September 6, 2022

Chiquita Brooks-LaSure Administrator
Centers for Medicare & Medicaid Services Department of Health and
Human Services Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted Electronically via www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts. [CMS-1770-P, RIN 0938-AU81]

Dear Administrator Brooks-LaSure,

I am pleased to submit this comment letter on behalf of OneOncology in response to the formal request for comments regarding the proposed "CY 2023 Payment Policies under the Medicare Physician Fee Schedule (MPFS) and Other Changes to Part B Payment Policies, (CMS-1770-P)", as published by the Center for Medicare and Medicaid Services (CMS).

OneOncology was founded by community oncologists, for community oncologists, with the mission of improving the lives of everyone living with cancer. Our goal is to enable community oncology practices to remain independent and to improve patient access to care in their communities, all at a lower cost than in the hospital setting. OneOncology supports our platform of community oncology practices through group purchasing, operational optimization, practice growth, and clinical innovation. Our 750 cancer care providers care for 478,000 patients at 546 sites of care nationwide, including approximately 238,000 Medicare beneficiaries per year (inclusive of Medicare Advantage) and approximately 129,000 traditional Medicare beneficiaries per year.

OneOncology acknowledges the importance CMS's ongoing efforts to improve payment policies for cancer care services that better achieve the Quadruple AIM: (1) Access to high quality cancer care for Medicare beneficiaries; (2) Enhancing the patient experience; (3) Minimizing the cost of cancer care for patients and the Medicare Trust Funds; (4) Workforce health among care teams dedicated to the treatment of cancer and blood disorders and whom OneOncology serves.

OneOncology is committed to promoting value-based cancer care and we appreciate CMS's willingness to engage stakeholders in discussions of proposed changes to the Quality Payment Program (QPP) policies, and specifically those policies that will have a significant impact on value-based payment reform in oncology. We remain eager to engage with the leadership of CMS and the

Center for Medicare and Medicaid Innovation (CMMI) to advance our common goals for value-based payment reform in oncology. We also acknowledge that there are policy proposals within the 2023 MPFS Proposed Rule that will have significant implications for community oncology practices that participate in CMMI's Enhancing Oncology Model (EOM) starting in July of 2023. These comments are intended to express our support for CMS's objectives in implementing value-based payment reforms that advance the Quadruple AIM for cancer care.

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Executive Summary of OneOncology's Comments on the APM and Quality Payment Program sections within the CY 2023 MPFS Proposed Rule:

1. OneOncology urges CMS to reconsider the requirement that participants in the more advanced Risk Arrangement option (RA-2) of CMMI's Enhancing Oncology Model (EOM) also must meet the QP thresholds for Advanced APM status.
2. OneOncology urges CMS to retain the option for participants in RA-2 of EOM to have Qualifying Advanced APM Participant (QP) status assigned at the entity-level; and we have significant concerns regarding CMS's consideration to assign QP status only at the individual provider-level.
3. OneOncology recommends CMS's reconsideration of the removal of the lump sum incentive payment for Advanced APM participation, and we appreciate that within this Proposed Rule CMS is requesting comments regarding important questions about Advanced APM participation incentives.
4. OneOncology supports CMS's current proposal that participation in the Advancing Cancer Care MIPS Value Pathway (MVP) should remain voluntary for oncology practices participating in MIPS, and we would currently recommend that CMS avoid setting any future target for making this MVP mandatory for cancer care providers participating in MIPS.

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1. OneOncology urges CMS to eliminate the requirement that participants in the more advanced Risk Arrangement Option (RA-2) of CMMI's Enhancing Oncology Model also must meet the QP thresholds in order to qualify for QP status.

On pg. 46256 in Section IV.A.1.a. of the 2023 Medicare Physician Fee Schedule (MPFS) Proposed Rule (PR), the Center for Medicare and Medicaid Services (CMS) states that it plans "to continue developing Quality Payment Program policies that more effectively reward high-quality of care for patients and increase opportunities for Advanced Alternative Payment Model (A-APM) participation."

OneOncology highly commends the Center for Medicare and Medicaid Innovation (CMMI) in recognizing that cancer care is a medical specialty that warrants an oncology-specific APM, and further commends CMMI's efforts to develop the Enhancing Oncology Model (EOM) and the recent publication of the EOM Request for Applications (RFA). We specifically support CMMI's including an EOM Risk Arrangement (RA) option that meets the statutory requirements of an Advanced APM (i.e. RA-2).

