



Evidence-Based ONCOLOGY™

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ALSO IN THIS ISSUE



VALUE-BASED PURCHASING AND MORE.

A session of the Institute for Value-Based Medicine® (IVBM) in Nashville, Tennessee, offered highlights of where value-based purchasing works and where it doesn't, as well as an overview of where the Oncology Care Model (OCM) has succeeded and where it needs work, [SP350-SP351](#).

RADIATION ONCOLOGY.

Miranda Lam, MD, presented the attendees at IVBM with data and issues surrounding CMS' proposal for the mandatory Radiation Oncology Model, [ajmc.com/link/4408](#).



LAM

COA PAYER EXCHANGE SUMMIT. Community Oncology Alliance (COA) invites shared stories of success with the OCM as well as challenges as practices weigh the future of 2-sided risk in Tyson's Corner, Maryland, [SP356-SP358](#).

AMCP NEXUS. Data collaboration, genomic testing, and the review of the pharmaceutical pipeline were highlights of the Academy of Managed Care Pharmacy (AMCP) Nexus 2019 meeting in National Harbor, Maryland, [SP358-SP361](#).

MULTIPLE MYELOMA DISPARITIES.

New results show that novel therapies for multiple myeloma take longer to reach African American and Hispanic patients, [SP370](#).



COMMENTARY

Empower Physicians to Fight Financial Toxicity With Biosimilars

Kathy Oubre, MS

ONCOLOGY PRACTICES SEE THE TOLL financial toxicity¹ exacts on patients and their families every day. The financial burdens of cancer treatment are damaging even when they don't directly affect care—and research shows that all too often, they do. Patients struggling under the burdens of cancer care are more likely to be nonadherent with their prescribed treatment regimen, failing to fill prescriptions, delaying office visits, and forgoing critical diagnostic tests.² More affordable care is better care, and payers should empower providers to steer patients toward superior-value options whenever available. When it comes to oncology biologics, this means giving providers the power to prescribe biosimilars.

CONTINUED ON SP374 »

ONCOLOGY CARE FIRST

Can Cancer Care Lead the Way Toward a Value-Based Future?

Keely Macmillan, MPH

THE 2019 MEDICARE TRUSTEES REPORT forecasts insolvency of the Hospital Insurance Trust Fund in 2026, sooner than prior projections.¹ A significant contributor to this unsustainable healthcare cost curve for Medicare beneficiaries is cancer-related spending.² To address this challenge, Medicare is engaging oncologists through new, value-based programs to identify ways to reduce inefficiency and unwarranted variation in spending.

On November 1, 2019, CMS released an informal request for information (RFI) on Oncology Care First (OCF), the highly anticipated successor to the current Oncology Care Model (OCM), which sunsets in 2021. The RFI, which solicits feedback through the extended deadline of December 13, 2019, is an important step in the development of successful models with robust engagement.³

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ADVOCACY PERSPECTIVE

Improving Survival in Lung Cancer: Commitment of The Lung Ambition Alliance

Giorgio Scagliotti, MD, PhD

FOR TOO LONG, lung cancer has had one of the worst prognoses of any cancer. It is the leading cause of cancer-related deaths worldwide (**Figure 1**); only 1 in 5 people with lung cancer will be alive 5 years after diagnosis.^{1,2}

New advances are creating the opportunity to transform the diagnosis, treatment, and management of lung cancer. However, survival rates have improved only modestly and are lagging behind those of other common cancers (**Figure 2**).³ The time for us to act is now: to come together as a community, to bend the lung cancer survival curve faster, and to significantly improve patient outcomes in this devastating disease.

CONTINUED ON SP387 »

Approximately **1 in 5** cancer deaths are attributed to **lung cancer**.

SP387



Source: World Health Organization, International Agency for Research on Cancer, Latest global cancer data: Cancer burden rises to 18.1 million new cases and 9.6 million cancer deaths in 2018. [who.int/cancer/PRGlobocanFinal.pdf](#). Accessed November 22, 2019.

ONCOLOGY CARE FIRST: COMMENTARY

Can Cancer Care Lead the Way Toward a Value-Based Future?

Keely Macmillan, MPH

CONTINUED FROM COVER

OCF is built on the same framework as other recently announced Medicare “First” models, including Primary Care First⁴ and Kidney Care First.⁵ These models offer prospective payments for providing enhanced care services to an aligned patient population and hold provider participants accountable for quality and cost through retrospective performance-based payments (PBPs).

