



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

April 2, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Ave., SW  
Washington, DC 20201

RE: Oncology Care Model: Request for Applications

Dear Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write in response to the "Oncology Care Model (OCM): Request for Applications" [notice](#) published in the February 17, 2015 *Federal Register*.

The AAFP is pleased that CMS continues to utilize the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. We remain hopeful that the agency and the physician practices selected for participation in this model will be able to reduce Medicare expenditures while improving cancer care for approximately 175,000 cancer care episodes for Medicare fee-for-service beneficiaries over this course of this 5-year model.

The OCM will provide selected physician practices with a monthly per beneficiary per month (PBPM) payment to pay for the enhanced services driven by the practice requirements, aimed at transforming practices towards comprehensive, person-centered, and coordinated care. The OCM PBPM will be \$160 per OCM beneficiary per month for the duration of each 6-month episode, and will remain constant for the 5-year model.

While the AAFP is supportive of this program and the use of PBPM payments, we are compelled to remind CMS that the Comprehensive Primary Care (CPC) initiative also requires participating practices to provide enhanced services driven by the practice requirements, aimed at transforming practices towards a comprehensive, person-centered, and coordinated care. However, we are concerned that PBPM in the CPC program are one-fourth of those provided in the OCM PBPM. In fact, many of the OCM model requirements overlap and are similar to those required of CPC initiative practices. Some overlapping requirements include: 24/7 access to a provider with real-time access to the practice's medical records; use data to drive continuous quality improvement; actively engage with patients to develop care plans; and provide care coordination to ensure continuity. While the OCM model PBPM will be \$160, the CPC initiative provides an \$8-\$40 (average \$20) PBPM to CPC selected primary care practices during the first two years of the demonstration. And whereas the OCM PBPM will remain constant for the duration of the 5-year model, the

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PBPM to CPC selected primary care practices will decrease to an average of \$15 in years 3 and 4 of that initiative. The significant, glaring discrepancy between the two program's PBPM payments is of great concern to the AAFP.

Though AAFP realizes Medicare beneficiaries with cancer require significant resources, we are nevertheless alarmed with the large PBPM payment differential between the OCM and CPC initiative given the substantially similar practice transformation requirements in each case. The vast difference in payment of the OCM versus the CPC initiative perpetuates the current payment disparity between primary care and subspecialists that CMS has previously communicated they would like to alleviate. If CMS implements this model, it will further drive a delta between payments for services provided by primary care and specialty care. We believe the OCM continues the current pay disparity that undervalues primary care, which leads medical students to choose other specialties, thus further perpetuating the shortage of primary care physicians.

The AAFP finds this discrepancy highly concerning and urges CMS to reevaluate the savings generated by the CPC and as a result consider increasing the CPC initiative's PBPM to a level that is equal or at least much closer to the PBPM planned for the OCM. First year results from the CPC initiative shows a reduction in high cost areas such as hospitalizations (2% decrease), emergency department visits (3% reduction), and specialist visits (2% decline). In the first year, the CPC initiative reduced total monthly Medicare expenditures without care management fees during the first program year by \$14 per beneficiary, or 2 percent. Impacts were large enough to offset most of the CPC initiative's monthly care management fees, which average \$20 per beneficiary per month among participating CPC practices. This implies that CPC as a whole was close to cost neutral during the first year.

True and meaningful primary care transformation is complex and a long-term endeavor. Research has shown that this process can take 18 months to 3 years. Since the first year CPC initiative results were so favorable, we urge CMS to ramp up and expand the CPC initiative nationally soon and to eliminate or radically decrease the payment gap between primary care PBPMs and specialty PBPMs.

We appreciate the opportunity to comment on the Oncology Care Model and hope it's a success for the agency, the participating oncology practices, and the Medicare patients receiving cancer care within this model. Again, we strongly urge CMS to eliminate or significantly reduce the glaring discrepancy in PBPM payments between the OCM and CPC initiative that continues the status quo of the current payment environment and, in so doing, make a financial commitment to primary care commensurate with its verbal commitment. For any questions you might have please contact Heidi Robertson-Cooper, Senior Strategist, Health Care Quality, at 913-906-6000 ext. 4174 or [hrobertson-cooper@aafp.org](mailto:hrobertson-cooper@aafp.org).

Sincerely,



Reid B. Blackwelder, MD, FAAFP  
Board Chair