We further acknowledge the logical rationale for defining EOM Beneficiaries based on the seven specified cancer types and receipt of anti-cancer treatments (i.e. chemotherapy, immunotherapy, or radiopharmaceuticals).

OneOncology recognizes that the Qualifying Participant (QP) Thresholds for A-APM participation are established by statute. OneOncology also recognizes the importance of establishing QP thresholds that require a sufficiently substantial portion of a physician group provider's (PGP's) patients be managed within an APM in order to achieve QP or Partial QP status. However, those thresholds as defined by the statute are contradictory to important considerations in high-quality care for patients with cancer and blood disorders in the community oncology setting, for example:

- Cancer survivors who are undergoing guideline-concordant surveillance and follow-up care with a medical oncologist are included in the denominator of the QP thresholds, but would not meet the definition of an EOM Beneficiary and therefore would not be accounted for in the numerator of the QP thresholds.
- Cancer patients who are being treated with only hormonal therapy are counted in the denominator of the QP thresholds but would not meet the definition of an EOM Beneficiary and therefore would not be accounted for in the numerator of the QP thresholds.
- Patients who are receiving treatment for non-cancerous benign hematology diseases are counted in the denominator of QP thresholds but would not meet the definition of an EOM Beneficiary and therefore would not be accounted for in the numerator of the QP thresholds.

The combined impact of these types of considerations is that the QP thresholds, as statutorily defined, are contradictory to the achievement of QP status for community oncology practices.

Recommendation: OneOncology therefore recommends that CMS recognize that the statutorily defined QP thresholds and EOM program design are contradictory to its objective of promoting Advanced APM participation among community oncology PGPs. CMS and CMMI should utilize the full extent of its flexibility to develop solutions that would allow for community oncology PGPs participating in RA-2 of EOM to qualify for QP status.

2. OneOncology urges CMS to retain the option for participants in RA-2 of EOM to have Advanced APM participation status assigned at the entity-level.

Pages 46336 through 46344 [Section IV.C.11.e.(2)] of the Proposed Rule describes the ways in which CMS has determined QP status under the QPP and includes a request for information (RFI) regarding the potential that CMS would make QP determination only at the individual provider-level and eliminate the option for QP determinations to be assigned at the entity-level.

CMS describes its laudable policy intentions and advantages of its <u>current</u> QP status determination policies as follows, and we believe it's worth noting that these stated advantages of its current policies are especially applicable to community oncology PGPs:

- *"At that time, we believed that this policy promoted administrative simplicity and collaboration among group members instead of imposing barriers or burden."*
- *"We recognized that while many beneficiaries are attributed to an APM Entity based on the services rendered by one eligible clinician, many of the eligible clinicians participating in the APM Entity play a role in the actual diagnosis, treatment, and management of the many beneficiaries in the APM Entity's patient population. Each of these individual eligible clinicians can potentially be viewed as being instrumental to providing quality care to the beneficiary in alignment with*

the objectives of the APM, regardless of whether the specific services they furnish are used for purposes of APM-specific attribution methods."

Below we've considered each of the four rationale CMS has cited for the methodology change discussed in this Request for Information (RFI) within this section of the Proposed Rule, and we explain why each of these rationale will inadequately justify the described methodology change due to lack of utility in effectuating CMS's policy objectives noted above.

1) *"First, as explained later in this section of the proposed rule, we believe that making all QP determinations at the individual eligible clinician level would substantially reduce the practice of APM Entities removing specialists from their participation lists."*

   - As noted in the CY 2017 Quality Payment Program final rule (81 FR 77439 through 77448), in stating the rationale for the current QP determination methodology, assigning QP status at the entity-level is remarkably consequential in reducing the administrative burden of A-APM participation for cancer care PGPs who have participated in Medicare's Oncology Care Model (OCM) and who may elect to participate in EOM. In other words, the extent to which the current methodology would reduce administrative burden for oncology PGPs far outweighs any advantages of removing cancer care providers from an EOM Participant's provider list. Therefore, this new policy would only serve to severely hinder A-APM participation for oncology PGPs, and retaining the current policy would not in any way promote the removal of cancer care providers from EOM participation lists.