The OCF RFI retains many of the favorable facets of the OCM program, including its voluntary status, the opportunity for oncologists to earn additional revenue by reducing expenditures for 6-month episodes of care for Medicare beneficiaries undergoing chemotherapy, and its qualification as an advanced alternative payment model (APM) under the Quality Payment Program, created by the 2015 Medicare Access and CHIP Reauthorization Act (MACRA).⁶

The second-generation oncology bundled payment model also strives to improve key aspects of the original program that unintentionally created disincentives for providers. One notable change is a potential revision to how CMS adjusts for new, high-cost drugs. In OCM, one of the only Medicare risk models holding participants accountable for Part D drug expenditures, the novel therapies adjustment is applied at the participant level across all cancer types in aggregate. Because novel therapies are not consistently or uniformly available among different cancer types, the single novel therapy adjustment has created advantages and disadvantages for OCM participants at the practice level because of variation in the mix of cancer types among peer practices and within a singular practice over time. CMS’ consideration in OCF to apply the novel therapy adjustment separately for each cancer type would improve this misalignment. Similarly, a trend factor applied separately by cancer type would remove unfair rewards or penalties that result from variation in patient mix, both internally over time and compared with other groups.

Archway Health’s analysis of 20 OCM practices suggests that to successfully use cancer-specific trend factors and novel therapies adjustments, covariates in the model need to be better calibrated. For example, attributes such as radiation therapy or lung cancer are too strongly correlated with PBPs instead of price, pointing to a flaw in the OCM model. We expect that running a separate regression for each cancer type, similar to how CMS runs a separate regression for each episode of care in the Bundled Payment for Care Improvement (BPCI) Advanced program, will better calibrate covariates.

In OCF, CMS also proposes to improve the alignment methodology for the prospective monthly management payments. In OCM, Monthly Enhanced Oncology Services payments are not available for patients receiving only hormonal therapy when no evaluation and management visit occurs within the 6-month episode period, which led to attribution-related frustration among participants early in the model. In OCF, aligned beneficiaries covered in the Monthly Population Payments (MPPs) include patients undergoing hormonal therapy only, as well as those under active surveillance or survivors of cancer undergoing care management from their oncologist.

CMS is also changing its approach to getting providers to take risk in OCF. The potential model would have 3 risk tracks that allow providers to pick their pace of assuming risk. Two of these tracks would force downside risk onto current OCM participants

immediately, and the third would allow new providers to stay in an upside-only arrangement for 2 performance periods. This contrasts with OCM, in which participants originally could stay in the upside-only arrangement indefinitely. After the program launched, CMS amended the program and required practices to earn a PBP to stay in the upside-only track. In December 2019, OCM practices that have yet to earn a PBP will be required to switch to the 2-sided risk track or be forced to drop from the program. The OCF RFI indicates that CMS is pushing providers toward assuming downside risk and also recognizing that some organizations need to get their bearings first in a new program before being held accountable.

Although the OCF RFI incorporates learnings from OCM, it does not seem to take into account the social determinants of health (SDOH), a critical consideration for any care management model and today’s healthcare environment. Social determinants, including access to transportation and healthcare services, affect a wide range of health outcomes and risks.⁷ As an example, oncologists treating patients who live in rural areas may face greater barriers to having patients attend visits and appointments than providers treating patients in areas with more transportation options and less burdensome commutes. Greater consideration for SDOH should be a goal of the OCF RFI process.

The OCF RFI comes on the heels of another major alternative payment policy proposal aiming to improve the value of care received by Medicare beneficiaries being treated for cancer. In contrast to the voluntary OCF program, the proposed Radiation Oncology (RO) model, announced in July 2019, would be mandatory and affect payment for 40% of the radiation therapy volume provided to Medicare beneficiaries nationwide, if finalized.⁸

The model proposes a fixed prospective payment, which includes both professional and technical components, that would vary based on 17 cancer types. Early analysis suggests that this model may incentivize more efficient treatment schedules, and the final rule is expected in late 2019 or early 2020.

