Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the "MASON—Making Accountable Sustainable Oncology Networks"

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) Proposal Review Process described in *Physician-Focused Payment Models: PTAC Proposal Submission Instructions,* physician-focused payment models (PFPMs) that contain the information requested by PTAC's *Proposal Submission Instructions* will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full PTAC for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** MASON—Making Accountable Sustainable Oncology Networks

2. **Submitting Organization or Individual:** Innovative Oncology Business Solutions Inc. (IOBS)

3. **Submitter's Abstract:**

   "MASON facilitates the transition from volume to value by building on the principles of the Community Oncology Medical Home (COME HOME), the Oncology Care Model (OCM), fee for service payments, the model of Ambulatory Payment Classifications (APCs), and Diagnosis Related Groups (DRGs), to use a combination of claims and clinical data to create an Oncology Payment Category (OPC) visible online to practices and CMS, that does not require revision of already existing payer or financial software systems. The OPC creates an accurate cost target that will be a valuable tool for optimizing patient management while avoiding the actuarial risks of adverse patient clinical characteristics. Practices will be at risk only for factors they can control, thereby avoiding damage to the oncology care delivery infrastructure across the country.

Practices and payers build a value based model, using familiar constructs like facility fees and APCs. Pathways, created by physicians and based on National Cancer Care Network (NCCN) guidelines, provide trusted decision support to manage the tsunami of data as genomics and socioeconomic factors are incorporated into treatment decisions. Quality measurement becomes electronically generated using a state of the art cognitive computing solution that measures compliance with pathways and patient satisfaction while avoiding potentially expensive inaccurate chart abstraction errors. This allows the practice and individual physicians to drill down to the disease level and the individual patient level. Payment for chemotherapy and its infusion becomes transparent. Regimen choice can be matched with the toxicity assessment and eventually with costs to provide true outcome measures. As experience is gained and the OPCs are iteratively made increasingly accurate, data-driven bundled payments become possible. When physicians in other specialties develop pathways to manage their patients whose chronic disease includes acute exacerbations, MASON will provide a toolkit for transformation to a value based system."

B. Summary of the PRT Review

The proposal, MASON - Making Accountable Sustainable Oncology Networks (available on the ASPE PTAC website), was received by PTAC on February 18, 2018. The PRT conducted its review of the revised proposal between April 4, 2018 and October 1, 2018.

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets criterion and deserves priority consideration	Unanimous
2. Quality and Cost (High Priority)	Does not meet criterion	Unanimous
3. Payment Methodology (High Priority)	Does not meet criterion	Unanimous
4. Value over Volume	Meets criterion	Unanimous
5. Flexibility	Meets criterion	Unanimous
6. Ability to Be Evaluated	Meets criterion	Unanimous
7. Integration and Care Coordination	Meets criterion	Unanimous
8. Patient Choice	Meets criterion	Unanimous
9. Patient Safety	Meets criterion	Unanimous
10. Health Information Technology	Meets criterion	Unanimous

C. PRT Process

During this time, the PRT reviewed the proposal, the submitter's responses to questions posed by the PRT, all public comment letters received on the proposal, and a review team-commissioned environmental scan on current issues in cancer care and payment. The PRT also consulted with the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) to better understand key aspects (and potential effects) of the proposed model and with CMS's Center for Medicare and Medicaid Innovations (CMMI) to learn more about CMMI's Oncology Care Model (OCM).

The PRT's summary of the proposal and evaluation of the proposal compared to the Secretary's criteria for PFPMs are below. The environmental scan and public comments received on the proposal are available on the ASPE PTAC website.

1. Proposal Summary:

The proposal is for a pilot program involving 16 oncology practices that compose the National Cancer Care Alliance (NCCA). The model consists of a prescribed *care model* with a specified infrastructure to support oncology practice transformation combined with a *payment model* to support infrastructure costs and incentivize adherence to evidence-based care pathways.

The care model would require use of:

1. Triage pathways that refer patients to the appropriate site of care in a timely manner, with the goal of avoiding inappropriate emergency department visits and inpatient stays.
2. Diagnostic and Therapeutic Pathways (DTP) that are updated by National Cancer Care Alliance (NCCA) physicians and reflect the consensus for the latest evidence-based care.
3. A Cognitive Computing Platform (CCP) that codifies these established, evidence-based triage pathways and clinical pathways in order to generate data on compliance with standards of care and quality assurance.
4. Data Science Processes that can identify natural breakpoints in the Medicare Claims data and correlate those subsets with the clinical characteristics of the patients obtained from the electronic health records (EHRs).