2) *"Second, the change to make all QP determinations at the individual eligible clinician level would increase the number of eligible clinicians who are determined to be QPs for whom their individual participation would qualify them, but whose APM Entities did not qualify because other eligible clinicians in the APM Entity reduced its Threshold score."*

   - Our internal analysis has shown that the policy change discussed in this RFI would reduce the number of eligible cancer care clinicians in the community setting who would qualify as QPs. Therefore this policy change would be contrary to the stated objectives to increase A-APM participation and would only negatively impact that objective.

     One important reason for this is that high quality treatment for cancer care has become increasingly complex and increasingly sub-specialized. Because of the limited cancer types that are included in EOM (for logically and economically sound reasons as noted in the prior section of this letter), clinicians who treat the excluded diseases would not benefit from Advanced APM participation at the entity level.

     The policy proposed in this RFI would drive wedges in oncology PGPs between those who treat cancer types included in EOM versus those who primarily treat excluded cancer types, which will detract from advantages that Medicare Beneficiaries currently gain from seeking care in community practices that include sub-specialists for a broad range of cancer types and manage A-APM participation as a unified entity.

     As we noted above, tracking which clinicians would or wouldn't qualify for A-APM status would be overwhelmingly burdensome and detract from A-APM participation.

3) *"Third, if we were to begin making all QP determinations at the individual eligible clinician level, that approach would eliminate the number of eligible clinicians who become QPs for a year, but whose individual participation in their Advanced APM(s) is well below the Threshold Score. ….Because the APM Entity Threshold Scores (using the payment amount and patient count methods) that are used to make APM Entity-level QP determinations are based on an aggregate calculation across all eligible clinicians participating in the APM Entity group, eligible clinicians in the APM Entity group who furnish proportionally fewer services that lead to attribution of patients or payment amounts to the APM Entity are likely to lower the APM Entity's Threshold Score. For example, primary care physicians may furnish proportionally more evaluation and management (office visit) services which are frequently the basis for attribution of patients and payment amounts to the numerator of the APM Entity's Threshold Score; whereas specialist physicians may furnish proportionally more diagnostic tests and surgical procedures which are not usually part of the attribution basis to the APM Entity."*

   - Again, our internal analysis has shown that the policy change described in this RFI would detract from the number on eligible cancer care clinicians who would qualify for A-APM participation. Therefore, this policy change would be contrary to stated objectives to increase A-APM participation and would only negatively impact that objective.

     To be clear, we have concerns about the limitations in the attribution methodology of EOM and the impact this will have on A-APM status as noted in the above section of this comment letter. However, the solutions that CMS is proposing in this RFI would actually worsen the impact of these concerns, not improve them.

     As an example, palliative care specialist providers or benign hematology disease specialists that are often part of oncology PGPs often make important contributions to care of Medicare beneficiaries attributed to EOM as part of unified care teams. However, according to the current attribution methodology of EOM and QP threshold methodology, these providers serve to lower the QP threshold scores of the entities in which they provide care, and this is a major problem with the QP threshold methodology and attribution methodology of the program for which we urge CMS and CMMI to develop solutions. However, the solutions discussed in this RFI would not improve these problems, rather this would only make these problems worse while eliminating the advantages of maintaining the current policy.

4) *"Finally, we are concerned that, under our current policy to make most QP determinations at the APM Entity level, some eligible clinicians who furnish relatively fewer of their services through an APM Entity may receive a disproportionate financial benefit because they achieve QP status as a result of the care furnished by other eligible clinicians in the APM Entity, while their APM Incentive Payment is calculated based on all of the covered professional services they furnish during the base year—both as part of the APM Entity and elsewhere. Our policy to make most QP determinations at the APM Entity level allows these windfall financial rewards because we calculate the Threshold Scores using the aggregate of payment amounts or patient counts for attributed patients based on Medicare Part B covered professional services furnished by all the eligible clinicians in the APM Entity, whether they furnished a few or many of such services. Once an eligible clinician receives QP status for a year, the APM Incentive Payment is calculated based on paid claims for that individual QP's covered professional services across all their TINs in the base year. This can allow an eligible clinician with minimal Advanced APM participation to receive a large APM Incentive Payment, which we do not believe aligns with the intent of the Quality Payment Program. Though,*

as we note above, QPs for payment year 2025 (QP Performance Period 2023) will not, by statute, receive a financial incentive for achieving such status, beginning in payment 2026 (QP Performance Period 2024) financial incentives once again will apply in the form of the enhanced QP conversion factor, which in turn compounds each year after that and therefore increases over time.