CMS’ goals of reducing care costs and improving care quality are evident through the proposed OCF and RO models. For maximum provider engagement in both oncology payment models, it is imperative that CMS’ payment models continue to make adjustments that do not penalize historically efficient providers and create value-based innovators across the continuum of care. As providers consider their participation in these programs, they should be aware that frequent and robust data and appropriate quality measurement are critical pieces of a successful program. Additionally, we at Archway encourage providers considering the models to engage with CMS during the comment periods to help the agency build models that align incentives with high-quality patient care. ♦

AUTHOR INFORMATION

Keely Macmillan, MPH, is senior vice president of Policy and Solutions Management at Archway Health. A recognized expert in alternative payment models, she has more than 12 years of healthcare experience in guiding specialty providers to success in accountable care organizations (ACOs), bundled payments, value-based purchasing, and MACRA’s Quality Payment Program.

ABOUT ARCHWAY HEALTH

Archway Health works with providers and employers to design and execute care and risk management initiatives that improve care and reduce costs. Archway is currently working with leading healthcare providers participating in risk-based contracts including bundled payment programs under the Center for Medicare and Medicaid Innovation such as BPCI Advanced, OCM, and the Comprehensive Care for Joint Replacement model. Archway also works with Medicare and commercial ACOs, self-insured employers, and commercial payers. To support »



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these programs, Archway collaborates with organizations to analyze their opportunities and risks and deploys a comprehensive platform of analytics, patient tracking tools, Value-Based Risk Protection stop-loss programs, and advisory services.

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ONCOLOGY CARE FIRST: PROVIDER PERSPECTIVES

Kashyap Patel, MD, Sees Collaboration Going Into Oncology Care First

An Interview With Mary Caffrey

The interview is edited slightly for clarity.

PARTICIPANTS IN THE ONCOLOGY CARE MODEL (OCM) have speculated greatly about what will come after the 5-year pilot program ends on June 30, 2021.¹ The suspense ended November 1, 2019, when the Center for Medicare & Medicaid Innovation (CMMI) unveiled a request for information (RFI) regarding Oncology Care First (OCF), a proposed successor model that would build on the lessons learned from OCM. When the RFI was released, CMMI had already scheduled a listening session for November 4, 2019, on the future of the OCM, and the short comment period left some stakeholders uneasy (The original 3-week comment period was extended to December 13, see **Cover**).

But Kashyap Patel, MD, the chief executive officer of Carolina Blood and Cancer Care Associates—a leading OCM practice—and associate editor of *Evidence-Based Oncology*[™] (*EBO*), said he's optimistic. As cochair of the Payment Reform Committee for the Community Oncology Alliance, Patel took part in the listening session with CMMI's Christina Ritter, director of the Patient Care Models Group, as well as Lara Strawbridge and Hillary Cavanaugh, who are developing the successor model for CMMI. A few days later, Patel shared his early thoughts on the OCF with *EBO*.

EBO: Everyone has been waiting to see what will happen with the OCM as we look toward the end of the 5-year model. What do you think have been its biggest successes?

PATEL: That's a very nice question. You've touched my heart, because I always believed we have the resources, technology, and intelligence to shift care

from volume to value—and the OCM was the primer for that. There has been a large learning curve over the past 3 years. After the model was announced, we had 197 practices become a part of that. It took a learning curve of about 2 years, so far, for everyone to figure out what was expected of us, but now almost 80% of practices have reached success in addressing the benchmark prices [for cancer therapies], as well as improvement in the quality of care. So, the OCM has really allowed us to explore the road map to success in the transition from volume to value.

EBO: There was an element of surprise when CMMI released the RFI for Oncology Care First. Can you discuss the nature of the RFI and your initial reaction?

PATEL: It was very interesting. I was speaking on 2-sided risk at the Association of Community Cancer Centers conference in Orlando, Florida, in the last session. I was talking about the OCM and the future of the OCM, and we also had Alexandra Chong[, PhD,] from CMMI, speaking right after I was done. And as I headed out of the room, I saw this [news] flash saying that CMMI had announced the RFI for Oncology Care First. So, it was a surprise, but it was a pleasant surprise for me. I am an eternal optimist. As an oncologist, I deal with the chance of 15% to 20% survival every day of my life, and so to see something like OCF coming out on Friday afternoon made my weekend. The reason is because we're all worried about what is going to happen after 5 years. We've made a substantial improvement in the way we are dealing with care, but it's coming with a price—we've had new employees, we've changed the way we work; [there are] new technology

investments, new CT [computed tomography] scan machines. And when I look at all the investment, I was getting anxiety [to the point] where I was losing sleep: What will happen once the summer of 2020 comes and OCM is kind of over? And when I saw the OCF model, I was happy.

