

LETTER OF INTENT

December 28, 2017

Physician-Focused Payment Model Technical Advisory Committee, PTAC@hhs.gov
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Letter of Intent – Barbara L. McAneny MD MACP FASCO; CEO [Innovative Oncology Business Solutions, Inc.](#) (IOBS). Topic: Making Accountable Sustainable Oncology Networks (MASON)

Dear Committee Members,

On behalf of Innovative Oncology Business Solutions, Inc, I would like to express intent to submit a Physician-Focused Payment Model, MASON, for PTAC review on January 29, 2018.

Payment Model Overview: As the developer of the [COME HOME Model](#) and a contributor to and participant in the [Oncology Care Model](#), it has become apparent to me that an alternative payment model option is needed for practices that have already partly transformed into value-based practices. MASON proposes to use the processes and data collection systems developed for COME HOME combined with Medicare Claims data, to develop more granular and accurate target costs so that the practices could be at risk for patient care but not for the actuarial risk of having an adverse selection of patients. Target costs will be determined and continually improved by an iterative process that combines claims data and clinical data to create Oncology Payment Categories (OPCs). These OPCs would be modified by Hierarchical Condition Categories (HCCs), approved by CMS, and each patient would be assigned an OPC as a virtual account visible to the practice. Because the practices can only select less expensive drug options in a minority of clinical situations, and because new, very effective therapies are expensive, the majority of pharmacy costs are not under the control of the practices. Therefore, the cost of drugs would be excluded from the OPC and paid at slightly over invoice prices, allowing for greater transparency. The OPC would be focused on the costs of care that can be controlled by the oncology practice. Prospective payments for the MASON oncology medical home processes, as described in COME HOME and ASCO's Patient Centered Oncology Payment proposal, would be made for every patient enrolled in an OPC. The practice infrastructure required to decrease hospitalization and to coordinate and manage care, requires dependable, prospective financial support, and cannot wait for shared savings. Current fee for service payments and a facility fee to cover the overhead for pharmacy and infusion suites, as well as the MASON oncology medical home payments, would be included in the OPC target. Pathway compliance reporting as developed in COME HOME is the best way to ensure the selection of the correct evidence-based genomic testing, imaging and therapy. No shared savings would be available unless the practice meets the quality standards of pathway compliance and patient satisfaction. At the conclusion of an episode of care, the actual adjudicated costs of care would be compared to the OPC, and money either returned to CMS, or savings would be shared. The pilot project would purchase adequate reinsurance so that failure to control costs would neither cost CMS money nor put the practice out of business, ensuring that the infrastructure of cancer care delivery is not

jeopardized. Over time, realistic costs of the components of cancer care would be determined, and physicians would accept risk to manage patients based on achievable, sustainable, and clinically appropriate algorithms. Oncologists would also have data about which members of the patient care teams were more cost effective, and use that information to create more efficient networks. Experience with OPCs would thereby accelerate the development of sustainable bundled payment methodologies.

Goals of the MASON Model:

1. Pilot an extension of COME HOME and OCM to develop an alternative payment methodology for oncology, with realistic targets, acceptable risk and improved patient choice and satisfaction;
2. Develop a transparent, accountable payment method for the essential components of cancer care (physician visits, pharmacy, infusion, radiation, imaging and Oncology Medical Home), that preserves patient and physician choice and the infrastructure of cancer care delivery, including small or independent practices;
3. Develop mechanisms of determining quality that are more accurate, electronically documented and result in practice transformation;
4. Develop an APM to be offered to the oncology community that builds on the savings of COME HOME and incorporates more than nominal risk, with an option for bundled payments.

Expected Participants: The practices of 220+ oncologists who are members of the [National Cancer Care Alliance](#) (NCCA) and their patients.

Implementation Strategy: NCCA practices have agreed in concept to participate, and have implemented some COME HOME processes. Software developed for COME HOME will provide quality data as pathway compliance. The practices have agreed to maintain, update and develop new pathways. A vendor to aggregate claims and clinical data has been identified and is able to provide the OPCs. IOBS serves as the administrator for NCCA and will implement the pathways, coordinate the vendors and data scientists to create the OPCs, and collect and submit the data. OCM practices that are not MASON participants can serve as the control group.

Timeline: Some NCCA practices have maintained COME HOME processes and could begin data collection within 3-6 months. Others will need the first 6-12 months to implement processes on a staggered schedule. By year 2, additional pathways will have been developed and data collection to create OPCs will begin. By year 3, practices will have sufficient expertise and IOBS will have sufficient experience with OPCs that risk sharing can begin. By year 4 and 5, ongoing fine-tuning of OPCs will occur as the model is scaled to interested oncology practices nationwide.



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