In light of this potential conflict between Advanced APM goals and the existing QP Threshold Score calculation methodology, we are considering whether it would be better to make all QP determinations at the individual eligible clinician level using the unique National Provider Identifier (NPI) associated with an eligible clinician participating in an Advanced APM."

- We acknowledge the critical importance of these concerns for CMS, and would support CMS's intention to limit perverse incentives associated with various A-APMs participation options in the ACO program. We agree that CMS should take action reduce any undue advantages for A-APM ACO participants that are contrary to the stated objectives and overall spirit of the relevant QPP statutes and rule-making.

  However our experience with Medicare's OCM and our expectation with EOM is that the current policies did not in any way contribute to any undue advantages for Advanced APM Participants. Furthermore, to our knowledge, the technical possibility for such undue advantages to occur would have no impact in the decisions of community oncology PGPs to pursue QP status through EOM participation.

  In summary, despite the valid concerns with the current policy that were raised in this RFI, the policy change discussed in this RFI would not meaningfully address these concerns in ways that are applicable to oncology-specific APMs. However, if CMS were to move forward with these changes, the impact would be catastrophic for oncology-specific A-APM participation due to the administrative complexity of managing individual provider participation in different forms of QPP participation. The policy changes described in this RFI would be detrimental comprehensive cancer care because it would divide cancer care teams in a way that would detract from CMMI's stated policy intentions.

Recommendation: OneOncology recommends that CMS allow for CMMI program staff to determine the degree to which CMS's stated concerns with the current policy are applicable to each CMMI model, and defer to CMMI program staff regarding which CMMI models should have the elimination of QP status assignment at the entity-level due to the applicability of the rationale for this policy as stated in this RFI. This would allow the incentives for APM participation at the entity-level to be retained where applicable and modification of the currently policy where the concerns raised in this RFI are applicable.

3. OneOncology is concerned that the elimination of Advanced APM participation incentives in 2023 and the extremely limited financial incentives for A-APM participation in the subsequent QPP performance years will yield a strong disincentive for participation in the more advanced risk arrangement of CMMI's Enhancing Oncology Model (EOM).

The Proposed Rule repeatedly emphasizes CMS's policy intention to increase Advanced APM participation, and even suggests that "we [CMS] believe that MIPS should be a first step on a glide path towards Advanced APM participation" [Pg. 46334, Section IV.C.11.d.].

However, under the currently proposed program design for MIPS and EOM, CMS is overwhelmingly incentivizing oncology PGPs to fully participate in MIPS and refrain from participating in the more advanced risk arrangement option (RA-2) of EOM, and perhaps this could prove to be the case to the extent that oncology PGPs will completely refrain from participation in EOM entirely (under either risk arrangement option of the model).

This perspective is consistent with CMS's acknowledgement that, "*Beginning in payment year 2025, the statutory incentive structure under the Quality Payment Program for eligible clinicians who participate in Advanced APMs stands in contrast to the incentives for MIPS eligible clinicians." [Pg. 46333, Section IV.C.11.d.]*

CMS further supports this assertion in clarifying the following:

- *"After performance year 2022, which correlates with payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become QPs for a year."*
- *"In performance year 2023, which correlates with payment year 2025, the statute does not provide for any type of incentive for eligible clinicians who become QPs."*
- *"In place of the 5 percent APM bonus payment, CMS has proposed to replace this with a 0.75 percent conversion factor."*

The proposed rule outlines the following questions that CMS has posed for public comment that relate to OneOncology's concerns regarding financial and non-financial incentives for oncologists to participate in MIPS and forego participation in EOM, especially RA-2 [Section IV.C.11.d.]:

A. *What are your primary considerations going forward as you choose whether to participate in an Advanced APM or be subject to MIPS reporting requirements and payment adjustments? What factors are the most important as you make this decision?*

   - The primary considerations in community oncology PGPs' decisions to participate in EOM as compared to fully participating in MIPS include: (1) financial incentives and penalties associated each of the EOM and MIPS participation options, and clarity in the likelihood of positive and negative results for each participation option of each program; (2) administrative burden and resource needs, or other non-financial advantages and disadvantages associated with each EOM and MIPS participation option.