There is a little skepticism because CMS had scheduled a listening session for Monday [November 4, 2019]. Now, when there is an announcement from CMMI on Friday afternoon at 4 p.m. [November 1, 2019], the first reaction from many of my colleagues was "Oh, so they didn't want to give us time to ask questions." And I put it differently. I said, "Look, they actually designed the model.

We asked for an extension [for deciding whether to move to 2-sided risk]. Lara Strawbridge [of CMMI] and Dr [Anand] Shah [of CMS], as well as other stakeholders, designed a new model pretty much along the same line of what it is right now. They've incorporated a large number of elements that we requested, and they've continued to work with us. And at the listening session, they opened up the podium to continue to work, and this is not onetime.... They'll be writing comments, we'll be writing comments—it's more like a collaborative work.

One concern that everyone had was the short turnaround time for the comment period (later extended). [From] the time they announced the model, there is a 3-week timeline.... People are getting ready for travel, so these were some of the elements of surprise. But I still feel that there has been a genuine intention on the part of CMMI, as well as the team, to consider what has progressed



PATEL

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over the past 3 years to accommodate continuation of the model.

EBO: During the listening session, it appeared that CMMI tried to incorporate feedback from oncologists about appropriate ways to hold practices accountable for drug costs. Can you discuss areas where OCF reflects provider feedback?

PATEL: OCF is built on the success of the OCM as a pilot experiment. One of the challenges we had was patient attribution—we did not know when it was going to happen. In the OCF model, CMMI has promised us they will be updating [attribution data] every month so there will not be an element of surprise. Second, we were struggling with the drug costs. For example, the newer therapies, such as immunotherapies, could be much higher compared with benchmark prices, and they've actually looked at novel therapies in a much more robust way. And the third thing was the trend factor—the cancer-specific trend factor. [These are] 3 big elements that we've always been struggling with in the original model, and CMMI has promised and considered how they will adjust the pricing model based on these 3 factors.

EBO: A point that you raised during the listening session, with support from Barbara McAneny, MD, who developed the COME HOME model, was the concern about the handling of electronic PROs [patient-reported outcomes]. Disbursement of technology among cancer patients is very uneven. Can you discuss your concerns with ePROs?

PATEL: Absolutely. As soon as Lara Strawbridge said they were incorporating ePROs, my eyes went all over—I said, “I have patients who don't have a smartphone. They still use a flip phone.” They live in areas where there aren't even cell phone towers. Depending on the access to the technology, the ePRO reporting could be quite variable. At the same time, I want to be sure we respect technology, so our suggestion and request to CMMI—and we will be commenting on this, as well—will be to collect the ePROs at the point of care, when the patient comes to the clinic. We would invest more in the technology; we could buy some iPads so our employees could sit down with the patients to help them [record responses]. But we don't want to make it very burdensome. Patients are sick. They have many more issues. To ask them to answer a hundred questions [at every appointment] may make them very tired. So, we want to create a balance between the expectations of the technology and dissemination of knowledge, and at the same time respect the patients' ability and capacity to work with us.

EBO: Is it appropriate to have caregivers take part in the ePRO initiative?

PATEL: Caregivers could be a critical part of ePROs, but if patients have flip phones, then I don't expect caregivers will have smart phones, either. We're talking about patients living paycheck to paycheck. They don't have secondary insurance. They don't have transportation. So, for them to have technology and pay \$100 a month for access to the internet

may be too much to expect. But we definitely would work with them, or our employee would work with them, to figure out how to do the ePRO. Or, maybe at some stage, we could have that done at a home visit, taking the technology along with creating a temporary hot spot to ensure that we fulfill the expectation. At the same time, we want to have some sort of balance between the expectation of the ePRO and what we can deliver.

EBO: What other takeaways did you have from the listening session?

PATEL: I was elated to see the enthusiasm among my colleagues—with skepticism. Whenever government comes in with some program, there is always some skepticism.... But on the whole, I see an environment of collaboration, a cooperative and conducive environment to improve the quality of care for cancer patients.

There's also an element of risk they expect us to take—small downside risk. And although that could be a matter of concern for many practices, when you look at the alternate path, the MIPS [Merit-based Incentive Payment System] track, MIPS has a 9% downside going from 2021 onward anyway.² So, with either track, you have risk involved. ♦

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Stephen M. Schleicher, MD, MBA, Addresses “Accountability Versus Control” in Oncology Care First

An Interview With Mary Caffrey

The interview is edited slightly for clarity.

