infrastructure to allow for risk adjustment and reporting

***Inclusion of ePROs in the clinical redesign criteria***

We strongly support CMMI's desire to include the new care redesign activity, which is also designated as an Enhanced Service, which is to gradually implement electronic patient-reported outcomes (ePROs).

Including ePROs in value-based programs is important for a variety of reasons, as they:

- Determine if patients benefit from treatment in ways that matter to them, providers and society;
- Address many issues that providers should be discussing with their patients that ultimately will affect their clinical outcomes (e.g., by enabling early detection or decline that warrants intervention or enabling providers to track response to treatment and modify as needed);
- Give consumers essential information about the effect of a treatment or condition and how soon they can expect to return to normal functioning or have reduced symptoms;
- Give consumers essential information for provider choice; and
- Represent a key element of patient-centered care.

***Configuration of Quality Measures to reflect ePRO adoption and performance***

The RFI suggests that CMMI will continue to use the six OCM quality measures as the basis of performance recognition and rewards. Our experience with supporting payers' use of outcome measures indicates the importance of a measurement strategy that assists providers in building foundational capability, rather than incenting outcomes performance within the payment model's early years. We suggest that CMMI give a firm signal to participants that payment will ultimately be tied to improved health outcomes, but that interim measures will recognize meaningful progress towards demonstrating that capability and making use of outcomes data in care improvement activities.

We recognize that many providers do not now have the capability to administer ePRO tools, track patients over time, and successfully contact them for follow-up outcome measurements. We recommend that CMMI develop a ladder of measures, implemented sequentially over time, that rewards annual progress in building this capability and demonstrating that PRO data is being used in clinical practice. This "measure cascade" provides initial incentives for administering the appropriate PRO tool to a defined population of patients. Incentives are then shifted to reward successful tracking of patients over time and completing a 2<sup>nd</sup> or subsequent outcome measurement that can be compared to

the baseline measure. Next, incentives reward calculation and reporting of changes in patient outcomes over time. Finally, the incentives simply reward performance, in terms of optimal outcomes for a defined population. The measure cascade accommodates providers with varying levels of capability as they can participate at the stage appropriate to their level of maturity. Table 1 provides a proposed measure cascade for depression – which could be used to support increased performance for the current OCM-5, for example. Ultimately, we want quality to be assessed through improvements and achievements in PROs and other outcomes, but payers (both public and private) need to invest in moving the market towards this understanding and capability.

**Table 1: Proposed PRO Measure Cascade for Depression – replacing OCM-5**

Measure	Numerator	Denominator	Type	Year	Source
Depression Utilization of PHQ-9	Completed PHQ-9 at least once during a 4-month period in which there was a qualifying visit	Patients age 18 and older with the diagnosis of major depression or dysthymia		6 mos	NQF 0712
Screening Rate at Baseline	Completed screens	Total primary care population age 12+	Process	1	
6-Month Treatment Response	Number of patients with paired surveys reporting > 50% reduction from baseline PHQ-9 score that is greater than XX	Total completed PHQ-9 baseline surveys with PHQ-9 > 9 in reporting window	Outcome	2	MNCM
6-Month Disease Remission	Number of patients with follow-up survey reporting PHQ-9 < 5	Total completed PHQ-9 baseline surveys with PHQ-9 > 9 in +/- 20-day reporting window	Outcome	3	NQF 0711

A similar measure cascade should be developed to replace the OCM-6 measure, which emphasizes patient experience but not patient health outcomes. Particularly since the OCF payment model is intended largely for patients undergoing chemotherapy, it is important to evaluate provider performance at minimizing pain and fatigue while maximizing health-related quality of life. Many such measurement instruments now exist, and PBGH and other CMS grantees are presently demonstrating PROMs suitable for use in MACRA and other payment models. Given the expected launch of OCF in 2021, it would be appropriate for CMMI to include a “pay-for-reporting” measure reflecting significant use of an appropriate instrument in 2021, shifting to collection of paired outcome measures in 2022, and to assessments of improved health outcomes by 2023.

**Table 2: Proposed PRO Measure Cascade for Oncology – replacing OCM-6**

Measure	Numerator	Denominator	Type	Year	Comment
Baseline Screening Rate (may not be component of final PRO-PM)	# Completed Surveys using approved instrument: pain, fatigue, HRQOL	Total eligible patients >= 18 with breast, colon or NSLC cancer receiving initial chemo	Process	2021	Baseline is administered from 7 days prior to the day of first chemotherapy

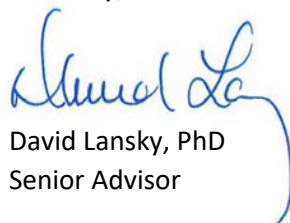
Measure	Numerator	Denominator	Type	Year	Comment
Survey 2 Screening Rate	# Completed Surveys at 2 <sup>nd</sup> time point	Total eligible patients	Process	2021	Survey 2 is administered on the last day of chemotherapy or up to 7 days following
Survey 3 Screening Rate	# Completed Surveys at 3 <sup>rd</sup> time point	Total eligible patients	Process	2021	Survey 3 is administered 90 days after completion of chemotherapy or up to 30 days following
Paired Completion Rate	<i>Completed Baseline paired with Surveys 2 &amp; 3 OR Paired Surveys 2 &amp; 3</i>	Total eligible patients	Process	2022	
Meaningful Change, Favorable Score or O/E Score Following Chemotherapy	Number of patients with paired surveys reporting meaningful change, favorable score or O/E score	Total eligible patients	Outcome	2023	

Recognizing that neither NQF nor CMS have identified preferred instruments and ePROs for MACRA or CMMI payment purposes, this schedule allows recognition for use of ANY appropriate and approved instrument during years 1 and 2 of OCF, with convergence on a single, CMS-approved instrument by 2023. In practice, we believe that program participants could be advised to use one or two consensus instruments for data collection in years 1 and 2, and it is unlikely that the instrument itself would change in year 3 – though there may be new specifications for measure construction, risk adjustment, etc. by that time.

Some oncology practices are already using ePROs to monitor and manage patient care. For that reason, we would recommend weighting the potential quality bonus for performing well on these measures to more highly reward rapid movement towards full outcomes accountability.

Thank you for the opportunity to comment on how CMS can incorporate patient-reported outcomes in the OCF model. If you have any questions about our comments, please contact me at [DLansky@pbgh.org](mailto:DLansky@pbgh.org) or Rachel Brodie at [RBrodie@pbgh.org](mailto:RBrodie@pbgh.org).

Sincerely,



David Lansky, PhD  
 Senior Advisor