     EOM Participants in the more aggressive EOM risk arrangement (RA-2) could potentially gain the following financial incentives relative to full participation in MIPS:
     - Monthly Enhanced Oncology Services (MEOS) payments – $70 per beneficiary per month (PBPM) fully at risk in performance-based payment (PBP)/ Performance-based Recoupment (PBR) reconciliation for beneficiaries not dually eligible for Medicaid and Medicare; or $100 PBPM (for EOM beneficiaries dually eligible for Medicaid and Medicare) with $70 at risk in PBP/PBR reconciliation.
     - Performance-based payments/ performance-based recoupments, which we currently estimate would most likely fall within a range of +5% to -5% of benchmark episode costs for most participating practices.
     - 0.0% conversion factor adjustment in 2023, 0.75% conversion factor adjustment beginning in performance year 2024.

A MIPS participant who does not participate in EOM could gain the following financial incentives:

- Use of CPT codes that PGP's are prohibited from using under EOM, such as Principal Care Management (99424, 99425, 99426, 99427), Chronic Care Management (99490, 99439, 99487, 99489, 99491) Transitional Care Management (99495, 99496), Advance Care Planning (99497), among others.
- MIPS incentives (6.9% estimated maximum positive payment adjustment as described in this section of the Proposed Rule, in which CMS notes that participants in APMs who convert to participating fully in MIPS will tend to be in the top tier of MIPS performance)
- Conversion factor growth rate of up to 0.25%

In assessing the EOM-related documents that CMMI has published to date, we expect the administrative burden for clinicians and care teams participating in EOM will be overwhelmingly more extensive than those associated with MIPS participation when considered alongside the financial incentives associated with each program as noted above. This most notably applies to the clinical data and quality measure reporting, and ePRO and HRSN data collection requirements.

In short, the removal of the lump-sum Advanced APM participation incentive significantly reduces the overall advantage of EOM RA-2 relative to MIPS APM or full MIPS participation.

Despite the remarkably burdensome clinical data and quality measure reporting requirements of OCM, the financial incentives under OCM were much more supportive of Advanced APM participation relative to full MIPS participation relative for the following reasons:

1) OCM program design elements were significantly more conducive to Participants' exceeding the QP thresholds and thus qualifying for the A-APM participation incentives, and this would not be the case under EOM because of the following factors:
    a. EOM program design elements that reduce the likelihood that a PGP will meet the QP thresholds, as discussed in detail throughout this letter.
    b. The statutorily required phasing-out of the A-APM participation bonus.
2) MEOS payments were higher in OCM relative to EOM

B. *If you are participating in an Advanced APM now and have been or could be a QP for a year, will the end of the 5 percent lump-sum APM Incentive Payments beginning in the 2025 payment year (associated with the 2023 QP Performance Period) cause you to consider dropping your participation in the Advanced APM, which would mean forgoing QP determinations, thereby ensuring you are subject to MIPS reporting requirements and payment adjustments?*

- Yes. Removal of the 5% lump-sum bonus would result in a drastic reduction in financial incentives necessary to support the additional burden of EOM Participant Redesign Activities relative to full MIPS participation. The A-APM participation lump sum bonus has been a critical factor in practices' risk arrangement decisions under OCM in the past and will remain so as practices consider EOM participation options.

C. *Going forward, attaining QP status for a year through sufficient participation in one or more Advanced APMs will enable an eligible clinician to, for a year: (1) continue receiving any financial*

incentive payments available under the Advanced APM(s) in which they participate, subject to the terms and conditions applicable to the specific Advanced APM(s); (2) be paid under the PFS in the payment year using the a higher QP conversion factor (0.75 percent rather than 0.25 percent) beginning in payment year 2026; and (3) not be subject to MIPS reporting requirements or payment adjustments. Do these three conditions provide sufficient incentives for you to participate in an Advanced APM, or would you instead decide to be subject to MIPS reporting requirements and payment adjustments?