This care model infrastructure supports the generation of Oncology Payment Categories (OPCs), which group patients based on disease state, comorbidities, and treatment plan. A target price based on the expected costs of caring for patients in a given OPC is assigned. OPCs have not yet been developed but are modeled after CMS's Ambulatory Payment Classification for care delivered in the outpatient hospital setting. They will be generated using a machine learning algorithm and cognitive computing infrastructure.

In this model, an episode is initiated upon first consultation with an oncologist. Relevant clinical factors and patient preferences will be used to select a treatment plan and broader care plan, motivating the categorization of the patient into an OPC and an assigned OPC target price. The target price is designed to reflect all cancer care-related expenses. All drugs, including parenteral and oral chemotherapy, are excluded from the OPC target amount. While Hierarchical Condition Categories (HCCs) and the variation in cost due to comorbidities are recognized, claims related to pre-existing diagnoses are not included. There is an appeals process for providers to request a procedure or treatment be removed from inclusion against the virtual account if it is unrelated to the cancer treatment.

OPC assignment prompts creation of a "virtual account," visible to both providers and patients, that tracks cancer care expenditures against the target amount, including care received by external providers. If patients are managed in a way that reduces their expenditures below the target amount, the participating practice shares in these savings if quality benchmarks are sufficiently met. The model also relies on a reinsurance mechanism that covers expenses over the target amount.

Services are paid in a fee-for-service (FFS) manner, with retrospective reconciliation. The OPC target price includes evaluation and management (E&M) visits, a one-time $750 payment for new patient consultation, infusion center facility fees, variable radiation and infusion inputs, hospital charges and facility fees, other physician care related to the cancer treatment, imaging, and laboratory services. There is a withhold of 4% from all E&M payments to form a quality pool.

Quality metrics reflect two components, defined as technical quality and customer service quality. Technical quality is measured via pathway compliance, which is extracted electronically from the EHR and is based on adherence to the pathways. Customer service quality is captured via patient and family surveys. For both measures, a threshold of 80% is required to be considered satisfactory.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High-Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Meets criterion and deserves priority consideration

While the CMS Alternative Payment Models (APM) portfolio already includes a model addressing the proposal's clinical area (cancer) and provider entities (oncologists) via the OCM, we believe the proposed model potentially represents a significant improvement on the OCM. Namely, the proposed model acknowledges the very granular and individualized

nature of treatment plans for different types of cancer, and the payment model reflects this precision by using evidence-based pathways as the basis for establishing payment amounts. This is in contrast with the relatively one-size-fits-all approach of OCM. The proposal directly addresses other perceived weaknesses of the OCM, namely the uniform six-month time frame, which is not appropriate for many cancers; the emphasis on chemotherapy; and the use of total cost of care (TCOC) as a basis for calculating performance-based payments. In contrast, the proposed model is not based on a predefined time frame, but rather the episode length reflects the specific disease and the care plan selected. In addition, participating providers are directly incentivized to provide care coordination and other services beyond those directly related to chemotherapy, acknowledging that in some cases chemotherapy is not the most appropriate course of action. Finally, the payment model attempts to hold oncologists accountable only for cancer-related expenditures, rather than TCOC. It is our understanding that CMMI is in the process of iteratively reviewing and potentially revising the OCM, and while it is not clear that they are addressing these components, we believe that successful implementation of these aspects of the proposed model would represent a substantial strengthening of how cancer care is addressed in the CMS APM portfolio.

Criterion 2. Quality and Cost (High-Priority Criterion). **Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.**

PRT Qualitative Rating: Does not meet criterion

In terms of quality, using evidence-based treatment pathways and measuring and rewarding clinical quality based on adherence to these pathways is a clear strength of the proposal and would be expected to improve the quality of care. We had concerns about the OPCs that are instrumental in this model for classifying patients and determining clinical pathways and payment levels. Namely, the OPCs are not currently operational, and developing them is a time-intensive process that will require frequent and similarly time-intensive updating to reflect ever-evolving developments in both pharmaceutical and therapeutic advances in cancer care. While the OPCs represent a granularity in care that is much needed in this clinical area, there were also concerns about generalizability of the OPCs; if they are developed based on the utilization patterns of a select group of practices that does not reflect the practices of the broader population, the benchmarks and classifications may not be representative for broad scaling. We are also concerned about how compliance with the pathways is assessed and whether deviations that are voluntary are distinguished from unexpected events that trigger clinically necessary protocol changes. It is even possible that such an occurrence could switch a patient to a new OPC, potentially further muddling how compliance is gauged. Thus, while the emphasis on cancer-related costs rather than TCOC was an appealing aspect of this model, we have concerns about the practicability of generating accurate and timely OPCs and thus are not confident in the ability of this model to generate cost savings.

