

**Initial Feedback¹ of the Preliminary Review Team of the Physician-Focused Payment Model Technical Advisory Committee (PTAC)
On the
MASON - Making Accountable Sustainable Oncology Networks
Proposal**

Submitted by Innovative Oncology Business Solutions Inc. (IOBS)

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A. 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 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

¹ This initial feedback is preliminary feedback from a Preliminary Review Team (PRT) subcommittee of the PTAC and does not represent the consensus or position of the full PTAC; Initial feedback is not binding on the full Committee. PTAC may reach different conclusions from that communicated from the PRT as initial feedback; and Provision of initial feedback will not limit the PRT or PTAC from identifying additional weaknesses in a submitted proposal after the feedback is provided. Revising a proposal to respond to the initial feedback from a PRT does not guarantee a favorable recommendation from the full PTAC to the Secretary of Health and Human Services (HHS).

proposed model is not based on a pre-defined 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 would note on this point, however, that setting the threshold for satisfactory performance at 80% seems too permissive, since deviations from the pathways was framed as rare. We also 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. The use of current claims from the participating practices as the basis for OPC development also potentially limits the opportunity for generating cost savings. 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. 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.

Nonetheless, we had numerous concerns about the payment model. First, we would like more empirical justification for the payment amounts associated with the different reimbursed services, such as the care management payments. Second, 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 are also wary of using existing claims as the basis for establishing the OPC payment levels, and adjusting them in real-time, since it essentially uses fee-for-service amounts as the basis for the payment structure, which may limit the opportunity for savings. Finally, we have significant concerns about the approach to adjudicating whether a service is related to cancer, and thus should be included in the calculation- the submitter proposes handling this on a case by case basis, which may be feasible for a demonstration but is unwieldy and impractical for a national model. A national model of this type requires a systematic way of designating claims as either related or unrelated to cancer care.

In addition, while we are supportive of the notion of an administrative fee related to drug purchasing and administration, we believe that setting this fee as a percentage of a drug's cost may incentivize prescribing of more expensive drugs. We also felt the 2% hold-back for quality was not substantial enough.

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 complexity of the model and 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: Does not meet criterion

We found the review of accounts and 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. Without the OPCs defined for review, it is thus difficult to assess the impact of this model on value.

In addition, the model's partitioning of cancer care by oncologists from cancer and related care by other clinicians may have a negative effect on value. For example, certain types of cancer care lend themselves to palliative integration, or require much closer coordination with surgeons. While this may be accounted for in the OPCs, this was not immediately clear, and reflects a tension between defining cancer care too narrowly, and thus excluding related ancillary services, and too broadly, in which case it mirrors the issues with TCOC and diminishes the notion of assigning accountability only for utilization within the participating provider's purview.

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 judgement 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: Does not meet criterion

The as-yet undeveloped nature of the OPCs, and the lingering concerns about specific elements of the payment formula, as outlined in criterion 3 above, render us unable to assert that this model is evaluable in terms of the PFPM goals. It is likely that further detail on the payment model would reveal that it either is currently evaluable or can be modified to be evaluable. 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 caveat, as mentioned in criterion 4 above, 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. 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 electronic health records. 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.

B. PRT Comments

This proposal is highly responsive to the CMMI 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.

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