ON OCTOBER 31, 2019, authors from Tennessee Oncology, OneOncology, and Tuple Health published an article in *JAMA Oncology* that offered a stunning conclusion: Even if a practice in the Oncology Care Model (OCM) complied precisely with current guidelines from the National Comprehensive Cancer Network (NCCN) for metastatic non-small cell lung cancer and did everything right, drug costs would make it impossible to meet the financial targets spelled out in the model.¹ The authors offered a solution: Instead of being judged against unattainable benchmarks, OCM practices should be measured based on their adherence to clinical pathways or ability to document why a pathway didn't make sense for a particular patient.

Almost on cue, the next day, the Center for Medicare & Medicaid Innovation (CMMI) released its proposal for Oncology Care First (OCF), the would-be successor to the OCM.² One of the paper's authors, Tennessee Oncology's Stephen M. Schleicher, MD, MBA, was pleased to see that OCF reflected some of the issues he had his colleagues had discussed. Schleicher, who also serves as medical director for value-based care for OneOncology, a network that includes 242 providers, discussed the findings and CMMI's proposal with *Evidence-Based Oncology*[™] (EBO):

EBO: Please describe your practice's overall experience with the OCM. What changes have had the biggest impact on clinical outcomes?

SCHLEICHER: I'm a medical oncologist at Tennessee Oncology; we are part of OneOncology, where I am chair of the Quality and Value Committee. I've been very passionate about value-based payment for the past 5 to 6 years since the Affordable Care Act came out and, specifically, as an oncologist, when the OCM came to fruition.

Our experience with the OCM, most importantly, has been a learning experience. I think that's one of the biggest benefits of the model and why it has been a voluntary pilot. We're getting lots of information about how we're doing in keeping patients out of the emergency room when we can and how we're using hospice. »



SCHLEICHER

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We've had the opportunity to get rewarded through the care-management fees to provide nurse navigators, to help be the bridge between when the patient is in clinic and when the patient is at home. We've learned how to continue that communication and help direct patients to the clinic for fluids instead of to the emergency [department], to help assess a patient's pain and act quickly before the pain gets out of control—similarly with nausea and constipation. So, we've been able to, through the resources provided from Medicare as part of the OCM, hire some additional staff to help with that.

Staff is one thing; secondly, with the analytic capabilities we've been encouraged to develop through our partners with Flatiron Health and now with OneOncology, as I mentioned, an understanding of our utilization patterns and how they compare with our peers', both within the Oncology Care Model and without. Those are some huge benefits of the model, and one of the most exciting aspects of the model involves all we have learned to improve the care we're delivering to our patients.

EBO: In your recent paper in *JAMA Oncology*,¹ one of the central points you and your co-authors make is that practices should be held accountable for adhering to clinical pathways or documenting good reasons the pathway does not make sense. How did you arrive at that conclusion?

SCHLEICHER: So, it's a great question. The impetus for putting this paper together was the whole issue of accountability versus control. As oncologists, we want to be accountable for things we do incorrectly, of course—even if that's not on purpose. But delivering a more expensive chemotherapy to a patient when there's a better option, using an emergency room instead of a clinic for things that could be handled outpatient—those are things we can be accountable for, that we can control, and we should be accountable for. But there also are aspects of cancer care that we have no control over, and the main thing there—the elephant in the room—is the price of drugs.

New drugs have tremendous benefit for patients. We want to be able to give new drugs to our patients. Immunotherapy is really the big thing that has boomed since the start of the OCM. But those drugs that have good benefits also have high price tags, and we want to make sure we can give those drugs to patients without being penalized, because in the current OCM, the total cost of drug use is something we are accountable for and could be penalized for.

What we wanted to do with the paper and this research is understand how well the OCM is incorporating the new prices of drugs into their expected costs of treating cancer patients. We looked at lung cancer... The field has [advanced] even since the time of the data that we looked at for this paper. But since the start of the OCM, immunotherapy made its way into the second-line treatment of metastatic non-small cell lung cancer with both Keytruda [pembrolizumab] and Opdivo [nivolumab], which both have survival benefits. We thought that was a good opportunity to look and see if, when we used these drugs correctly—which we can control—we are still over target on what we should be spending,

and if it's due to the price alone, we cannot control that. And that's a problem with a value-based care model—trying to improve the quality of care and the cost of care if we can't control that.