Criterion 3. Payment Methodology (High-Priority Criterion). **Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.**

PRT Qualitative Rating: Does not meet criterion

A clear strength of this proposal is the payment model's attention to care coordination and other medical home activities, which broadens the scope of the model beyond OCM's focus on chemotherapy. In addition, we appreciated the concept of basing payment on cancer-related care rather than TCOC, thereby holding participating providers accountable only for the utilization that is under their direct influence. We are also supportive of the inclusion of an administrative fee related to drug purchasing and administration and endorse the submitter's revision of this fee to a flat rate rather than a percentage of the drug price. We also appreciate the submitter's responsiveness to our request for more empirical justification for the payment amounts in the proposed model.

Nonetheless, we had numerous concerns about the payment model. First, we are again concerned about the process for developing the OPCs that is the basis for the cancer-related care payment structure. This process is time-intensive and unstable, in that it will need to be updated to reflect new drugs and therapeutic changes. On a more granular level, we are concerned about the use of HCCs as the driver of predictions for cancer-related expenditures, since it has not been established as accurate for cancer-related spending specifically. We also have operational concerns about the approach to adjudicating whether a service is related to the cancer episode. While we appreciate the submitter's new, creative suggestion to cluster codes to help make this determination, rather than use an appeals process, such an approach is undeveloped and untested.

Thus, while we were enthusiastic about the concept of linking payment to cancer-related utilization and broadening the scope from chemotherapy to include care coordination and other services, the as-yet-undeveloped nature of the OPCs prevents us from endorsing this proposal on this criterion.

Criterion 4. Value over Volume. **Provide incentives to practitioners to deliver high-quality health care.**

PRT Qualitative Rating: Meets criterion

We found the review of accounts and the process of identifying providers delivering low-value care, as captured by pathway deviations and other metrics, to be compelling and likely to improve the value of cancer care. Nonetheless, the payment model challenges addressed in the previous criterion, such as the practical issues associated with isolating cancer care expenditures from expenditures for other conditions, complicate the model's

effort to improve value. We would also note that how deviations from OPC pathways are handled is likely to affect the value proposition of the model, since unexpected events may in some cases trigger a change in pathway that may appear to be noncompliance, depending on how comprehensively the OPCs are defined.

Criterion 5. Flexibility. **Provide the flexibility needed for practitioners to deliver high-quality health care.**

PRT Qualitative Rating: Meets criterion

The combination of the evidence-based pathways and a process for accommodating deviations from those pathways balanced the need for incentivizing high-quality care while also allowing for physician autonomy in tailoring that care. We would like to see a more nuanced process for accommodating deviations in the quality measurement process; while clinicians have the opportunity to enter a justification for going off-pathway, it was not clear how these justifications would be factored into the quality scoring process to avoid penalizing practices for appropriate deviations. If unaddressed, this could create misalignment between the provider's best clinical judgment and the model's financial incentives.

Criterion 6. Ability to Be Evaluated. **Have evaluable goals for quality of care, cost, and any other goals of the PFPM.**

PRT Qualitative Rating: Meets criterion

The submitter has articulated metrics for capturing quality of care, cost, and patient satisfaction for the proposed model. The as-yet-undeveloped nature of the OPCs, and the lingering concerns about specific elements of the payment formula, do give us a bit of pause. In addition, we have concerns about using the OCM patient cohort as the comparator and would prefer to also see non-OCM cohorts used in the control group.

Criterion 7. Integration and Care Coordination. **Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.**

PRT Qualitative Rating: Meets criterion

We were enthusiastic about the proposal's emphasis on cancer care to include more than just chemotherapy, as reflected in aspects such as how an episode is defined and the direct incentives around care coordination that are not linked with a specific treatment approach. Furthermore, we appreciated that this model was inclusive of independent practice physicians, rather than being designed with integrated health systems in mind.