- MIPS participation would be preferred in this scenario for the following reasons:
  1) The administrative burden of EOM participation is likely to exceed that of MIPS, given the information we have available today regarding each program.
  2) The financial incentives associated with RA-2 of EOM would be less than those associated with full participation in MIPS, considering the increased financial risk associated with RA-2 relative to MIPS the increased administrative burden and resource strain that EOM will place on community oncology Participants. As noted by CMS in this section of the Proposed Rule, participants in APMs who convert to participating fully in MIPS will tend to be in the top tier of MIPS performance.

D. *Are there other advantages of MIPS participation that might lead a clinician to prefer MIPS over participation in an Advanced APM, such as: (1) quality measurement that may be specific to a particular practice area or specialty area; or (2) the desire for more precise accountability through public reporting of quality measure performance in the future?*

- Yes. The financial incentives available through EOM are misaligned with the additional administrative burden of the program relative to the participation options available under MIPS. Furthermore, contrary to full participation in MIPS, participation in EOM results in restricted utilization of important CPT care management codes such as Principal Care Management (99424, 99425, 99426, 99427), Chronic Care Management (99490, 99439, 99487, 99489, 99491) Transitional Care Management (99495, 99496), Advance Care Planning (99497), among others.

Recommendations: CMS should further consider all potential options to increase the financial incentives and other forms of incentives for EOM RA-2 participation. The currently proposed design of EOM and MIPS yields substantial incentives towards full MIPS participation. Reinstatement of the lump sum Advanced APM participation bonus or a conversion factor adjustment of equal impact during the 2023 and 2024 performance years would be necessary to adequately incentivize RA-2 participation due to the increased financial risk associated with RA-2 EOM participation relative to full MIPS participation and the increase in resources that managing EOM participation will require.

4. OneOncology supports CMS's current proposal that participation in the Advancing Cancer Care MIPS Value Pathway should remain voluntary for oncology practices participating in MIPS, and we would currently recommend that CMS avoid setting any future target for making this MVP mandatory for cancer care providers participating in MIPS.

In the 2022 MPFS proposed rule, CMS proposed sunsetting traditional MIPS reporting beginning with the 2028 performance year. Beginning on page 46264 [Section IV.C.7.a.] of the 2023 MPFS Proposed Rule, CMS provides the following update regarding the mandatory nature of MVPs: *"MVPs will be available for voluntary reporting beginning with the CY 2023 MIPS performance period, and we intend for MVPs to become the only method to participate in MIPS in future years, although we have not yet finalized the timing for the sunset of traditional MIPS."*

CMS summarizes its policy intention for the implementation of MVPs as follows: *"We are moving to MIPS Value Pathways (MVPs) to improve value, reduce burden, inform patient choice in selecting clinicians, and reduce barriers to participation in Alternative Payment Models (APMs)."* [Pg. 46263, Section IV.C.7.a.]

However, at this point these speculative advantages of MVP participation have yet to be demonstrated through the actual experience of MVP participants. The practical experience of community oncology practices that have participated in OCM and MIPS has been that CMS consistently understates the practice expense and resources needed to comply with reporting requirements of these programs. Therefore, we remain highly skeptical that the proposed MVPs will result in the advantages of reduced administrative burden that CMS has stated as its intention.

Furthermore, the survival of smaller independent community oncology practices remains dependent on the current flexibility of MIPS measure selection. Therefore, if CMS were to implement mandatory MVP reporting this would immediately jeopardize the ability of smaller community oncology practices to remain independent, and severely accelerate trends in the consolidation of small community oncology practices with large hospital systems.

Recommendation: CMS should continue to postpone the sunsetting of traditional MIPS and mandatory MVP participation for oncology PGPs until practical experience with the Advancing Cancer Care MVP has been demonstrated to result in reducing administrative burden of MIPS participation.

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We appreciate this opportunity to comment on these QPP and APM related considerations in the 2023 Medicare Physician Fee Schedule Proposed Rule as they relate to our common goals of advancing value-based payment in oncology and achieving the Quadruple Aim in cancer care.

You may contact me or Aaron Lyss (aaron.lyss@oneoncology.com), Senior Director of Payment and Policy Innovation, at any time with any questions regarding these comments.

Sincerely,

Jeff Patton, MD
Chief Executive Officer
OneOncology