So, that's why we looked at lung cancer. We looked at all our cases where Medicare told us we had spent more than expected, and within that, where we had prevented everything that was the goal of the OCM. [We looked at cases where] we prevented emergency [department] visits, we prevented hospitalizations, postacute care, inappropriate chemotherapy at end of life—all these aspects that we can control and one should be able to prevent. We saw that in many of our cases—over half—we had done all that, but we were still over target because we had used either Keytruda or Opdivo in the second-line setting for metastatic non-small cell lung cancer. That was NCCN compliant at the time and is still standard of care, although we now often use immunotherapy first line. We found in that group of patients that we were over target for using the right drug at the right time for patients that deserved to have that drug, yet the model, despite Medicare's best attempts, couldn't account for that, and that is what we are trying to communicate with the paper.

Our conclusion was that we were pathway or guideline concordant, which is what we can control and that's what we should be doing; the cost was higher because of the price, which we can't control. So maybe the pathway concordance—following pathways we can all agree on—is a better measure of us using the right drug than the cost of care itself, from a drug perspective.

EBO: And the data you present were consistent across the practices that you surveyed?

SCHLEICHER: Exactly. We have 30 clinics in Tennessee Oncology right now—OneOncology has over 100—but we were looking at Tennessee Oncology, and this was not clinic specific; this was across all our providers at the different clinical sites.

EBO: The day after your paper appeared, CMMI released a request for information on a model that is being called Oncology Care First, or OCF, which will be the successor to OCM when it expires in 2021. What are your observations so far about OCF?

SCHLEICHER: OCF, I think, is an example of Medicare being very thoughtful—of recognizing that we need to change the way care is delivered but also recognizing that cancer is a very difficult disease because it is very heterogeneous—every patient with cancer is different, every cancer is different. We have high costs of care both from utilization and drugs. So, I think they tried to come up with a thoughtful model to do this.

There were 2 components of the OCF model that I thought are definite improvements from OCM that relate to our paper in terms of the accountability versus control. The first is how they calculate the expected cost of treating cancer care and how drug costs are incorporated into that; there are 2 mechanisms for that through the trend factor that accounts for overall implementation of healthcare costs, and the novel therapy adjustment, which is

how a practice is using new drugs that have been FDA approved compared with their peers.

In the OCM, they applied this across all cancer types and all patients in conglomerate; OCF, they will look at the specific cancer itself. When a new drug or a new indication comes to that disease, they will try to account for that change at the [level of the] disease itself—which, hopefully, improves the accuracy of predicting the cost of care as healthcare standards of care change in oncology. That's a benefit and shows that Medicare was listening to us as we all provided feedback during the OCM, and it is clearly very relevant to the paper we just published in *JAMA Oncology*.

A second improvement is how providers should be accountable for some of the low-risk cancers, such as low-risk breast, low-risk bladder, and low-risk prostate. Let's take low-risk breast cancer—that could be a patient who had surgery, chemotherapy, and radiation therapy 4 to 5 years ago but still requires antiestrogen therapy—a hormonal pill. In that case, the provider might be seeing the woman every 6 months to prescribe that pill; standard of care might be a mammogram once a year for a patient who still has her breasts intact, with an exam. In the current setting, if we are treating a patient like that but they go to the emergency room because they have a stroke or because they need a hip replacement or they have a heart attack—something completely unrelated to their disease—we are still accountable for that care under the current OCM. They have corrected this in the current OCF by removing these patients from the accountability portion of the total cost of care, such that we are more accountable for patients for whom we are providing intense chemotherapy, seeing them regularly and really are responsible for their care, versus patients we are seeing every 6 months who have other unrelated health problems that could throw off our ability to succeed in the value-based care model.

EBO: That would seem to make sense. Do you have any other observations as you move forward with alternative payment models?

SCHLEICHER: It's important for groups to be in these models, even if they are voluntary, just to learn about how they are doing compared with their peers and find opportunities for improvement. And as long as groups can publish on these matters and make it known to their other colleagues across the country interested in improving the value of care of cancer—if we can communicate that through publications such as ours [in *JAMA Oncology*], through conferences, through Medicare, to help these models get better over time, that's really how we succeed: all of us coming together versus working independently. ♦

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