One concern is that the model's effort to delineate cancer and non-cancer care may disincentivize care coordination beyond the core team of cancer care providers, a potential

problem in a Medicare population in which cancer occurs in individuals who often have multiple, chronic conditions. We are also concerned that the emphasis on spending, and granular detail on spending that is available to participating entities, may inhibit integration and coordination. Specifically, the possible exclusion of high-spending clinicians may not necessarily generate the highest-quality team.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating: Meets criterion

We deemed this proposal as meeting the criterion for patient choice. It is explicitly stated that patient preferences for providers and hospitals will be solicited and accommodated when feasible. Furthermore, the proposal briefly describes a patient "app" that will facilitate timelier and more direct patient-initiated communication with the clinical team. Nonetheless, we would have liked to see a more robust and detailed plan for shared decision-making, especially given the importance of patient preferences at many decision points in a cancer care trajectory, such as chemotherapy initiation near the end of life. An additional concern is the potentially cumbersome process of switching OPCs due to a change in care plan or disease status. This may inhibit patient choice if it delays a patient's desired changes in their care plan.

In addition, the process for and implications of patients exiting the model were not fully described and could introduce unintended incentives to disenroll patients who are relatively more expensive within a given OPC. This issue may be compounded in the absence of streamlined distinctions between cancer and non-cancer care.

Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.

PRT Qualitative Rating: Meets criterion

The evidence-based care pathways are likely to yield improvements in patient safety to the extent that they steer providers to care regimens that reflect the latest evidence and guidelines on safety of care. The data capture supporting these pathways and their quality compliance metric is also intended to facilitate monitoring that, in theory, can support patient safety goals. The transparency and detail of the virtual accounts, which will include data on providers both in and out of the APM entity practice, offers additional visibility that in theory could improve patient safety to the extent that it is used to evaluate collaborating providers.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Qualitative Rating: Meets criterion

This proposal employs health information technology in a variety of ways to both support the model's infrastructure and facilitate its ongoing operation. The machine learning and cognitive computing platform are vital to the development and updating of the OPCs, and participating practices in the pilot version of this proposal will all be advanced users of EHRs. The virtual accounts are another technological backbone of the proposed model, though on this point we did want more detail as to the interoperability of systems across participating providers.

E. PRT Comments

This proposal is a deeply thoughtful response to the potential for and challenges of incorporating the principles of alternative payment models into how we deliver and pay for cancer care. It is highly responsive to the CMMI request for information (RFI) emphasizing small-scale testing of payment interventions. The PRT found a number of aspects of the proposal conceptually appealing and believes that they would represent substantial improvements on the currently operational OCM. The submitter made persuasive arguments about the need for more flexibility and granularity than OCM currently provides, and also for the importance of a cancer model that addresses the entire care continuum (rather than just chemotherapy) while only holding participants accountable for the utilization under their purview.

Despite our agreement with the submitter as to the general direction such a model should take, we have significant concerns about how these specific aspects are executed in the submitted model. Our largest concern in this regard is that the OPCs have not yet been developed, and the time-intensive nature of developing them will limit the agility of this model in terms of keeping pace with the latest evidence and new treatments as they become available. Important details were lacking as to the process of developing the OPCs, and we had other concerns about generalizability if this model were to be implemented on a national scale.

Nonetheless, the submitter has thought deeply about the perceived weaknesses in OCM, and we concur with the general points in terms of both the need for and the challenges associated with a more precise approach to cancer payment that reflects the nuance in treatment based on complexity.

Ultimately, we believe that developing stronger APMs will require CMS to develop the infrastructure for collecting and evaluating sources of clinical data that it currently lacks the capacity to incorporate. While there is a stated interest from CMS in models that could be devised using administrative claims data alone, timely collection of clinical data on a large enough sample is essential for designing payment models that are tailored to the

complexity of different conditions. In this case, the type of granular cancer model advocated for here would require additional clinical data that CMS does not currently collect. Cancer as a clinical area represents a superb prototype for testing whether CMMI can develop this data infrastructure.

We understand that CMMI is continually reviewing OCM for potential revision, so the considerations mentioned here may already be underway. Preceded by Hackensack Meridian Health and Cota Inc.'s "Oncology Bundled Payment Program Using CNA-Guided Care," MASON proposal represents the second sophisticated and thoughtful proposal reviewed by PTAC to create a more granular and flexible approach to cancer payment than OCM currently affords.

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